

ACE PROPERTY AND 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 2024 ²						\$7060 ²	\$3530 ²					

¹Plans F and G also have a high deductible option which requires first paying a plan deductible of \$2800 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. High deductible Plan G is the same as high deductible Plan F except that where the annual out-of-pocket expenses are met with Medicare Part A expenses only, any subsequent Medicare Part B deductible expense incurred by the beneficiary after the required annual out-of-pocket expenses is met may not be paid for by the high deductible Plan G.

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

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

ACE PROPERTY AND CASUALTY INSURANCE COMPANY**VIRGINIA Standard Plans MALE Rates - ANNUAL**

FOR USE IN ZIP CODES: 220-225, 232-237

Attained Age	Preferred					Attained Age	Standard				
	HD						HD				
	Plan A	Plan F	Plan G	Plan G	Plan N		Plan A	Plan F	Plan G	Plan G	Plan N
0-64	1,543	N/A	N/A	N/A	N/A	0-64	1,774	N/A	N/A	N/A	N/A
65	1,543	1,788	1,558	618	1,180	65	1,774	2,056	1,791	711	1,357
66	1,543	1,788	1,558	618	1,180	66	1,774	2,056	1,791	711	1,357
67	1,543	1,788	1,558	618	1,180	67	1,774	2,056	1,791	711	1,357
68	1,543	1,838	1,558	618	1,186	68	1,774	2,112	1,791	711	1,364
69	1,551	1,892	1,566	620	1,202	69	1,783	2,175	1,801	714	1,383
70	1,571	1,949	1,586	629	1,224	70	1,807	2,241	1,824	723	1,408
71	1,617	2,008	1,634	647	1,261	71	1,861	2,308	1,879	745	1,450
72	1,674	2,077	1,690	670	1,305	72	1,926	2,388	1,945	771	1,501
73	1,733	2,150	1,750	694	1,350	73	1,993	2,472	2,012	797	1,553
74	1,793	2,224	1,811	718	1,398	74	2,062	2,559	2,083	825	1,606
75	1,866	2,314	1,884	746	1,453	75	2,145	2,662	2,165	858	1,671
76	1,940	2,407	1,959	777	1,511	76	2,231	2,767	2,254	893	1,738
77	2,017	2,503	2,037	807	1,572	77	2,319	2,878	2,343	928	1,807
78	2,098	2,603	2,118	840	1,635	78	2,413	2,993	2,437	966	1,881
79	2,181	2,707	2,203	873	1,700	79	2,509	3,113	2,534	1,004	1,954
80	2,268	2,815	2,292	908	1,767	80	2,609	3,238	2,636	1,044	2,033
81	2,370	2,942	2,394	949	1,848	81	2,726	3,383	2,754	1,092	2,124
82	2,478	3,073	2,502	991	1,931	82	2,849	3,535	2,877	1,140	2,220
83	2,589	3,211	2,615	1,036	2,018	83	2,977	3,693	3,007	1,191	2,320
84	2,704	3,355	2,732	1,083	2,108	84	3,111	3,859	3,142	1,245	2,425
85	2,827	3,506	2,856	1,131	2,204	85	3,250	4,033	3,284	1,300	2,534
86	2,954	3,665	2,984	1,182	2,303	86	3,398	4,215	3,431	1,360	2,649
87	3,087	3,829	3,118	1,236	2,407	87	3,549	4,405	3,586	1,420	2,767
88	3,225	4,002	3,258	1,290	2,514	88	3,709	4,602	3,747	1,485	2,892
89	3,371	4,182	3,405	1,349	2,628	89	3,876	4,809	3,915	1,551	3,023
90	3,522	4,370	3,558	1,410	2,747	90	4,050	5,026	4,092	1,622	3,158
91	3,681	4,567	3,717	1,474	2,869	91	4,234	5,253	4,275	1,694	3,301
92	3,847	4,772	3,886	1,539	3,000	92	4,423	5,490	4,468	1,771	3,448
93	4,019	4,988	4,060	1,609	3,134	93	4,623	5,736	4,668	1,850	3,605
94	4,200	5,212	4,243	1,681	3,276	94	4,831	5,994	4,879	1,933	3,767
95	4,390	5,447	4,434	1,757	3,423	95	5,048	6,264	5,099	2,020	3,937
96	4,587	5,692	4,633	1,835	3,578	96	5,275	6,545	5,328	2,111	4,114
97	4,793	5,949	4,841	1,918	3,739	97	5,512	6,840	5,568	2,206	4,300
98	5,009	6,217	5,060	2,004	3,908	98	5,760	7,148	5,819	2,305	4,492
99	5,235	6,496	5,288	2,095	4,083	99	6,020	7,470	6,081	2,409	4,695

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

ACE PROPERTY AND CASUALTY INSURANCE COMPANY**VIRGINIA Standard Plans MALE Rates - ANNUAL**

FOR USE IN ZIP CODES: ALL EXCEPT 220-225, 232-237

Attained Age	Preferred					Attained Age	Standard				
	HD						HD				
	Plan A	Plan F	Plan G	Plan G	Plan N		Plan A	Plan F	Plan G	Plan G	Plan N
0-64	1,302	N/A	N/A	N/A	N/A	0-64	1,497	N/A	N/A	N/A	N/A
65	1,302	1,509	1,315	521	996	65	1,497	1,736	1,512	600	1,145
66	1,302	1,509	1,315	521	996	66	1,497	1,736	1,512	600	1,145
67	1,302	1,509	1,315	521	996	67	1,497	1,736	1,512	600	1,145
68	1,302	1,551	1,315	521	1,001	68	1,497	1,783	1,512	600	1,151
69	1,309	1,597	1,321	523	1,014	69	1,505	1,836	1,520	603	1,167
70	1,326	1,645	1,339	531	1,033	70	1,525	1,892	1,540	610	1,188
71	1,365	1,694	1,379	546	1,064	71	1,571	1,948	1,586	629	1,224
72	1,413	1,753	1,427	565	1,101	72	1,626	2,016	1,641	651	1,267
73	1,463	1,815	1,477	586	1,140	73	1,682	2,087	1,698	673	1,311
74	1,514	1,877	1,528	606	1,180	74	1,741	2,159	1,758	697	1,356
75	1,575	1,953	1,590	630	1,227	75	1,810	2,247	1,828	724	1,410
76	1,637	2,031	1,654	655	1,275	76	1,883	2,336	1,902	754	1,467
77	1,702	2,113	1,719	681	1,327	77	1,957	2,429	1,977	784	1,525
78	1,771	2,197	1,788	709	1,380	78	2,036	2,526	2,057	815	1,587
79	1,841	2,285	1,860	737	1,435	79	2,117	2,627	2,139	848	1,650
80	1,915	2,376	1,935	766	1,492	80	2,202	2,733	2,225	881	1,716
81	2,001	2,483	2,021	801	1,560	81	2,301	2,855	2,324	921	1,793
82	2,091	2,594	2,112	836	1,629	82	2,404	2,983	2,429	963	1,873
83	2,185	2,711	2,207	875	1,703	83	2,513	3,117	2,538	1,006	1,959
84	2,283	2,832	2,306	914	1,780	84	2,626	3,257	2,652	1,051	2,047
85	2,386	2,959	2,410	955	1,860	85	2,743	3,404	2,771	1,097	2,138
86	2,493	3,093	2,518	998	1,944	86	2,868	3,557	2,896	1,148	2,236
87	2,605	3,232	2,631	1,043	2,031	87	2,996	3,718	3,026	1,199	2,336
88	2,722	3,378	2,750	1,089	2,122	88	3,131	3,885	3,163	1,253	2,441
89	2,845	3,530	2,874	1,139	2,218	89	3,272	4,059	3,305	1,309	2,552
90	2,972	3,688	3,003	1,190	2,318	90	3,419	4,242	3,453	1,369	2,666
91	3,107	3,855	3,138	1,244	2,422	91	3,573	4,434	3,608	1,429	2,786
92	3,247	4,028	3,280	1,299	2,532	92	3,734	4,634	3,771	1,495	2,911
93	3,393	4,210	3,426	1,358	2,646	93	3,902	4,841	3,940	1,561	3,043
94	3,545	4,399	3,581	1,419	2,765	94	4,077	5,060	4,118	1,631	3,179
95	3,706	4,597	3,742	1,483	2,890	95	4,261	5,287	4,304	1,705	3,323
96	3,872	4,804	3,910	1,549	3,020	96	4,452	5,525	4,497	1,782	3,472
97	4,046	5,021	4,086	1,619	3,156	97	4,652	5,773	4,700	1,862	3,629
98	4,228	5,247	4,271	1,692	3,298	98	4,862	6,034	4,911	1,945	3,792
99	4,418	5,482	4,463	1,768	3,446	99	5,081	6,305	5,132	2,033	3,963

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

VIRGINIA Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: 220-225, 232-237

Attained Age	Preferred					Attained Age	Standard				
	HD						HD				
	Plan A	Plan F	Plan G	Plan G	Plan N		Plan A	Plan F	Plan G	Plan G	Plan N
0-64	1,371	N/A	N/A	N/A	N/A	0-64	1,577	N/A	N/A	N/A	N/A
65	1,371	1,589	1,386	549	1,049	65	1,577	1,827	1,593	631	1,206
66	1,371	1,589	1,386	549	1,049	66	1,577	1,827	1,593	631	1,206
67	1,371	1,589	1,386	549	1,049	67	1,577	1,827	1,593	631	1,206
68	1,371	1,632	1,386	549	1,055	68	1,577	1,877	1,593	631	1,213
69	1,378	1,681	1,392	551	1,068	69	1,585	1,934	1,601	635	1,229
70	1,396	1,732	1,410	559	1,088	70	1,606	1,992	1,622	643	1,251
71	1,439	1,784	1,452	575	1,120	71	1,654	2,052	1,670	662	1,289
72	1,488	1,846	1,503	596	1,160	72	1,712	2,123	1,728	685	1,333
73	1,540	1,911	1,555	617	1,200	73	1,771	2,197	1,789	709	1,380
74	1,594	1,978	1,610	638	1,242	74	1,832	2,274	1,851	733	1,428
75	1,657	2,057	1,674	663	1,291	75	1,907	2,366	1,925	763	1,485
76	1,724	2,139	1,742	690	1,343	76	1,982	2,460	2,003	794	1,545
77	1,792	2,224	1,811	718	1,397	77	2,061	2,559	2,083	825	1,606
78	1,864	2,314	1,884	746	1,453	78	2,145	2,661	2,165	858	1,671
79	1,939	2,407	1,958	777	1,511	79	2,231	2,767	2,252	892	1,738
80	2,017	2,502	2,037	807	1,571	80	2,319	2,878	2,342	928	1,807
81	2,107	2,614	2,129	843	1,641	81	2,423	3,006	2,448	970	1,889
82	2,202	2,732	2,224	881	1,716	82	2,533	3,142	2,558	1,013	1,974
83	2,300	2,854	2,323	920	1,793	83	2,646	3,283	2,672	1,059	2,062
84	2,405	2,983	2,429	962	1,875	84	2,765	3,430	2,793	1,106	2,156
85	2,513	3,117	2,537	1,006	1,959	85	2,890	3,586	2,918	1,156	2,252
86	2,625	3,257	2,652	1,051	2,047	86	3,019	3,747	3,050	1,208	2,354
87	2,743	3,404	2,772	1,098	2,139	87	3,155	3,915	3,187	1,263	2,460
88	2,867	3,557	2,897	1,147	2,235	88	3,297	4,090	3,330	1,320	2,571
89	2,996	3,717	3,026	1,199	2,336	89	3,445	4,275	3,480	1,378	2,687
90	3,131	3,885	3,162	1,253	2,441	90	3,601	4,468	3,637	1,441	2,808
91	3,272	4,059	3,304	1,309	2,551	91	3,763	4,669	3,801	1,505	2,934
92	3,419	4,243	3,453	1,368	2,666	92	3,931	4,879	3,971	1,573	3,065
93	3,573	4,434	3,609	1,429	2,786	93	4,110	5,099	4,150	1,644	3,204
94	3,733	4,633	3,771	1,494	2,912	94	4,293	5,328	4,338	1,719	3,349
95	3,902	4,842	3,942	1,562	3,043	95	4,488	5,568	4,532	1,796	3,499
96	4,077	5,059	4,118	1,631	3,180	96	4,689	5,818	4,736	1,876	3,657
97	4,261	5,287	4,304	1,705	3,323	97	4,900	6,081	4,949	1,961	3,821
98	4,453	5,525	4,498	1,782	3,472	98	5,120	6,354	5,172	2,050	3,994
99	4,652	5,773	4,699	1,863	3,630	99	5,351	6,641	5,404	2,141	4,174

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

VIRGINIA Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: ALL EXCEPT 220-225, 232-237

Attained Age	Preferred					Attained Age	Standard				
	HD						HD				
	Plan A	Plan F	Plan G	Plan G	Plan N		Plan A	Plan F	Plan G	Plan G	Plan N
0-64	1,157	N/A	N/A	N/A	N/A	0-64	1,331	N/A	N/A	N/A	N/A
65	1,157	1,341	1,170	463	885	65	1,331	1,542	1,345	533	1,018
66	1,157	1,341	1,170	463	885	66	1,331	1,542	1,345	533	1,018
67	1,157	1,341	1,170	463	885	67	1,331	1,542	1,345	533	1,018
68	1,157	1,378	1,170	463	891	68	1,331	1,584	1,345	533	1,024
69	1,163	1,419	1,175	465	901	69	1,338	1,632	1,351	536	1,037
70	1,179	1,462	1,190	472	919	70	1,355	1,681	1,369	543	1,056
71	1,214	1,506	1,226	485	945	71	1,396	1,732	1,409	559	1,088
72	1,256	1,558	1,268	503	979	72	1,445	1,792	1,459	578	1,125
73	1,300	1,613	1,313	520	1,013	73	1,494	1,854	1,510	598	1,164
74	1,346	1,670	1,359	539	1,049	74	1,547	1,919	1,562	619	1,206
75	1,399	1,737	1,413	560	1,090	75	1,609	1,997	1,625	644	1,253
76	1,455	1,805	1,470	583	1,134	76	1,673	2,076	1,691	670	1,304
77	1,513	1,877	1,528	606	1,179	77	1,740	2,159	1,758	697	1,356
78	1,574	1,953	1,590	630	1,227	78	1,810	2,246	1,828	724	1,410
79	1,636	2,031	1,653	655	1,275	79	1,883	2,336	1,901	753	1,467
80	1,702	2,112	1,719	681	1,326	80	1,957	2,429	1,976	784	1,525
81	1,778	2,206	1,797	712	1,385	81	2,045	2,537	2,066	819	1,594
82	1,859	2,306	1,877	743	1,449	82	2,138	2,652	2,159	855	1,666
83	1,942	2,409	1,961	777	1,514	83	2,233	2,771	2,256	894	1,740
84	2,030	2,517	2,050	812	1,583	84	2,334	2,895	2,357	934	1,820
85	2,121	2,631	2,142	849	1,653	85	2,439	3,026	2,463	976	1,901
86	2,216	2,749	2,238	887	1,728	86	2,548	3,162	2,574	1,020	1,987
87	2,316	2,873	2,340	927	1,805	87	2,663	3,305	2,690	1,066	2,076
88	2,420	3,002	2,445	968	1,887	88	2,783	3,452	2,811	1,114	2,170
89	2,529	3,137	2,554	1,012	1,972	89	2,908	3,608	2,938	1,163	2,268
90	2,643	3,279	2,669	1,057	2,060	90	3,039	3,771	3,070	1,216	2,370
91	2,762	3,426	2,789	1,105	2,153	91	3,176	3,941	3,208	1,271	2,476
92	2,885	3,581	2,914	1,155	2,250	92	3,318	4,118	3,352	1,328	2,587
93	3,016	3,742	3,046	1,207	2,352	93	3,469	4,304	3,503	1,387	2,704
94	3,151	3,910	3,183	1,261	2,458	94	3,623	4,497	3,661	1,451	2,826
95	3,293	4,086	3,327	1,318	2,568	95	3,788	4,700	3,825	1,516	2,954
96	3,441	4,270	3,476	1,377	2,684	96	3,958	4,910	3,997	1,584	3,087
97	3,596	4,463	3,633	1,439	2,804	97	4,135	5,132	4,177	1,655	3,225
98	3,759	4,663	3,796	1,504	2,931	98	4,322	5,363	4,365	1,730	3,371
99	3,927	4,873	3,966	1,572	3,064	99	4,516	5,605	4,561	1,807	3,523

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

PREMIUM INFORMATION

We, ACE Property and Casualty Insurance Company, can only raise your premium if we raise the premium for all policies like yours in the Commonwealth. The change in the table of rates will apply to all covered persons in the same class. Class is defined as attained age, gender, 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. In addition, the premium may change on any premium due date if a new table of rates is applicable to the policy.

Premiums for other Medicare supplement policies that are issue age or community rated do not increase due to changes in your age.

While the cost of this policy at the covered individual's present age may be lower than the cost of a Medicare supplement policy that is based on issue age or community rated, it is important to compare the potential cost of these policies over the life of the policy.

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 and 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 and 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 and 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 and Casualty Insurance Company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information.

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

PLAN A

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 st thru 90 th day 91 st day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the additional 365 days	All but \$1632 All but \$408 a day All but \$816 a day \$0 \$0	\$0 \$408 a day \$816 a day 100% of Medicare eligible expenses \$0	\$1632 (Part A deductible) \$0 \$0 \$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21 st thru 100 th day 101 st day and after	All approved amounts All but \$204 a day \$0	\$0 \$0 \$0	\$0 Up to \$204 a day All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

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

PLAN A

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

*Once you have been billed \$240 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 \$240 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 \$0 Generally 80%	 \$0 Generally 20%	 \$240 (Part B deductible) \$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD First 3 pints Next \$240 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$240 (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 \$240 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 100% \$0 80%	 \$0 \$0 20%	 \$0 \$240 (Part B deductible) \$0

PLAN F

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 st thru 90 th day 91 st day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the additional 365 days	All but \$1632 All but \$408 a day All but \$816 a day \$0 \$0	\$1632 (Part A deductible) \$408 a day \$816 a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$0 \$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21 st thru 100 th day 101 st day and after	All approved amounts All but \$204 a day \$0	\$0 Up to \$204 a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

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

PLAN F

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

*Once you have been billed \$240 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 \$240 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 \$0 Generally 80%	 \$240 (Part B deductible) Generally 20%	 \$0 \$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	\$0	100%	\$0
BLOOD First 3 pints Next \$240 of Medicare Approved amounts* Remainder of Medicare Approved amounts	\$0 \$0 80%	All costs \$240 (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 \$240 of Medicare Approved Amounts*	\$0	\$240 (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 61 st thru 90 th day 91 st day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the additional 365 days	All but \$1632 All but \$408 a day All but \$816 a day \$0 \$0	\$1632 (Part A deductible) \$408 a day \$816 a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$0 \$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21 st thru 100 th day 101 st day and after	All approved amounts All but \$204 a day \$0	\$0 Up to \$204 a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

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

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

*Once you have been billed \$240 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 \$240 of Medicare Approved Amounts*	\$0	\$0	\$240 (Unless Part B deductible has been met)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	\$0	100%	\$0
BLOOD First 3 pints	\$0	All costs	\$0
Next \$240 of Medicare Approved Amounts*	\$0	\$0	\$240 (Unless Part B deductible has been met)
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

(continued)

PLAN G
PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies Durable medical equipment	100%	\$0	\$0
- First \$240 of Medicare Approved Amounts*	\$0	\$0	\$240 (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 \$2800 deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are \$2800. 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 \$2800 DEDUCTIBLE ** PLAN PAYS	IN ADDITION TO \$2800 DEDUCTIBLE ** YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 st thru 90 th day 91 st day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the additional 365 days	All but \$1632 All but \$408 a day All but \$816 a day \$0 \$0	\$1632 (Part A deductible) \$408 a day \$816 a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$0 \$0*** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21 st thru 100 th day 101 st day and after	All approved amounts All but \$204 a day \$0	\$0 Up to \$204 a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

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

HIGH DEDUCTIBLE PLAN G

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

*Once you have been billed \$240 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 \$2800 deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are \$2800. 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 \$2800 DEDUCTIBLE ** PLAN PAYS	IN ADDITION TO \$2800 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 \$240 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 Generally 80%	\$0 Generally 20%	\$240 (Unless Part B deductible has been met) \$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	\$0	100%	\$0
BLOOD First 3 pints Next \$240 of Medicare Approved amounts* Remainder of Medicare Approved amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$240 (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 \$2800 DEDUCTIBLE ** PLAN PAYS	IN ADDITION TO \$2800 DEDUCTIBLE ** YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies Durable medical equipment	100%	\$0	\$0
- First \$240 of Medicare Approved Amounts*	\$0	\$0	\$240 (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 \$2800 DEDUCTIBLE ** PLAN PAYS	IN ADDITION TO \$2800 DEDUCTIBLE ** YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

PLAN N

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 st thru 90 th day 91 st day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the additional 365 days	All but \$1632 All but \$408 a day All but \$816 a day \$0 \$0	\$1632 (Part A deductible) \$408 a day \$816 a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$0 \$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21 st thru 100 th day 101 st day and after	All approved amounts All but \$204 a day \$0	\$0 Up to \$204 a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

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

PLAN N

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

*Once you have been billed \$240 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 \$240 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 Generally 80%	\$0 Balance, other than up to \$20 per office visit and up to \$50 per emergency room visit. The copayment of up to \$50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	\$240 (Part B deductible) Up to \$20 per office visit and up to \$50 per emergency room visit. The copayment of up to \$50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD First 3 pints Next \$240 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$240 (Part B deductible) \$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

(continued)

PLAN N
PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies Durable medical equipment	100%	\$0	\$0
- First \$240 of Medicare Approved Amounts*	\$0	\$0	\$240 (Part B deductible)
- Remainder of Medicare Approved Amounts	80%	20%	\$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

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