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

SOUTH CAROLINA Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: 294, 295, 298, 299

	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	1,462	1,783	1,532	543	1,061	65	1,680	2,051	1,761	624	1,219
66	1,462	1,783	1,532	543	1,061	66	1,680	2,051	1,761	624	1,219
67	1,462	1,783	1,532	543	1,061	67	1,680	2,051	1,761	624	1,219
68	1,462	1,838	1,532	543	1,070	68	1,680	2,113	1,761	624	1,231
69	1,469	1,893	1,539	544	1,092	69	1,689	2,176	1,770	627	1,256
70	1,484	1,950	1,555	549	1,114	70	1,707	2,242	1,789	633	1,282
71	1,529	2,008	1,602	567	1,148	71	1,759	2,308	1,843	652	1,319
72	1,583	2,079	1,657	587	1,188	72	1,820	2,390	1,906	675	1,367
73	1,638	2,151	1,715	606	1,229	73	1,884	2,474	1,973	698	1,413
74	1,695	2,226	1,776	629	1,272	74	1,948	2,560	2,042	724	1,462
75	1,764	2,315	1,846	653	1,323	75	2,028	2,663	2,123	750	1,522
76	1,833	2,409	1,920	680	1,376	76	2,107	2,769	2,209	781	1,583
77	1,907	2,504	1,998	706	1,431	77	2,192	2,880	2,297	813	1,646
78	1,984	2,604	2,077	734	1,489	78	2,280	2,994	2,387	845	1,712
79	2,061	2,708	2,160	763	1,548	79	2,372	3,114	2,484	878	1,780
80	2,143	2,817	2,246	794	1,609	80	2,465	3,240	2,584	913	1,852
81	2,240	2,943	2,346	831	1,682	81	2,576	3,385	2,699	955	1,933
82	2,343	3,075	2,452	868	1,758	82	2,693	3,535	2,820	997	2,021
83	2,448	3,212	2,564	907	1,837	83	2,815	3,695	2,949	1,044	2,111
84	2,557	3,357	2,680	947	1,919	84	2,942	3,861	3,079	1,090	2,208
85	2,672	3,508	2,799	990	2,006	85	3,073	4,035	3,219	1,139	2,305
86	2,793	3,667	2,925	1,034	2,095	86	3,212	4,217	3,364	1,190	2,410
87	2,918	3,832	3,056	1,081	2,191	87	3,356	4,408	3,514	1,244	2,519
88	3,048	4,004	3,194	1,129	2,289	88	3,505	4,605	3,672	1,299	2,633
89	3,186	4,185	3,338	1,180	2,392	89	3,664	4,811	3,838	1,358	2,753
90	3,330	4,372	3,489	1,233	2,500	90	3,830	5,029	4,011	1,419	2,875
91	3,480	4,571	3,645	1,290	2,612	91	4,002	5,255	4,193	1,483	3,005
92	3,635	4,775	3,809	1,347	2,730	92	4,181	5,493	4,379	1,549	3,140
93	3,801	4,991	3,982	1,409	2,855	93	4,371	5,738	4,578	1,620	3,283
94	3,971	5,213	4,160	1,472	2,983	94	4,566	5,997	4,783	1,693	3,430
95	4,151	5,450	4,348	1,537	3,116	95	4,773	6,267	4,999	1,768	3,584
96	4,337	5,695	4,543	1,607	3,256	96	4,988	6,548	5,224	1,849	3,745
97	4,533	5,952	4,748	1,680	3,403	97	5,213	6,843	5,460	1,931	3,914
98	4,738	6,219	4,961	1,755	3,557	98	5,448	7,152	5,706	2,018	4,090
99	4,951	6,499	5,185	1,835	3,717	99	5,694	7,475	5,963	2,109	4,276

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

ACE PROPERTY & CASUALTY INSURANCE COMPANY

SOUTH CAROLINA Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: ALL EXCEPT 294, 295, 298, 299

	Preferred				
				HD Plan	
Attained Age	Plan A	Plan F	Plan G	G	Plan N
65	1,343	1,637	1,407	499	974
66	1,343	1,637	1,407	499	974
67	1,343	1,637	1,407	499	974
68	1,343	1,688	1,407	499	983
69	1,349	1,738	1,413	500	1,002
70	1,363	1,791	1,428	505	1,023
71	1,404	1,844	1,471	520	1,054
72	1,453	1,909	1,522	539	1,091
73	1,504	1,975	1,575	557	1,129
74	1,556	2,044	1,631	578	1,168
75	1,620	2,126	1,696	600	1,215
76	1,683	2,212	1,763	624	1,264
77	1,751	2,300	1,835	649	1,314
78	1,822	2,391	1,907	674	1,367
79	1,893	2,487	1,983	701	1,422
80	1,968	2,587	2,063	729	1,478
81	2,058	2,703	2,155	763	1,544
82	2,151	2,824	2,252	797	1,615
83	2,248	2,950	2,355	833	1,687
84	2,348	3,083	2,461	870	1,762
85	2,454	3,221	2,571	909	1,842
86	2,565	3,367	2,686	950	1,924
87	2,680	3,519	2,807	993	2,012
88	2,800	3,678	2,933	1,037	2,102
89	2,926	3,843	3,065	1,084	2,197
90	3,058	4,015	3,204	1,133	2,296
91	3,195	4,197	3,348	1,185	2,399
92	3,338	4,385	3,498	1,237	2,508
93	3,490	4,583	3,657	1,294	2,622
94	3,647	4,788	3,821	1,352	2,740
95	3,812	5,005	3,993	1,411	2,861
96	3,983	5,230	4,172	1,476	2,991
97	4,163	5,466	4,361	1,543	3,125
98	4,351	5,711	4,556	1,612	3,267
99	4,547	5,968	4,762	1,685	3,414

	Standard				
				HD Plan	
Attained Age	Plan A	Plan F	Plan G	G	Plan N
65	1,543	1,884	1,617	573	1,119
66	1,543	1,884	1,617	573	1,119
67	1,543	1,884	1,617	573	1,119
68	1,543	1,940	1,617	573	1,131
69	1,551	1,998	1,626	576	1,153
70	1,568	2,059	1,643	581	1,177
71	1,616	2,120	1,692	599	1,211
72	1,672	2,195	1,751	620	1,255
73	1,730	2,272	1,812	641	1,297
74	1,789	2,351	1,875	665	1,342
75	1,863	2,446	1,950	689	1,397
76	1,935	2,543	2,029	717	1,454
77	2,013	2,645	2,109	747	1,512
78	2,094	2,750	2,192	776	1,572
79	2,178	2,860	2,281	806	1,634
80	2,264	2,975	2,373	839	1,701
81	2,366	3,108	2,479	877	1,776
82	2,473	3,247	2,590	915	1,856
83	2,585	3,393	2,708	958	1,938
84	2,702	3,545	2,828	1,001	2,027
85	2,822	3,706	2,956	1,046	2,117
86	2,950	3,872	3,089	1,093	2,214
87	3,082	4,049	3,227	1,143	2,314
88	3,219	4,229	3,372	1,193	2,418
89	3,365	4,419	3,524	1,247	2,528
90	3,517	4,619	3,683	1,303	2,640
91	3,675	4,826	3,850	1,362	2,759
92	3,839	5,045	4,022	1,423	2,884
93	4,014	5,270	4,204	1,487	3,015
94	4,194	5,508	4,392	1,555	3,150
95	4,383	5,755	4,591	1,624	3,291
96	4,580	6,013	4,798	1,698	3,439
97	4,788	6,285	5,015	1,774	3,594
98	5,003	6,568	5,240	1,853	3,756
99	5,230	6,864	5,476	1,937	3,927

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

Household Discount Factor 0.93

ACE PROPERTY & CASUALTY INSURANCE COMPANY

SOUTH CAROLINA Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: 294, 295, 298, 299

	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	1,300	1,586	1,362	482	942	65	1,495	1,824	1,566	554	1,084
66	1,300	1,586	1,362	482	942	66	1,495	1,824	1,566	554	1,084
67	1,300	1,586	1,362	482	942	67	1,495	1,824	1,566	554	1,084
68	1,300	1,633	1,362	482	952	68	1,495	1,879	1,566	554	1,095
69	1,306	1,681	1,368	484	970	69	1,501	1,934	1,573	556	1,116
70	1,319	1,733	1,382	489	991	70	1,517	1,993	1,589	563	1,139
71	1,359	1,784	1,423	503	1,019	71	1,564	2,052	1,637	580	1,173
72	1,407	1,847	1,473	522	1,056	72	1,618	2,124	1,694	600	1,214
73	1,457	1,912	1,525	540	1,093	73	1,675	2,199	1,754	621	1,256
74	1,507	1,979	1,578	559	1,130	74	1,731	2,275	1,815	642	1,300
75	1,568	2,058	1,641	581	1,175	75	1,803	2,366	1,888	668	1,352
76	1,629	2,140	1,707	603	1,223	76	1,874	2,461	1,963	694	1,406
77	1,694	2,226	1,775	628	1,272	77	1,948	2,560	2,041	723	1,463
78	1,763	2,315	1,845	653	1,323	78	2,027	2,662	2,122	751	1,522
79	1,831	2,407	1,919	679	1,376	79	2,107	2,768	2,207	781	1,583
80	1,906	2,503	1,997	706	1,431	80	2,190	2,880	2,296	812	1,645
81	1,990	2,616	2,086	738	1,495	81	2,290	3,008	2,399	849	1,719
82	2,083	2,733	2,180	772	1,562	82	2,395	3,144	2,507	887	1,797
83	2,176	2,856	2,278	806	1,632	83	2,502	3,285	2,621	926	1,876
84	2,274	2,984	2,381	842	1,706	84	2,614	3,431	2,738	969	1,962
85	2,376	3,119	2,487	880	1,783	85	2,732	3,587	2,860	1,013	2,051
86	2,483	3,259	2,600	920	1,863	86	2,855	3,748	2,991	1,058	2,143
87	2,594	3,406	2,716	961	1,947	87	2,983	3,918	3,124	1,106	2,239
88	2,709	3,560	2,839	1,004	2,035	88	3,116	4,093	3,264	1,155	2,340
89	2,832	3,720	2,966	1,050	2,126	89	3,256	4,277	3,411	1,207	2,446
90	2,961	3,888	3,100	1,097	2,222	90	3,404	4,470	3,565	1,261	2,556
91	3,094	4,061	3,240	1,147	2,323	91	3,557	4,671	3,726	1,319	2,670
92	3,232	4,245	3,386	1,198	2,428	92	3,716	4,882	3,893	1,377	2,791
93	3,377	4,435	3,539	1,252	2,537	93	3,885	5,101	4,069	1,440	2,917
94	3,531	4,635	3,698	1,308	2,651	94	4,059	5,331	4,251	1,504	3,048
95	3,688	4,843	3,864	1,367	2,770	95	4,243	5,571	4,444	1,572	3,186
96	3,855	5,061	4,038	1,429	2,896	96	4,433	5,821	4,644	1,643	3,329
97	4,030	5,290	4,220	1,493	3,025	97	4,634	6,083	4,853	1,717	3,479
98	4,211	5,528	4,411	1,560	3,162	98	4,842	6,357	5,072	1,795	3,635
99	4,401	5,776	4,610	1,631	3,304	99	5,061	6,642	5,301	1,874	3,800

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

Household Discount Factor 0.93

ACE PROPERTY & CASUALTY INSURANCE COMPANY

SOUTH CAROLINA Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: ALL EXCEPT 294, 295, 298, 299

	Preferred				
				HD Plan	
Attained Age	Plan A	Plan F	Plan G	G	Plan N
65	1,194	1,456	1,251	443	865
66	1,194	1,456	1,251	443	865
67	1,194	1,456	1,251	443	865
68	1,194	1,500	1,251	443	874
69	1,199	1,544	1,256	445	891
70	1,211	1,591	1,269	449	910
71	1,248	1,639	1,307	462	936
72	1,292	1,696	1,353	479	970
73	1,338	1,756	1,400	496	1,003
74	1,384	1,818	1,449	513	1,038
75	1,440	1,890	1,507	534	1,079
76	1,496	1,966	1,567	554	1,123
77	1,555	2,044	1,630	577	1,168
78	1,619	2,126	1,695	600	1,215
79	1,682	2,211	1,762	623	1,264
80	1,750	2,299	1,834	649	1,314
81	1,828	2,403	1,916	678	1,373
82	1,913	2,510	2,002	709	1,435
83	1,998	2,623	2,092	740	1,499
84	2,088	2,740	2,187	773	1,567
85	2,182	2,864	2,284	808	1,637
86	2,280	2,993	2,388	845	1,711
87	2,382	3,128	2,495	883	1,788
88	2,488	3,270	2,607	922	1,869
89	2,600	3,416	2,724	964	1,952
90	2,719	3,571	2,847	1,007	2,040
91	2,841	3,730	2,975	1,053	2,133
92	2,968	3,899	3,110	1,100	2,230
93	3,102	4,073	3,250	1,149	2,330
94	3,242	4,256	3,396	1,201	2,435
95	3,387	4,448	3,549	1,255	2,544
96	3,540	4,648	3,709	1,312	2,659
97	3,701	4,858	3,876	1,371	2,778
98	3,867	5,077	4,050	1,433	2,903
99	4,042	5,305	4,234	1,498	3,035

	Standard				
				HD Plan	
Attained Age	Plan A	Plan F	Plan G	G	Plan N
65	1,373	1,675	1,438	509	996
66	1,373	1,675	1,438	509	996
67	1,373	1,675	1,438	509	996
68	1,373	1,726	1,438	509	1,005
69	1,379	1,776	1,445	511	1,025
70	1,393	1,830	1,460	517	1,046
71	1,436	1,885	1,503	533	1,077
72	1,486	1,951	1,556	551	1,115
73	1,538	2,019	1,611	570	1,153
74	1,590	2,089	1,667	590	1,194
75	1,655	2,173	1,734	613	1,242
76	1,721	2,260	1,802	637	1,292
77	1,789	2,351	1,874	664	1,343
78	1,862	2,445	1,949	690	1,397
79	1,935	2,542	2,027	717	1,454
80	2,012	2,645	2,108	746	1,511
81	2,103	2,762	2,204	780	1,579
82	2,199	2,887	2,302	814	1,650
83	2,297	3,017	2,407	851	1,723
84	2,400	3,151	2,515	890	1,802
85	2,509	3,294	2,627	930	1,883
86	2,622	3,442	2,747	972	1,968
87	2,739	3,598	2,869	1,016	2,056
88	2,862	3,759	2,997	1,060	2,149
89	2,990	3,928	3,133	1,108	2,246
90	3,126	4,105	3,274	1,158	2,347
91	3,267	4,290	3,422	1,211	2,452
92	3,413	4,484	3,575	1,265	2,563
93	3,568	4,685	3,737	1,323	2,679
94	3,727	4,896	3,904	1,382	2,800
95	3,897	5,116	4,081	1,443	2,926
96	4,071	5,345	4,265	1,509	3,057
97	4,256	5,586	4,457	1,577	3,195
98	4,447	5,838	4,658	1,648	3,339
99	4,648	6,100	4,869	1,721	3,489

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

Household Discount Factor 0.93

PREMIUM INFORMATION

ACE Property & Casualty Insurance Company may change your premium on any premium due date if a new table of rates is applicable to the policy. The change in the table of rates will apply to all covered persons in the same class. Class is defined as attained age, sex, underwriting class, state of issue, and your most recent zip code of residence in the state of issue. Premiums are based on your attained age and will change on your policy anniversary date. You will be notified, in writing, at least thirty-one (31) days in advance if a new table of rates is applicable to 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 & 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*	$0	$0	$257 (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 $257 of Medicare Approved amounts*	$0	$0	$257 (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)

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.