

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 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.

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.

LOUISIANA Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: 700-704, 707-708

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	7,077	8,200	7,145	2,834	5,413	0-64	8,138	9,433	8,216	3,260	6,224
65	1,769	2,050	1,786	709	1,353	65	2,034	2,358	2,054	815	1,556
66	1,769	2,050	1,786	709	1,353	66	2,034	2,358	2,054	815	1,556
67	1,769	2,050	1,786	709	1,353	67	2,034	2,358	2,054	815	1,556
68	1,769	2,107	1,786	709	1,360	68	2,034	2,422	2,054	815	1,564
69	1,778	2,170	1,796	711	1,378	69	2,045	2,495	2,066	819	1,586
70	1,802	2,235	1,819	722	1,404	70	2,072	2,570	2,092	829	1,615
71	1,855	2,302	1,874	742	1,446	71	2,134	2,647	2,155	854	1,663
72	1,920	2,382	1,939	768	1,496	72	2,209	2,739	2,230	884	1,721
73	1,987	2,466	2,007	796	1,548	73	2,285	2,835	2,307	914	1,781
74	2,057	2,551	2,076	823	1,603	74	2,365	2,934	2,389	946	1,842
75	2,139	2,653	2,160	855	1,667	75	2,460	3,052	2,483	984	1,916
76	2,225	2,760	2,247	891	1,733	76	2,558	3,173	2,584	1,024	1,993
77	2,313	2,870	2,336	926	1,803	77	2,659	3,301	2,687	1,065	2,072
78	2,406	2,985	2,429	963	1,875	78	2,767	3,432	2,794	1,108	2,157
79	2,502	3,104	2,527	1,001	1,950	79	2,877	3,570	2,906	1,152	2,241
80	2,601	3,228	2,629	1,041	2,027	80	2,993	3,713	3,023	1,197	2,331
81	2,718	3,374	2,746	1,088	2,119	81	3,126	3,879	3,158	1,252	2,436
82	2,842	3,524	2,869	1,136	2,214	82	3,267	4,053	3,300	1,308	2,545
83	2,969	3,683	2,999	1,188	2,314	83	3,414	4,235	3,448	1,366	2,661
84	3,101	3,848	3,133	1,242	2,418	84	3,567	4,425	3,603	1,427	2,781
85	3,242	4,021	3,275	1,297	2,527	85	3,728	4,625	3,766	1,491	2,906
86	3,388	4,203	3,422	1,356	2,642	86	3,897	4,833	3,935	1,560	3,038
87	3,540	4,391	3,575	1,417	2,760	87	4,070	5,052	4,112	1,629	3,173
88	3,699	4,589	3,737	1,479	2,883	88	4,254	5,278	4,297	1,703	3,316
89	3,865	4,796	3,905	1,547	3,013	89	4,445	5,515	4,490	1,778	3,467
90	4,039	5,012	4,081	1,617	3,150	90	4,645	5,764	4,692	1,860	3,622
91	4,221	5,238	4,263	1,690	3,290	91	4,855	6,024	4,902	1,942	3,786
92	4,411	5,473	4,456	1,765	3,440	92	5,073	6,296	5,124	2,031	3,955
93	4,610	5,720	4,655	1,845	3,595	93	5,301	6,578	5,354	2,122	4,134
94	4,817	5,977	4,865	1,928	3,757	94	5,540	6,874	5,595	2,217	4,320
95	5,035	6,247	5,085	2,015	3,926	95	5,789	7,184	5,847	2,317	4,515
96	5,261	6,527	5,313	2,105	4,103	96	6,049	7,506	6,110	2,421	4,718
97	5,497	6,822	5,552	2,200	4,287	97	6,321	7,844	6,385	2,530	4,931
98	5,745	7,129	5,803	2,298	4,481	98	6,606	8,198	6,673	2,643	5,152
99	6,003	7,449	6,064	2,402	4,683	99	6,904	8,567	6,973	2,763	5,385

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

LOUISIANA Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: ALL EXCEPT 700-704, 707-708

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	5,888	6,823	5,945	2,358	4,504	0-64	6,770	7,848	6,836	2,713	5,179
65	1,472	1,706	1,486	589	1,126	65	1,693	1,962	1,709	678	1,295
66	1,472	1,706	1,486	589	1,126	66	1,693	1,962	1,709	678	1,295
67	1,472	1,706	1,486	589	1,126	67	1,693	1,962	1,709	678	1,295
68	1,472	1,753	1,486	589	1,131	68	1,693	2,015	1,709	678	1,301
69	1,480	1,805	1,494	592	1,146	69	1,701	2,076	1,719	681	1,320
70	1,499	1,859	1,514	600	1,168	70	1,724	2,138	1,741	690	1,343
71	1,543	1,916	1,559	618	1,203	71	1,776	2,202	1,793	711	1,383
72	1,598	1,981	1,613	639	1,245	72	1,838	2,279	1,855	735	1,432
73	1,653	2,052	1,670	662	1,288	73	1,901	2,359	1,920	760	1,482
74	1,711	2,122	1,728	685	1,334	74	1,968	2,441	1,987	787	1,533
75	1,780	2,208	1,797	712	1,387	75	2,046	2,540	2,066	819	1,594
76	1,851	2,296	1,870	741	1,442	76	2,128	2,640	2,150	852	1,658
77	1,924	2,388	1,944	770	1,500	77	2,212	2,746	2,235	886	1,724
78	2,002	2,483	2,021	801	1,560	78	2,302	2,855	2,325	922	1,794
79	2,081	2,583	2,102	833	1,622	79	2,394	2,970	2,418	958	1,865
80	2,164	2,686	2,187	866	1,686	80	2,490	3,089	2,515	996	1,939
81	2,262	2,807	2,284	905	1,763	81	2,601	3,227	2,627	1,042	2,027
82	2,364	2,932	2,387	945	1,842	82	2,718	3,372	2,745	1,088	2,118
83	2,470	3,064	2,495	989	1,925	83	2,840	3,524	2,869	1,137	2,214
84	2,580	3,202	2,607	1,033	2,012	84	2,968	3,682	2,998	1,188	2,314
85	2,697	3,345	2,725	1,079	2,103	85	3,101	3,848	3,133	1,241	2,417
86	2,818	3,497	2,847	1,128	2,198	86	3,242	4,021	3,274	1,298	2,528
87	2,945	3,654	2,975	1,179	2,296	87	3,386	4,203	3,421	1,355	2,640
88	3,077	3,818	3,109	1,231	2,399	88	3,539	4,391	3,575	1,417	2,759
89	3,216	3,990	3,249	1,287	2,507	89	3,699	4,588	3,736	1,480	2,885
90	3,360	4,170	3,395	1,346	2,621	90	3,865	4,796	3,904	1,548	3,013
91	3,512	4,358	3,547	1,406	2,738	91	4,039	5,012	4,079	1,616	3,150
92	3,670	4,554	3,707	1,469	2,862	92	4,221	5,238	4,263	1,689	3,290
93	3,835	4,759	3,873	1,535	2,991	93	4,411	5,473	4,454	1,765	3,439
94	4,008	4,973	4,048	1,604	3,126	94	4,609	5,720	4,655	1,844	3,594
95	4,189	5,197	4,230	1,676	3,266	95	4,817	5,977	4,865	1,927	3,756
96	4,377	5,431	4,420	1,751	3,414	96	5,033	6,245	5,083	2,014	3,925
97	4,573	5,676	4,619	1,830	3,567	97	5,259	6,526	5,313	2,105	4,103
98	4,780	5,931	4,828	1,912	3,728	98	5,496	6,821	5,552	2,199	4,286
99	4,995	6,198	5,045	1,999	3,896	99	5,744	7,128	5,802	2,298	4,480

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

LOUISIANA Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: 700-704, 707-708

Attained Age	Preferred					Attained Age	Standard				
	Plan A	Plan F	Plan G	Plan G	Plan N		Plan A	Plan F	Plan G	Plan G	Plan N
0-64	6,290	7,290	6,358	2,517	4,810	0-64	7,235	8,382	7,308	2,896	5,533
65	1,572	1,823	1,589	629	1,203	65	1,809	2,096	1,827	724	1,383
66	1,572	1,823	1,589	629	1,203	66	1,809	2,096	1,827	724	1,383
67	1,572	1,823	1,589	629	1,203	67	1,809	2,096	1,827	724	1,383
68	1,572	1,872	1,589	629	1,210	68	1,809	2,153	1,827	724	1,391
69	1,580	1,928	1,596	632	1,225	69	1,818	2,218	1,836	728	1,409
70	1,601	1,986	1,617	641	1,248	70	1,841	2,284	1,860	737	1,435
71	1,650	2,046	1,666	659	1,284	71	1,897	2,353	1,915	759	1,478
72	1,706	2,116	1,723	684	1,330	72	1,964	2,435	1,982	785	1,529
73	1,767	2,192	1,784	707	1,377	73	2,030	2,519	2,051	813	1,582
74	1,828	2,269	1,847	732	1,425	74	2,101	2,608	2,122	841	1,638
75	1,901	2,360	1,920	761	1,481	75	2,187	2,713	2,208	875	1,703
76	1,977	2,453	1,998	792	1,541	76	2,273	2,821	2,297	910	1,772
77	2,055	2,551	2,076	823	1,602	77	2,364	2,934	2,389	946	1,842
78	2,138	2,653	2,160	855	1,667	78	2,460	3,051	2,483	984	1,916
79	2,223	2,760	2,246	891	1,733	79	2,558	3,173	2,583	1,023	1,993
80	2,313	2,869	2,336	926	1,802	80	2,659	3,301	2,685	1,065	2,072
81	2,416	2,998	2,441	967	1,882	81	2,779	3,448	2,807	1,113	2,166
82	2,525	3,133	2,550	1,010	1,968	82	2,905	3,604	2,933	1,162	2,263
83	2,638	3,273	2,664	1,056	2,057	83	3,035	3,765	3,065	1,214	2,365
84	2,758	3,420	2,785	1,104	2,150	84	3,171	3,934	3,203	1,269	2,473
85	2,882	3,575	2,910	1,153	2,246	85	3,314	4,112	3,347	1,326	2,583
86	3,011	3,735	3,041	1,205	2,348	86	3,462	4,297	3,498	1,386	2,700
87	3,146	3,904	3,179	1,260	2,453	87	3,619	4,490	3,655	1,448	2,821
88	3,288	4,079	3,322	1,316	2,564	88	3,781	4,690	3,819	1,513	2,948
89	3,436	4,263	3,470	1,375	2,679	89	3,951	4,902	3,991	1,581	3,081
90	3,591	4,455	3,626	1,437	2,799	90	4,129	5,123	4,171	1,652	3,220
91	3,752	4,655	3,789	1,502	2,925	91	4,316	5,355	4,359	1,726	3,364
92	3,920	4,866	3,960	1,569	3,058	92	4,508	5,595	4,554	1,804	3,515
93	4,098	5,084	4,138	1,639	3,195	93	4,713	5,847	4,759	1,885	3,674
94	4,281	5,313	4,325	1,713	3,340	94	4,923	6,110	4,974	1,971	3,840
95	4,474	5,552	4,520	1,791	3,489	95	5,146	6,386	5,198	2,059	4,013
96	4,675	5,802	4,722	1,871	3,647	96	5,377	6,672	5,431	2,152	4,194
97	4,886	6,063	4,936	1,955	3,810	97	5,619	6,973	5,675	2,249	4,382
98	5,107	6,336	5,158	2,044	3,982	98	5,872	7,287	5,931	2,350	4,580
99	5,335	6,621	5,389	2,136	4,163	99	6,136	7,615	6,198	2,456	4,787

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

LOUISIANA Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: ALL EXCEPT 700-704, 707-708

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	5,233	6,066	5,290	2,094	4,002	0-64	6,019	6,974	6,080	2,410	4,603
65	1,308	1,516	1,322	523	1,000	65	1,505	1,744	1,520	602	1,151
66	1,308	1,516	1,322	523	1,000	66	1,505	1,744	1,520	602	1,151
67	1,308	1,516	1,322	523	1,000	67	1,505	1,744	1,520	602	1,151
68	1,308	1,558	1,322	523	1,007	68	1,505	1,791	1,520	602	1,157
69	1,315	1,604	1,328	526	1,019	69	1,512	1,845	1,528	606	1,172
70	1,332	1,653	1,345	533	1,038	70	1,532	1,900	1,547	613	1,194
71	1,373	1,702	1,386	548	1,069	71	1,578	1,958	1,593	632	1,230
72	1,420	1,761	1,434	569	1,106	72	1,634	2,026	1,649	653	1,272
73	1,470	1,824	1,484	588	1,145	73	1,689	2,096	1,707	676	1,316
74	1,521	1,887	1,536	609	1,185	74	1,748	2,170	1,766	700	1,363
75	1,581	1,963	1,598	633	1,232	75	1,819	2,257	1,837	728	1,417
76	1,645	2,041	1,662	659	1,282	76	1,891	2,347	1,911	757	1,474
77	1,710	2,122	1,728	685	1,333	77	1,967	2,441	1,987	787	1,533
78	1,779	2,208	1,797	712	1,387	78	2,046	2,539	2,066	819	1,594
79	1,850	2,296	1,868	741	1,442	79	2,128	2,640	2,149	851	1,658
80	1,924	2,387	1,944	770	1,499	80	2,212	2,746	2,234	886	1,724
81	2,010	2,494	2,031	805	1,566	81	2,312	2,868	2,336	926	1,802
82	2,101	2,607	2,122	840	1,638	82	2,417	2,998	2,441	967	1,883
83	2,195	2,723	2,217	878	1,711	83	2,525	3,132	2,550	1,010	1,967
84	2,294	2,846	2,317	918	1,789	84	2,638	3,273	2,664	1,056	2,057
85	2,398	2,974	2,421	959	1,869	85	2,757	3,421	2,785	1,103	2,149
86	2,505	3,107	2,530	1,003	1,953	86	2,881	3,575	2,910	1,153	2,246
87	2,618	3,248	2,645	1,048	2,041	87	3,011	3,736	3,041	1,205	2,347
88	2,735	3,394	2,764	1,095	2,133	88	3,146	3,902	3,178	1,259	2,453
89	2,859	3,547	2,887	1,144	2,229	89	3,287	4,079	3,321	1,315	2,563
90	2,988	3,707	3,017	1,195	2,329	90	3,435	4,263	3,470	1,375	2,679
91	3,122	3,873	3,153	1,249	2,434	91	3,590	4,455	3,627	1,436	2,799
92	3,262	4,048	3,295	1,305	2,544	92	3,751	4,655	3,789	1,501	2,925
93	3,409	4,230	3,443	1,364	2,659	93	3,921	4,865	3,960	1,568	3,057
94	3,562	4,420	3,598	1,426	2,779	94	4,096	5,084	4,139	1,640	3,195
95	3,723	4,620	3,761	1,490	2,903	95	4,282	5,313	4,324	1,713	3,339
96	3,890	4,827	3,929	1,556	3,034	96	4,474	5,551	4,519	1,790	3,489
97	4,066	5,045	4,107	1,627	3,170	97	4,675	5,802	4,722	1,871	3,646
98	4,249	5,272	4,292	1,700	3,313	98	4,886	6,062	4,935	1,956	3,810
99	4,439	5,509	4,484	1,777	3,463	99	5,105	6,336	5,156	2,043	3,982

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

PREMIUM INFORMATION

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

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY

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

RIGHT TO RETURN POLICY

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

POLICY REPLACEMENT

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

NOTICE

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

COMPLETE ANSWERS ARE VERY IMPORTANT

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

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

PLAN A

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

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

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

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* 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)

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 <ul style="list-style-type: none">- First \$240 of Medicare Approved Amounts*- Remainder of Medicare Approved Amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$240 (Unless Part B deductible has been met) \$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 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

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.