

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					

¹Plans 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.

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.

INDIANA Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: 463-464

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	1,597	3,856	3,345	1,281	2,442	0-64	1,835	4,434	3,845	1,471	2,810
65	1,597	1,928	1,672	641	1,221	65	1,835	2,217	1,923	736	1,405
66	1,597	1,928	1,672	641	1,221	66	1,835	2,217	1,923	736	1,405
67	1,597	1,928	1,672	641	1,221	67	1,835	2,217	1,923	736	1,405
68	1,597	1,987	1,672	641	1,221	68	1,835	2,285	1,923	736	1,405
69	1,604	2,048	1,680	642	1,227	69	1,844	2,353	1,933	739	1,412
70	1,628	2,109	1,705	651	1,246	70	1,872	2,424	1,960	751	1,433
71	1,677	2,171	1,757	671	1,284	71	1,930	2,498	2,020	772	1,477
72	1,735	2,247	1,818	695	1,329	72	1,997	2,582	2,091	799	1,529
73	1,796	2,326	1,881	719	1,375	73	2,065	2,673	2,163	826	1,583
74	1,859	2,405	1,947	744	1,423	74	2,137	2,768	2,239	856	1,637
75	1,933	2,504	2,025	773	1,479	75	2,223	2,879	2,328	891	1,702
76	2,011	2,602	2,106	805	1,537	76	2,311	2,994	2,422	924	1,768
77	2,089	2,707	2,189	835	1,600	77	2,402	3,112	2,518	963	1,839
78	2,174	2,815	2,278	870	1,663	78	2,502	3,237	2,619	1,001	1,915
79	2,261	2,929	2,368	905	1,731	79	2,600	3,368	2,723	1,041	1,989
80	2,350	3,045	2,464	941	1,799	80	2,703	3,501	2,831	1,083	2,068
81	2,456	3,182	2,573	983	1,881	81	2,825	3,659	2,958	1,132	2,163
82	2,568	3,324	2,689	1,026	1,966	82	2,953	3,825	3,090	1,181	2,259
83	2,682	3,475	2,810	1,073	2,055	83	3,086	3,996	3,231	1,234	2,364
84	2,803	3,631	2,936	1,121	2,146	84	3,223	4,175	3,375	1,290	2,470
85	2,929	3,794	3,068	1,173	2,245	85	3,368	4,363	3,530	1,347	2,582
86	3,061	3,963	3,205	1,225	2,346	86	3,520	4,558	3,687	1,410	2,698
87	3,197	4,142	3,351	1,280	2,451	87	3,678	4,765	3,853	1,472	2,818
88	3,342	4,329	3,501	1,338	2,561	88	3,844	4,978	4,025	1,537	2,946
89	3,492	4,524	3,658	1,398	2,676	89	4,017	5,202	4,208	1,607	3,078
90	3,649	4,727	3,822	1,461	2,798	90	4,196	5,437	4,397	1,681	3,217
91	3,814	4,942	3,995	1,526	2,923	91	4,386	5,682	4,593	1,756	3,362
92	3,985	5,164	4,175	1,595	3,055	92	4,583	5,938	4,800	1,834	3,512
93	4,164	5,397	4,361	1,666	3,192	93	4,790	6,207	5,016	1,916	3,670
94	4,352	5,638	4,559	1,743	3,336	94	5,005	6,486	5,242	2,002	3,837
95	4,548	5,893	4,764	1,821	3,486	95	5,231	6,778	5,479	2,094	4,009
96	4,752	6,157	4,978	1,902	3,644	96	5,465	7,080	5,725	2,189	4,191
97	4,965	6,436	5,202	1,987	3,809	97	5,711	7,399	5,982	2,286	4,379
98	5,191	6,725	5,437	2,077	3,980	98	5,969	7,734	6,251	2,387	4,577
99	5,424	7,028	5,680	2,169	4,158	99	6,237	8,082	6,532	2,496	4,783

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

INDIANA Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: ALL EXCEPT 463-464

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	1,462	3,532	3,063	1,173	2,237	0-64	1,680	4,061	3,522	1,347	2,574
65	1,462	1,766	1,532	587	1,118	65	1,680	2,031	1,761	674	1,287
66	1,462	1,766	1,532	587	1,118	66	1,680	2,031	1,761	674	1,287
67	1,462	1,766	1,532	587	1,118	67	1,680	2,031	1,761	674	1,287
68	1,462	1,820	1,532	587	1,118	68	1,680	2,092	1,761	674	1,287
69	1,469	1,875	1,539	588	1,124	69	1,689	2,155	1,770	677	1,293
70	1,491	1,931	1,562	597	1,141	70	1,715	2,220	1,796	688	1,312
71	1,536	1,988	1,609	614	1,176	71	1,768	2,288	1,850	707	1,353
72	1,589	2,058	1,665	636	1,217	72	1,829	2,365	1,915	732	1,400
73	1,645	2,130	1,723	658	1,259	73	1,891	2,449	1,981	756	1,450
74	1,703	2,203	1,783	681	1,303	74	1,957	2,535	2,050	784	1,499
75	1,770	2,293	1,854	708	1,355	75	2,036	2,637	2,132	816	1,559
76	1,841	2,383	1,929	737	1,408	76	2,117	2,742	2,219	846	1,619
77	1,914	2,479	2,005	765	1,465	77	2,200	2,850	2,306	882	1,684
78	1,991	2,579	2,086	797	1,523	78	2,292	2,964	2,398	917	1,753
79	2,070	2,683	2,169	829	1,585	79	2,382	3,084	2,494	953	1,822
80	2,153	2,789	2,257	862	1,648	80	2,476	3,206	2,593	992	1,894
81	2,249	2,914	2,357	900	1,723	81	2,587	3,351	2,709	1,037	1,981
82	2,352	3,044	2,463	940	1,801	82	2,705	3,503	2,830	1,082	2,069
83	2,456	3,183	2,573	983	1,882	83	2,826	3,660	2,960	1,130	2,165
84	2,567	3,325	2,689	1,027	1,966	84	2,952	3,824	3,091	1,181	2,262
85	2,683	3,475	2,810	1,074	2,056	85	3,085	3,996	3,233	1,234	2,364
86	2,804	3,630	2,935	1,122	2,149	86	3,224	4,174	3,377	1,291	2,471
87	2,928	3,793	3,069	1,172	2,244	87	3,368	4,364	3,529	1,348	2,581
88	3,061	3,964	3,206	1,225	2,346	88	3,521	4,559	3,687	1,408	2,698
89	3,198	4,144	3,350	1,280	2,451	89	3,680	4,765	3,854	1,472	2,819
90	3,342	4,330	3,500	1,338	2,563	90	3,843	4,979	4,027	1,540	2,947
91	3,493	4,526	3,659	1,398	2,677	91	4,017	5,204	4,207	1,608	3,079
92	3,650	4,729	3,824	1,461	2,798	92	4,197	5,438	4,397	1,680	3,216
93	3,814	4,943	3,994	1,526	2,924	93	4,387	5,685	4,594	1,755	3,362
94	3,986	5,164	4,175	1,596	3,056	94	4,584	5,940	4,801	1,834	3,515
95	4,165	5,397	4,363	1,668	3,193	95	4,791	6,207	5,018	1,917	3,672
96	4,352	5,639	4,559	1,742	3,337	96	5,005	6,485	5,244	2,004	3,838
97	4,548	5,895	4,764	1,820	3,488	97	5,231	6,777	5,479	2,094	4,011
98	4,754	6,160	4,980	1,902	3,646	98	5,467	7,083	5,726	2,186	4,192
99	4,968	6,437	5,202	1,987	3,809	99	5,712	7,403	5,983	2,286	4,381

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

INDIANA Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: 463-464

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	1,420	3,427	2,975	1,137	2,173	0-64	1,632	3,941	3,420	1,308	2,497
65	1,420	1,714	1,487	568	1,086	65	1,632	1,970	1,710	654	1,249
66	1,420	1,714	1,487	568	1,086	66	1,632	1,970	1,710	654	1,249
67	1,420	1,714	1,487	568	1,086	67	1,632	1,970	1,710	654	1,249
68	1,420	1,766	1,487	568	1,086	68	1,632	2,030	1,710	654	1,249
69	1,426	1,820	1,494	571	1,090	69	1,639	2,093	1,718	656	1,255
70	1,446	1,874	1,516	580	1,108	70	1,664	2,155	1,743	666	1,274
71	1,491	1,931	1,562	596	1,142	71	1,716	2,221	1,796	686	1,312
72	1,543	1,997	1,616	618	1,181	72	1,774	2,296	1,859	709	1,359
73	1,597	2,066	1,672	639	1,222	73	1,836	2,377	1,923	734	1,406
74	1,653	2,139	1,730	661	1,264	74	1,899	2,460	1,989	760	1,454
75	1,718	2,226	1,799	687	1,315	75	1,975	2,559	2,070	792	1,512
76	1,786	2,314	1,871	715	1,366	76	2,054	2,661	2,153	822	1,573
77	1,858	2,405	1,947	744	1,422	77	2,137	2,767	2,239	856	1,636
78	1,933	2,503	2,025	773	1,478	78	2,223	2,878	2,328	889	1,701
79	2,009	2,602	2,105	805	1,537	79	2,311	2,994	2,422	924	1,768
80	2,089	2,707	2,188	835	1,598	80	2,402	3,112	2,517	963	1,839
81	2,183	2,828	2,288	874	1,672	81	2,509	3,253	2,630	1,005	1,923
82	2,281	2,955	2,390	913	1,747	82	2,623	3,399	2,748	1,049	2,009
83	2,384	3,088	2,497	954	1,827	83	2,742	3,552	2,871	1,096	2,101
84	2,491	3,227	2,608	996	1,910	84	2,865	3,712	3,001	1,145	2,196
85	2,604	3,373	2,727	1,042	1,995	85	2,995	3,879	3,136	1,198	2,295
86	2,722	3,523	2,849	1,089	2,085	86	3,128	4,052	3,277	1,254	2,399
87	2,842	3,682	2,978	1,138	2,179	87	3,269	4,235	3,424	1,309	2,506
88	2,970	3,847	3,112	1,190	2,276	88	3,416	4,423	3,579	1,366	2,618
89	3,105	4,021	3,251	1,243	2,380	89	3,571	4,624	3,740	1,428	2,737
90	3,243	4,201	3,399	1,299	2,485	90	3,730	4,832	3,908	1,493	2,860
91	3,390	4,392	3,551	1,357	2,597	91	3,899	5,051	4,083	1,560	2,988
92	3,542	4,590	3,710	1,418	2,715	92	4,073	5,278	4,267	1,631	3,121
93	3,702	4,796	3,878	1,481	2,838	93	4,258	5,516	4,459	1,703	3,263
94	3,868	5,013	4,053	1,548	2,966	94	4,449	5,764	4,661	1,780	3,411
95	4,043	5,237	4,234	1,618	3,098	95	4,648	6,024	4,870	1,862	3,565
96	4,224	5,473	4,424	1,691	3,239	96	4,858	6,294	5,089	1,945	3,724
97	4,414	5,719	4,624	1,767	3,384	97	5,076	6,577	5,318	2,032	3,893
98	4,613	5,977	4,832	1,846	3,538	98	5,306	6,875	5,557	2,122	4,068
99	4,820	6,247	5,048	1,929	3,697	99	5,543	7,184	5,806	2,219	4,252

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

INDIANA Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: ALL EXCEPT 463-464

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	1,300	3,139	2,724	1,041	1,990	0-64	1,495	3,609	3,132	1,198	2,287
65	1,300	1,570	1,362	521	995	65	1,495	1,805	1,566	599	1,144
66	1,300	1,570	1,362	521	995	66	1,495	1,805	1,566	599	1,144
67	1,300	1,570	1,362	521	995	67	1,495	1,805	1,566	599	1,144
68	1,300	1,618	1,362	521	995	68	1,495	1,860	1,566	599	1,144
69	1,306	1,667	1,368	523	998	69	1,501	1,917	1,573	601	1,149
70	1,325	1,717	1,389	532	1,015	70	1,524	1,974	1,596	610	1,167
71	1,366	1,768	1,430	546	1,046	71	1,571	2,034	1,645	629	1,202
72	1,414	1,829	1,480	566	1,082	72	1,625	2,103	1,702	649	1,245
73	1,462	1,893	1,532	586	1,119	73	1,681	2,177	1,761	673	1,288
74	1,514	1,959	1,585	605	1,158	74	1,739	2,253	1,822	696	1,332
75	1,574	2,039	1,648	630	1,204	75	1,809	2,344	1,896	725	1,385
76	1,636	2,120	1,714	655	1,252	76	1,881	2,437	1,972	753	1,441
77	1,701	2,203	1,783	681	1,302	77	1,957	2,534	2,050	784	1,498
78	1,770	2,292	1,854	708	1,354	78	2,036	2,636	2,132	815	1,558
79	1,840	2,383	1,928	737	1,408	79	2,117	2,742	2,219	846	1,619
80	1,914	2,479	2,004	765	1,464	80	2,200	2,850	2,305	882	1,684
81	1,999	2,590	2,095	800	1,531	81	2,298	2,979	2,409	920	1,761
82	2,089	2,707	2,189	837	1,600	82	2,403	3,113	2,517	961	1,840
83	2,184	2,829	2,287	874	1,673	83	2,512	3,253	2,630	1,004	1,924
84	2,282	2,955	2,389	913	1,749	84	2,624	3,399	2,749	1,049	2,011
85	2,385	3,089	2,497	954	1,827	85	2,743	3,552	2,872	1,097	2,102
86	2,493	3,227	2,609	997	1,910	86	2,865	3,711	3,001	1,148	2,197
87	2,603	3,372	2,728	1,042	1,996	87	2,994	3,879	3,136	1,199	2,295
88	2,721	3,524	2,850	1,090	2,085	88	3,128	4,051	3,278	1,252	2,397
89	2,844	3,682	2,978	1,138	2,179	89	3,271	4,235	3,425	1,308	2,506
90	2,971	3,848	3,113	1,190	2,276	90	3,416	4,426	3,580	1,367	2,620
91	3,105	4,023	3,252	1,243	2,379	91	3,571	4,627	3,740	1,429	2,736
92	3,244	4,204	3,398	1,299	2,487	92	3,731	4,834	3,908	1,494	2,859
93	3,391	4,393	3,552	1,356	2,599	93	3,900	5,052	4,084	1,560	2,989
94	3,543	4,591	3,712	1,418	2,717	94	4,075	5,279	4,269	1,630	3,124
95	3,703	4,797	3,878	1,482	2,838	95	4,257	5,517	4,460	1,705	3,265
96	3,869	5,012	4,052	1,549	2,966	96	4,450	5,765	4,661	1,781	3,411
97	4,043	5,238	4,235	1,618	3,100	97	4,649	6,024	4,870	1,861	3,565
98	4,225	5,475	4,426	1,691	3,241	98	4,860	6,297	5,089	1,944	3,726
99	4,414	5,721	4,624	1,767	3,386	99	5,077	6,580	5,318	2,032	3,894

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.

NOTE: The policy fee is fully refundable if the policy is not issued, delivery of the policy is refused or the policy is returned with the policy's 30-day free look period.

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 \$1676 All but \$419 a day All but \$838 a day \$0 \$0	\$0 \$419 a day \$838 a day 100% of Medicare eligible expenses \$0	\$1676 (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 \$209.50 a day \$0	\$0 \$0 \$0	\$0 Up to \$209.50 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 \$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 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 \$1676 All but \$419 a day All but \$838 a day \$0 \$0	\$1676 (Part A deductible) \$419 a day \$838 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 \$209.50 a day \$0	\$0 Up to \$209.50 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 \$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 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 \$1676 All but \$419 a day All but \$838 a day \$0 \$0	\$1676 (Part A deductible) \$419 a day \$838 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 \$209.50 a day \$0	\$0 Up to \$209.50 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 \$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 Durable medical equipment	100%	\$0	\$0
- 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 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 \$1676 All but \$419 a day All but \$838 a day \$0 \$0	\$1676 (Part A deductible) \$419 a day \$838 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 \$209.50 a day \$0	\$0 Up to \$209.50 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 \$257 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

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

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

(continued)

HIGH DEDUCTIBLE PLAN G
PARTS A & B

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$2870 DEDUCTIBLE ** PLAN PAYS	IN ADDITION TO \$2870 DEDUCTIBLE ** YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies Durable medical equipment	100%	\$0	\$0
- 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 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 \$1676 All but \$419 a day All but \$838 a day \$0 \$0	\$1676 (Part A deductible) \$419 a day \$838 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 \$209.50 a day \$0	\$0 Up to \$209.50 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 \$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 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.	\$257 (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 \$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

(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 \$257 of Medicare Approved Amounts*	\$0	\$0	\$257 (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.