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]					

[1]Plans 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.

[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.

ACE PROPERTY & CASUALTY INSURANCE COMPANY

ILLINOIS Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: 600, 602-604, 606-608

	Preferred				
				HD	
Attained Age	Plan A	Plan F	Plan G	Plan G	Plan N
0-64	5,248	6,394	5,300	2,100	4,096
65	1,543	1,754	1,558	618	1,169
66	1,543	1,754	1,558	618	1,169
67	1,543	1,754	1,558	618	1,169
68	1,543	1,808	1,558	618	1,179
69	1,551	1,862	1,567	621	1,203
70	1,574	1,918	1,590	630	1,228
71	1,620	1,976	1,637	649	1,265
72	1,677	2,045	1,694	672	1,310
73	1,735	2,116	1,753	695	1,355
74	1,797	2,190	1,814	720	1,402
75	1,867	2,278	1,886	748	1,458
76	1,943	2,370	1,963	778	1,516
77	2,022	2,464	2,041	808	1,577
78	2,101	2,562	2,123	841	1,641
79	2,185	2,664	2,207	874	1,706
80	2,274	2,772	2,296	910	1,774
81	2,376	2,896	2,400	950	1,853
82	2,482	3,026	2,506	994	1,938
83	2,593	3,161	2,620	1,038	2,024
84	2,709	3,303	2,737	1,085	2,115
85	2,832	3,452	2,861	1,133	2,210
86	2,961	3,608	2,989	1,184	2,309
87	3,094	3,771	3,124	1,237	2,415
88	3,233	3,940	3,265	1,294	2,523
89	3,378	4,118	3,412	1,352	2,636
90	3,530	4,302	3,565	1,413	2,755
91	3,690	4,497	3,726	1,477	2,879
92	3,856	4,698	3,895	1,543	3,009
93	4,029	4,911	4,070	1,612	3,146
94	4,211	5,130	4,253	1,686	3,288
95	4,400	5,362	4,444	1,761	3,434
96	4,600	5,604	4,645	1,840	3,589
97	4,806	5,856	4,855	1,923	3,750
98	5,021	6,119	5,074	2,008	3,920
99	5,248	6,394	5,300	2,100	4,096

	Standard				
				HD	
Attained Age	Plan A	Plan F	Plan G	Plan G	Plan N
0-64	6,035	7,355	6,096	2,416	4,712
65	1,775	2,018	1,792	710	1,343
66	1,775	2,018	1,792	710	1,343
67	1,775	2,018	1,792	710	1,343
68	1,775	2,079	1,792	710	1,357
69	1,785	2,141	1,802	714	1,384
70	1,811	2,206	1,828	724	1,413
71	1,865	2,271	1,884	747	1,453
72	1,929	2,352	1,948	772	1,506
73	1,996	2,434	2,016	800	1,557
74	2,066	2,519	2,087	827	1,611
75	2,148	2,620	2,169	860	1,677
76	2,234	2,725	2,258	896	1,744
77	2,325	2,834	2,346	930	1,814
78	2,415	2,946	2,442	967	1,887
79	2,513	3,064	2,539	1,005	1,961
80	2,614	3,188	2,641	1,046	2,041
81	2,732	3,330	2,760	1,094	2,131
82	2,855	3,479	2,884	1,142	2,227
83	2,982	3,636	3,012	1,194	2,326
84	3,117	3,799	3,148	1,248	2,433
85	3,257	3,971	3,290	1,303	2,541
86	3,403	4,149	3,438	1,362	2,656
87	3,557	4,338	3,594	1,423	2,777
88	3,717	4,531	3,756	1,488	2,901
89	3,883	4,734	3,924	1,555	3,034
90	4,061	4,949	4,101	1,625	3,169
91	4,242	5,171	4,285	1,697	3,311
92	4,435	5,405	4,479	1,775	3,461
93	4,635	5,646	4,680	1,853	3,618
94	4,842	5,901	4,891	1,939	3,780
95	5,060	6,166	5,112	2,025	3,949
96	5,288	6,443	5,340	2,116	4,127
97	5,526	6,734	5,582	2,212	4,313
98	5,775	7,037	5,833	2,312	4,507
99	6,035	7,355	6,096	2,416	4,712

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

Household Discount Factor .93

ACE PROPERTY & CASUALTY INSURANCE COMPANY

ILLINOIS Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: 601, 605

	Preferred				
				HD	
Attained Age	Plan A	Plan F	Plan G	Plan G	Plan N
0-64	5,054	6,158	5,104	2,023	3,945
65	1,486	1,689	1,500	595	1,126
66	1,486	1,689	1,500	595	1,126
67	1,486	1,689	1,500	595	1,126
68	1,486	1,741	1,500	595	1,136
69	1,494	1,793	1,509	598	1,158
70	1,516	1,847	1,531	607	1,182
71	1,560	1,903	1,577	625	1,218
72	1,615	1,970	1,631	647	1,261
73	1,671	2,038	1,688	670	1,304
74	1,731	2,109	1,747	693	1,350
75	1,797	2,193	1,816	720	1,404
76	1,871	2,282	1,890	750	1,460
77	1,947	2,373	1,966	778	1,519
78	2,023	2,467	2,044	810	1,580
79	2,104	2,566	2,125	841	1,643
80	2,189	2,669	2,211	876	1,708
81	2,288	2,788	2,311	915	1,785
82	2,390	2,914	2,413	957	1,866
83	2,497	3,044	2,523	999	1,949
84	2,609	3,181	2,636	1,045	2,037
85	2,727	3,324	2,755	1,091	2,129
86	2,851	3,474	2,879	1,140	2,224
87	2,979	3,631	3,008	1,191	2,325
88	3,113	3,794	3,144	1,246	2,429
89	3,253	3,965	3,286	1,302	2,539
90	3,399	4,143	3,433	1,361	2,653
91	3,553	4,331	3,588	1,422	2,772
92	3,713	4,524	3,751	1,486	2,898
93	3,880	4,729	3,919	1,552	3,030
94	4,055	4,940	4,095	1,623	3,166
95	4,237	5,164	4,280	1,696	3,306
96	4,429	5,396	4,473	1,772	3,456
97	4,628	5,639	4,675	1,852	3,611
98	4,835	5,893	4,886	1,934	3,775
99	5,054	6,158	5,104	2,023	3,945

	Standard				
				HD	
Attained Age	Plan A	Plan F	Plan G	Plan G	Plan N
0-64	5,812	7,082	5,871	2,327	4,537
65	1,709	1,944	1,725	684	1,294
66	1,709	1,944	1,725	684	1,294
67	1,709	1,944	1,725	684	1,294
68	1,709	2,002	1,725	684	1,307
69	1,719	2,062	1,735	688	1,333
70	1,744	2,124	1,760	698	1,361
71	1,796	2,187	1,814	719	1,400
72	1,857	2,265	1,876	743	1,450
73	1,922	2,344	1,942	770	1,499
74	1,990	2,426	2,009	796	1,551
75	2,068	2,523	2,089	829	1,615
76	2,151	2,624	2,174	863	1,680
77	2,239	2,729	2,259	896	1,747
78	2,326	2,837	2,351	931	1,817
79	2,420	2,951	2,445	968	1,888
80	2,517	3,070	2,543	1,007	1,965
81	2,631	3,207	2,658	1,053	2,052
82	2,750	3,350	2,777	1,100	2,145
83	2,872	3,501	2,900	1,150	2,240
84	3,002	3,658	3,031	1,202	2,343
85	3,136	3,823	3,168	1,255	2,447
86	3,277	3,995	3,311	1,312	2,558
87	3,426	4,177	3,461	1,370	2,674
88	3,580	4,363	3,617	1,433	2,794
89	3,739	4,559	3,778	1,497	2,921
90	3,910	4,766	3,949	1,565	3,051
91	4,085	4,980	4,127	1,634	3,189
92	4,271	5,205	4,313	1,709	3,332
93	4,463	5,437	4,507	1,785	3,484
94	4,663	5,683	4,710	1,867	3,640
95	4,873	5,938	4,923	1,950	3,803
96	5,092	6,204	5,142	2,038	3,974
97	5,321	6,484	5,375	2,130	4,153
98	5,562	6,776	5,617	2,226	4,340
99	5,812	7,082	5,871	2,327	4,537

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

Household Discount Factor .93

ACE PROPERTY & CASUALTY INSURANCE COMPANY

ILLINOIS Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: ALL EXCEPT 600-608

	Preferred				
				HD	
Attained Age	Plan A	Plan F	Plan G	Plan G	Plan N
0-64	4,616	5,625	4,662	1,848	3,603
65	1,358	1,543	1,371	543	1,029
66	1,358	1,543	1,371	543	1,029
67	1,358	1,543	1,371	543	1,029
68	1,358	1,591	1,371	543	1,037
69	1,365	1,638	1,379	546	1,058
70	1,385	1,688	1,398	554	1,080
71	1,425	1,738	1,440	571	1,112
72	1,475	1,799	1,490	591	1,152
73	1,526	1,861	1,542	612	1,192
74	1,581	1,927	1,596	633	1,233
75	1,642	2,004	1,659	658	1,282
76	1,709	2,085	1,727	685	1,334
77	1,779	2,168	1,796	710	1,387
78	1,848	2,254	1,867	740	1,443
79	1,922	2,344	1,941	769	1,501
80	2,000	2,438	2,020	800	1,560
81	2,090	2,547	2,111	836	1,630
82	2,184	2,662	2,204	874	1,704
83	2,281	2,780	2,304	913	1,780
84	2,383	2,906	2,408	954	1,860
85	2,491	3,036	2,517	997	1,944
86	2,604	3,173	2,629	1,041	2,031
87	2,721	3,317	2,748	1,088	2,124
88	2,844	3,466	2,872	1,138	2,219
89	2,972	3,622	3,001	1,190	2,319
90	3,105	3,784	3,136	1,243	2,424
91	3,246	3,956	3,278	1,299	2,532
92	3,392	4,133	3,426	1,358	2,647
93	3,544	4,320	3,580	1,418	2,767
94	3,704	4,512	3,741	1,483	2,892
95	3,870	4,717	3,909	1,549	3,020
96	4,046	4,929	4,086	1,618	3,157
97	4,227	5,151	4,270	1,691	3,299
98	4,417	5,383	4,463	1,767	3,448
99	4,616	5,625	4,662	1,848	3,603

	Standard				
				HD	
Attained Age	Plan A	Plan F	Plan G	Plan G	Plan N
0-64	5,309	6,469	5,363	2,125	4,145
65	1,561	1,775	1,576	624	1,182
66	1,561	1,775	1,576	624	1,182
67	1,561	1,775	1,576	624	1,182
68	1,561	1,829	1,576	624	1,194
69	1,570	1,883	1,585	628	1,217
70	1,593	1,940	1,608	637	1,243
71	1,641	1,998	1,657	657	1,278
72	1,697	2,069	1,714	679	1,325
73	1,756	2,141	1,774	703	1,369
74	1,817	2,216	1,835	727	1,417
75	1,889	2,305	1,908	757	1,475
76	1,965	2,397	1,986	788	1,534
77	2,045	2,493	2,064	818	1,596
78	2,125	2,592	2,148	851	1,660
79	2,210	2,695	2,233	884	1,725
80	2,299	2,804	2,323	920	1,795
81	2,403	2,929	2,428	962	1,874
82	2,512	3,060	2,537	1,005	1,959
83	2,623	3,198	2,649	1,050	2,046
84	2,742	3,341	2,769	1,098	2,140
85	2,865	3,493	2,894	1,146	2,235
86	2,993	3,650	3,024	1,198	2,337
87	3,129	3,816	3,161	1,252	2,442
88	3,270	3,986	3,304	1,309	2,552
89	3,415	4,164	3,451	1,367	2,669
90	3,572	4,353	3,607	1,430	2,787
91	3,732	4,549	3,770	1,493	2,913
92	3,901	4,754	3,940	1,561	3,044
93	4,077	4,967	4,117	1,630	3,182
94	4,259	5,191	4,302	1,705	3,325
95	4,451	5,424	4,497	1,781	3,474
96	4,651	5,667	4,697	1,861	3,630
97	4,861	5,923	4,910	1,945	3,794
98	5,080	6,190	5,131	2,033	3,965
99	5,309	6,469	5,363	2,125	4,145

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

Household Discount Factor .93

ACE PROPERTY & CASUALTY INSURANCE COMPANY

ILLINOIS Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: 600, 602-604, 606-608

	Preferred				
				HD	
Attained Age	Plan A	Plan F	Plan G	Plan G	Plan N
0-64	4,664	5,683	4,712	1,867	3,641
65	1,371	1,560	1,386	548	1,038
66	1,371	1,560	1,386	548	1,038
67	1,371	1,560	1,386	548	1,038
68	1,371	1,607	1,386	548	1,049
69	1,379	1,654	1,393	551	1,069
70	1,399	1,705	1,413	560	1,092
71	1,441	1,756	1,455	577	1,123
72	1,491	1,817	1,506	598	1,164
73	1,543	1,881	1,558	618	1,204
74	1,598	1,948	1,613	640	1,246
75	1,660	2,025	1,677	664	1,295
76	1,726	2,106	1,745	692	1,348
77	1,796	2,190	1,814	719	1,402
78	1,867	2,278	1,886	748	1,458
79	1,943	2,369	1,963	777	1,516
80	2,022	2,463	2,041	808	1,577
81	2,112	2,574	2,132	845	1,648
82	2,206	2,689	2,228	883	1,722
83	2,305	2,810	2,328	922	1,798
84	2,409	2,936	2,434	964	1,880
85	2,517	3,069	2,544	1,008	1,964
86	2,631	3,207	2,657	1,054	2,053
87	2,750	3,352	2,777	1,100	2,145
88	2,872	3,503	2,903	1,150	2,243
89	3,003	3,661	3,032	1,202	2,343
90	3,138	3,826	3,170	1,256	2,449
91	3,281	3,996	3,312	1,313	2,560
92	3,427	4,177	3,462	1,373	2,675
93	3,582	4,364	3,617	1,433	2,796
94	3,742	4,560	3,781	1,497	2,921
95	3,911	4,766	3,951	1,566	3,053
96	4,087	4,980	4,128	1,635	3,191
97	4,272	5,205	4,315	1,710	3,334
98	4,463	5,440	4,509	1,787	3,484
99	4,664	5,683	4,712	1,867	3,641

	Standard				
				HD	
Attained Age	Plan A	Plan F	Plan G	Plan G	Plan N
0-64	5,364	6,536	5,418	2,146	4,187
65	1,577	1,795	1,593	631	1,195
66	1,577	1,795	1,593	631	1,195
67	1,577	1,795	1,593	631	1,195
68	1,577	1,849	1,593	631	1,206
69	1,586	1,903	1,602	636	1,230
70	1,609	1,961	1,626	645	1,256
71	1,657	2,020	1,674	663	1,293
72	1,715	2,090	1,732	686	1,338
73	1,774	2,163	1,792	710	1,384
74	1,837	2,239	1,855	736	1,433
75	1,910	2,328	1,928	764	1,490
76	1,986	2,422	2,006	796	1,550
77	2,066	2,519	2,085	827	1,612
78	2,147	2,619	2,169	860	1,677
79	2,234	2,724	2,257	894	1,744
80	2,325	2,834	2,346	929	1,813
81	2,428	2,960	2,452	972	1,895
82	2,538	3,093	2,563	1,016	1,980
83	2,651	3,233	2,677	1,061	2,068
84	2,770	3,376	2,799	1,110	2,162
85	2,895	3,529	2,923	1,158	2,260
86	3,024	3,687	3,056	1,212	2,362
87	3,163	3,855	3,193	1,265	2,468
88	3,303	4,028	3,338	1,323	2,579
89	3,452	4,209	3,488	1,382	2,696
90	3,608	4,398	3,645	1,444	2,817
91	3,772	4,596	3,810	1,510	2,943
92	3,942	4,804	3,981	1,578	3,075
93	4,120	5,020	4,161	1,648	3,215
94	4,304	5,245	4,347	1,723	3,359
95	4,497	5,481	4,544	1,799	3,511
96	4,700	5,727	4,748	1,881	3,668
97	4,912	5,986	4,961	1,966	3,833
98	5,134	6,255	5,185	2,054	4,006
99	5,364	6,536	5,418	2,146	4,187

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

Household Discount Factor .93

ACE PROPERTY & CASUALTY INSURANCE COMPANY

ILLINOIS Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: 601, 605

	Preferred				
				HD	
Attained Age	Plan A	Plan F	Plan G	Plan G	Plan N
0-64	4,491	5,473	4,537	1,798	3,507
65	1,320	1,502	1,334	528	999
66	1,320	1,502	1,334	528	999
67	1,320	1,502	1,334	528	999
68	1,320	1,548	1,334	528	1,010
69	1,328	1,593	1,341	531	1,030
70	1,348	1,642	1,361	540	1,051
71	1,388	1,691	1,401	556	1,082
72	1,436	1,750	1,450	575	1,121
73	1,486	1,812	1,500	595	1,159
74	1,539	1,875	1,553	617	1,199
75	1,599	1,950	1,615	639	1,247
76	1,662	2,028	1,681	666	1,298
77	1,730	2,109	1,747	692	1,350
78	1,797	2,193	1,816	720	1,404
79	1,871	2,281	1,890	748	1,460
80	1,947	2,372	1,966	778	1,519
81	2,033	2,479	2,053	813	1,587
82	2,124	2,589	2,146	850	1,658
83	2,220	2,706	2,242	888	1,732
84	2,319	2,827	2,343	928	1,811
85	2,424	2,955	2,449	970	1,892
86	2,533	3,088	2,559	1,015	1,977
87	2,648	3,227	2,674	1,059	2,066
88	2,766	3,374	2,796	1,108	2,160
89	2,892	3,525	2,920	1,157	2,256
90	3,022	3,684	3,052	1,209	2,358
91	3,159	3,848	3,190	1,264	2,465
92	3,300	4,022	3,334	1,322	2,576
93	3,450	4,202	3,483	1,380	2,692
94	3,604	4,391	3,641	1,442	2,813
95	3,766	4,589	3,805	1,508	2,940
96	3,936	4,796	3,975	1,575	3,073
97	4,114	5,012	4,155	1,646	3,210
98	4,298	5,238	4,342	1,721	3,355
99	4,491	5,473	4,537	1,798	3,507

	Standard				
				HD	
Attained Age	Plan A	Plan F	Plan G	Plan G	Plan N
0-64	5,165	6,294	5,218	2,067	4,032
65	1,519	1,728	1,534	608	1,151
66	1,519	1,728	1,534	608	1,151
67	1,519	1,728	1,534	608	1,151
68	1,519	1,780	1,534	608	1,162
69	1,528	1,832	1,543	612	1,184
70	1,550	1,888	1,566	621	1,209
71	1,595	1,945	1,612	638	1,245
72	1,651	2,013	1,667	661	1,288
73	1,708	2,083	1,725	684	1,333
74	1,769	2,156	1,787	708	1,380
75	1,839	2,242	1,856	735	1,435
76	1,912	2,332	1,932	767	1,493
77	1,990	2,426	2,008	796	1,552
78	2,067	2,522	2,089	829	1,615
79	2,151	2,623	2,173	861	1,680
80	2,239	2,729	2,259	894	1,746
81	2,338	2,850	2,361	936	1,825
82	2,444	2,979	2,468	979	1,907
83	2,553	3,113	2,578	1,022	1,991
84	2,668	3,251	2,695	1,069	2,082
85	2,788	3,398	2,815	1,115	2,176
86	2,912	3,551	2,943	1,167	2,275
87	3,046	3,712	3,075	1,218	2,376
88	3,181	3,879	3,215	1,274	2,483
89	3,324	4,053	3,359	1,330	2,596
90	3,475	4,236	3,510	1,391	2,713
91	3,632	4,426	3,669	1,454	2,834
92	3,796	4,626	3,834	1,520	2,961
93	3,967	4,834	4,007	1,587	3,096
94	4,144	5,051	4,186	1,659	3,235
95	4,331	5,278	4,376	1,733	3,381
96	4,526	5,515	4,572	1,812	3,533
97	4,731	5,764	4,778	1,893	3,692
98	4,943	6,023	4,993	1,978	3,858
99	5,165	6,294	5,218	2,067	4,032

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

Household Discount Factor .93

ACE PROPERTY & CASUALTY INSURANCE COMPANY

ILLINOIS Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: ALL EXCEPT 600-608

	Preferred				
				HD	
Attained Age	Plan A	Plan F	Plan G	Plan G	Plan N
0-64	4,103	4,999	4,145	1,642	3,203
65	1,206	1,372	1,219	482	913
66	1,206	1,372	1,219	482	913
67	1,206	1,372	1,219	482	913
68	1,206	1,414	1,219	482	923
69	1,213	1,455	1,225	485	941
70	1,231	1,500	1,243	493	960
71	1,268	1,544	1,280	508	988
72	1,312	1,599	1,325	526	1,024
73	1,358	1,655	1,371	543	1,059
74	1,405	1,713	1,418	563	1,096
75	1,460	1,781	1,475	584	1,139
76	1,518	1,853	1,535	609	1,186
77	1,580	1,927	1,596	632	1,233
78	1,642	2,004	1,659	658	1,282
79	1,709	2,084	1,727	684	1,334
80	1,779	2,167	1,796	710	1,387
81	1,857	2,264	1,875	743	1,449
82	1,940	2,365	1,960	777	1,515
83	2,028	2,472	2,048	811	1,582
84	2,119	2,583	2,141	848	1,654
85	2,214	2,699	2,237	886	1,728
86	2,314	2,821	2,337	927	1,806
87	2,419	2,948	2,443	967	1,887
88	2,527	3,082	2,554	1,012	1,973
89	2,641	3,220	2,667	1,057	2,061
90	2,760	3,365	2,788	1,105	2,154
91	2,886	3,515	2,914	1,155	2,252
92	3,014	3,674	3,045	1,207	2,353
93	3,151	3,838	3,182	1,261	2,459
94	3,292	4,011	3,326	1,317	2,570
95	3,440	4,192	3,475	1,377	2,685
96	3,595	4,381	3,631	1,439	2,807
97	3,758	4,578	3,795	1,504	2,932
98	3,926	4,785	3,966	1,572	3,065
99	4,103	4,999	4,145	1,642	3,203

	Standard				
				HD	
Attained Age	Plan A	Plan F	Plan G	Plan G	Plan N
0-64	4,718	5,749	4,766	1,888	3,683
65	1,388	1,579	1,401	555	1,051
66	1,388	1,579	1,401	555	1,051
67	1,388	1,579	1,401	555	1,051
68	1,388	1,626	1,401	555	1,061
69	1,396	1,674	1,409	559	1,082
70	1,415	1,725	1,430	567	1,105
71	1,457	1,776	1,472	583	1,137
72	1,508	1,839	1,523	604	1,177
73	1,560	1,903	1,576	624	1,217
74	1,616	1,969	1,632	647	1,261
75	1,680	2,048	1,696	672	1,311
76	1,747	2,130	1,765	700	1,363
77	1,817	2,216	1,834	727	1,418
78	1,888	2,304	1,908	757	1,475
79	1,965	2,396	1,985	786	1,534
80	2,045	2,493	2,064	817	1,595
81	2,136	2,603	2,157	855	1,667
82	2,232	2,721	2,254	894	1,742
83	2,332	2,843	2,355	934	1,819
84	2,437	2,970	2,462	976	1,902
85	2,547	3,104	2,572	1,019	1,988
86	2,660	3,244	2,688	1,066	2,078
87	2,782	3,391	2,809	1,112	2,171
88	2,906	3,543	2,937	1,164	2,268
89	3,036	3,702	3,068	1,215	2,371
90	3,174	3,869	3,206	1,271	2,478
91	3,318	4,043	3,352	1,328	2,589
92	3,467	4,226	3,502	1,388	2,705
93	3,624	4,415	3,660	1,449	2,828
94	3,786	4,614	3,823	1,516	2,955
95	3,956	4,821	3,997	1,583	3,088
96	4,135	5,038	4,177	1,655	3,227
97	4,321	5,265	4,364	1,729	3,372
98	4,516	5,502	4,561	1,807	3,524
99	4,718	5,749	4,766	1,888	3,683

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

Household Discount Factor .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.

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 $1632	$0	$1632 (Part A deductible)
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $816 a day	$816 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 $204 a day	$0	Up to $204 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 $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	All but $1632	$1632 (Part A deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $816 a day	$816 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 $204 a day	Up to $204 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 $240 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First $240 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 $0 Generally 80%	 $240 (Part B deductible) Generally 20%	 $0 $0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD First 3 pints Next $240 of Medicare Approved amounts* Remainder of Medicare Approved amounts	 $0 $0 80%	 All costs $240 (Part B deductible) 20%	 $0 $0 $0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

PLAN F

PARTS A & B

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

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

PLAN G

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1632	$1632 (Part A deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $816 a day	$816 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 $204 a day	Up to $204 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 $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	100%	$0	$0
Durable medical equipment - 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	All but $1632	$1632 (Part A deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $816 a day	$816 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 $204 a day	Up to $204 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 $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	100%	$0	$0
Durable medical equipment - First $240 of Medicare Approved Amounts*	$0	$0	$240 (Unless Part B deductible has been met)
- Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2800 DEDUCTIBLE ** PLAN PAYS	IN ADDITION TO $2800 DEDUCTIBLE ** YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN N

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1632	$1632 (Part A deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $816 a day	$816 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 $204 a day	Up to $204 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 $240 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $240 of Medicare Approved Amounts*	$0	$0	$240 (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 $240 of Medicare Approved Amounts*	$0	$0	$240 (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 $240 of Medicare Approved Amounts* - Remainder of Medicare Approved Amounts	100% $0 80%	$0 $0 20%	$0 $240 (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.