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. Every Company must make Plan "A" and either Plan C or F available for those eligible for Medicare prior to January 1, 2020 and either Plan D or G available for those eligible for Medicare on or after January 1 2020. Only applicants' **first** eligible for Medicare before 2020 may purchase Plans C, F, and high deductible F.

Note: A ✓ means 100% of the benefit is paid.

Benefits	Plans Available to All Applicants									Medicare first eligible before 2020 only		
	A	B	D	G	G[1]	K	L	M	N	C	F	F[1]
Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	
Medicare Part B coinsurance or copayment	✓	✓	✓	✓		50%	75%	✓	✓ copays apply[3]	✓	✓	
Blood (first three pints)	✓	✓	✓	✓		50%	75%	✓	✓	✓	✓	
Part A hospice care coinsurance or copayment	✓	✓	✓	✓		50%	75%	✓	✓	✓	✓	
Skilled nursing facility coinsurance			✓	✓		50%	75%	✓	✓	✓	✓	
Medicare Part A deductible		✓	✓	✓		50%	75%	50%	✓	✓	✓	
Medicare Part B deductible										✓	✓	
Medicare Part B excess charges				✓							✓	
Foreign travel emergency (up to plan limits)			✓	✓				✓	✓	✓	✓	
Out-of-pocket limit in 2025[2]						$7220[2]	$3610[2]					

[1]Plans F and G also have a high deductible option which requires first paying a plan deductible of $2870 before the plan begins to pay. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High deductible plan G does not cover the Medicare Part B deductible. However, high deductible plans F and G count your payment of the Medicare Part B deductible toward meeting the plan deductible.

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

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

Effective 1-1-2025

ACE PROPERTY & CASUALTY INSURANCE COMPANY

Policy Fee $25

KENTUCKY Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: 402, 410, 416-418

	Preferred				
				HD Plan	
Attained Age	Plan A	Plan F	Plan G	G	Plan N
0-64	1,909	2,361	1,946	775	1,500
65	1,766	2,085	1,800	717	1,387
66	1,766	2,085	1,800	717	1,387
67	1,766	2,085	1,800	717	1,387
68	1,766	2,168	1,800	717	1,387
69	1,766	2,254	1,800	717	1,387
70	1,836	2,344	1,872	745	1,443
71	1,900	2,426	1,937	770	1,494
72	1,949	2,486	1,986	789	1,530
73	1,996	2,549	2,035	810	1,569
74	2,047	2,612	2,086	830	1,608
75	2,096	2,677	2,137	850	1,647
76	2,150	2,744	2,191	872	1,689
77	2,203	2,813	2,246	894	1,731
78	2,258	2,884	2,302	917	1,775
79	2,315	2,956	2,359	939	1,819
80	2,362	3,015	2,408	958	1,855
81	2,409	3,075	2,456	976	1,891
82	2,456	3,138	2,504	997	1,930
83	2,505	3,200	2,554	1,017	1,968
84	2,556	3,264	2,606	1,037	2,008
85	2,593	3,313	2,644	1,053	2,038
86	2,631	3,361	2,683	1,068	2,068
87	2,672	3,413	2,724	1,084	2,100
88	2,710	3,463	2,763	1,100	2,130
89	2,752	3,514	2,806	1,117	2,162
90	2,794	3,568	2,848	1,134	2,195
91	2,835	3,622	2,890	1,152	2,228
92	2,878	3,676	2,934	1,168	2,261
93	2,921	3,731	2,978	1,186	2,296
94	2,964	3,787	3,023	1,203	2,330
95	3,009	3,844	3,067	1,222	2,364
96	3,055	3,901	3,114	1,239	2,400
97	3,099	3,960	3,160	1,258	2,436
98	3,146	4,019	3,207	1,278	2,472
99	3,193	4,080	3,255	1,295	2,509

	Standard				
				HD Plan	
Attained Age	Plan A	Plan F	Plan G	G	Plan N
0-64	2,195	2,716	2,238	891	1,726
65	2,030	2,398	2,069	824	1,597
66	2,030	2,398	2,069	824	1,597
67	2,030	2,398	2,069	824	1,597
68	2,030	2,493	2,069	824	1,597
69	2,030	2,593	2,069	824	1,597
70	2,113	2,697	2,154	857	1,659
71	2,185	2,790	2,227	887	1,717
72	2,240	2,860	2,284	908	1,761
73	2,297	2,932	2,341	930	1,805
74	2,353	3,005	2,399	953	1,850
75	2,411	3,079	2,458	979	1,895
76	2,471	3,155	2,520	1,004	1,942
77	2,533	3,234	2,583	1,028	1,992
78	2,596	3,316	2,647	1,054	2,040
79	2,662	3,398	2,713	1,082	2,092
80	2,715	3,466	2,769	1,102	2,134
81	2,770	3,537	2,824	1,122	2,175
82	2,825	3,609	2,879	1,147	2,218
83	2,883	3,681	2,939	1,169	2,263
84	2,940	3,753	2,997	1,192	2,310
85	2,982	3,809	3,041	1,210	2,344
86	3,027	3,865	3,085	1,228	2,378
87	3,072	3,924	3,132	1,247	2,414
88	3,117	3,982	3,178	1,265	2,451
89	3,166	4,041	3,228	1,284	2,486
90	3,212	4,103	3,275	1,304	2,525
91	3,261	4,164	3,324	1,325	2,563
92	3,310	4,227	3,374	1,345	2,600
93	3,358	4,291	3,424	1,363	2,640
94	3,409	4,356	3,475	1,383	2,678
95	3,461	4,420	3,528	1,405	2,719
96	3,512	4,486	3,581	1,426	2,760
97	3,564	4,556	3,633	1,448	2,800
98	3,616	4,622	3,687	1,468	2,844
99	3,671	4,692	3,742	1,490	2,886

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

ACE PROPERTY & CASUALTY INSURANCE COMPANY

KENTUCKY Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: ALL EXCEPT 402, 410, 416-418

	Preferred				
				HD Plan	
Attained Age	Plan A	Plan F	Plan G	G	Plan N
0-64	1,784	2,207	1,819	724	1,402
65	1,650	1,948	1,682	670	1,296
66	1,650	1,948	1,682	670	1,296
67	1,650	1,948	1,682	670	1,296
68	1,650	2,026	1,682	670	1,296
69	1,650	2,107	1,682	670	1,296
70	1,715	2,191	1,749	696	1,348
71	1,776	2,267	1,810	720	1,396
72	1,821	2,324	1,856	738	1,430
73	1,865	2,382	1,902	757	1,466
74	1,913	2,441	1,950	776	1,503
75	1,959	2,502	1,998	795	1,540
76	2,009	2,565	2,048	815	1,579
77	2,059	2,629	2,099	835	1,618
78	2,110	2,695	2,151	857	1,658
79	2,163	2,763	2,205	878	1,700
80	2,207	2,818	2,251	896	1,733
81	2,251	2,874	2,295	912	1,768
82	2,295	2,933	2,340	931	1,803
83	2,342	2,990	2,387	950	1,839
84	2,389	3,050	2,435	969	1,877
85	2,424	3,096	2,471	984	1,904
86	2,459	3,141	2,507	998	1,933
87	2,497	3,189	2,545	1,013	1,963
88	2,533	3,236	2,583	1,028	1,991
89	2,572	3,284	2,622	1,044	2,021
90	2,611	3,334	2,662	1,060	2,052
91	2,649	3,385	2,701	1,076	2,083
92	2,690	3,435	2,742	1,092	2,113
93	2,730	3,487	2,783	1,108	2,146
94	2,770	3,539	2,825	1,124	2,178
95	2,812	3,592	2,867	1,142	2,210
96	2,855	3,646	2,910	1,158	2,243
97	2,896	3,701	2,953	1,176	2,276
98	2,940	3,756	2,998	1,194	2,311
99	2,984	3,813	3,042	1,211	2,345

	Standard				
				HD Plan	
Attained Age	Plan A	Plan F	Plan G	G	Plan N
0-64	2,052	2,538	2,092	832	1,613
65	1,897	2,241	1,934	770	1,492
66	1,897	2,241	1,934	770	1,492
67	1,897	2,241	1,934	770	1,492
68	1,897	2,330	1,934	770	1,492
69	1,897	2,423	1,934	770	1,492
70	1,974	2,520	2,013	801	1,550
71	2,042	2,608	2,081	829	1,605
72	2,093	2,673	2,134	848	1,645
73	2,147	2,740	2,188	870	1,687
74	2,199	2,808	2,242	891	1,729
75	2,254	2,878	2,297	915	1,771
76	2,309	2,948	2,355	939	1,815
77	2,368	3,023	2,414	961	1,862
78	2,426	3,099	2,474	985	1,907
79	2,488	3,176	2,536	1,011	1,955
80	2,538	3,240	2,587	1,030	1,995
81	2,589	3,306	2,639	1,049	2,033
82	2,640	3,373	2,691	1,072	2,073
83	2,694	3,440	2,747	1,093	2,115
84	2,748	3,507	2,801	1,114	2,159
85	2,787	3,560	2,842	1,131	2,191
86	2,829	3,613	2,884	1,148	2,223
87	2,871	3,668	2,927	1,165	2,256
88	2,913	3,722	2,970	1,182	2,290
89	2,959	3,777	3,017	1,200	2,324
90	3,002	3,834	3,061	1,219	2,359
91	3,047	3,892	3,107	1,238	2,395
92	3,094	3,951	3,153	1,257	2,429
93	3,139	4,011	3,200	1,274	2,467
94	3,186	4,071	3,248	1,293	2,503
95	3,235	4,131	3,297	1,313	2,541
96	3,282	4,193	3,346	1,333	2,579
97	3,331	4,258	3,396	1,353	2,617
98	3,380	4,320	3,446	1,372	2,658
99	3,431	4,385	3,497	1,392	2,697

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

Household Discount Factor 0.93

ACE PROPERTY & CASUALTY INSURANCE COMPANY

KENTUCKY Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: 402, 410, 416-418

	Preferred				
				HD Plan	
Attained Age	Plan A	Plan F	Plan G	G	Plan N
0-64	1,697	2,099	1,730	689	1,333
65	1,570	1,853	1,600	637	1,233
66	1,570	1,853	1,600	637	1,233
67	1,570	1,853	1,600	637	1,233
68	1,570	1,927	1,600	637	1,233
69	1,570	2,004	1,600	637	1,233
70	1,632	2,083	1,664	662	1,283
71	1,689	2,157	1,722	685	1,327
72	1,731	2,210	1,765	702	1,360
73	1,775	2,266	1,809	719	1,394
74	1,819	2,322	1,854	737	1,429
75	1,864	2,380	1,900	756	1,464
76	1,911	2,439	1,947	775	1,501
77	1,958	2,500	1,996	794	1,539
78	2,007	2,563	2,046	815	1,578
79	2,058	2,627	2,098	835	1,617
80	2,099	2,680	2,140	852	1,649
81	2,141	2,734	2,182	868	1,682
82	2,184	2,789	2,226	886	1,715
83	2,227	2,844	2,271	904	1,749
84	2,272	2,901	2,316	922	1,785
85	2,306	2,944	2,350	936	1,811
86	2,339	2,988	2,385	950	1,838
87	2,375	3,033	2,421	964	1,866
88	2,410	3,078	2,457	978	1,894
89	2,447	3,124	2,494	993	1,922
90	2,483	3,171	2,531	1,008	1,951
91	2,521	3,219	2,570	1,023	1,980
92	2,559	3,268	2,608	1,039	2,010
93	2,596	3,316	2,647	1,054	2,040
94	2,635	3,366	2,686	1,069	2,071
95	2,675	3,416	2,726	1,086	2,101
96	2,714	3,468	2,767	1,102	2,133
97	2,755	3,520	2,808	1,119	2,165
98	2,797	3,573	2,851	1,135	2,198
99	2,837	3,627	2,893	1,152	2,231

	Standard				
				HD Plan	
Attained Age	Plan A	Plan F	Plan G	G	Plan N
0-64	1,952	2,414	1,989	792	1,534
65	1,805	2,131	1,840	732	1,419
66	1,805	2,131	1,840	732	1,419
67	1,805	2,131	1,840	732	1,419
68	1,805	2,216	1,840	732	1,419
69	1,805	2,304	1,840	732	1,419
70	1,878	2,397	1,914	761	1,475
71	1,942	2,480	1,980	788	1,527
72	1,991	2,541	2,030	807	1,565
73	2,041	2,606	2,081	828	1,604
74	2,091	2,671	2,132	848	1,644
75	2,143	2,736	2,185	869	1,684
76	2,198	2,804	2,240	892	1,726
77	2,251	2,875	2,295	914	1,771
78	2,308	2,948	2,353	937	1,814
79	2,366	3,021	2,412	961	1,860
80	2,414	3,082	2,461	980	1,897
81	2,461	3,144	2,509	998	1,933
82	2,511	3,207	2,559	1,019	1,972
83	2,563	3,271	2,612	1,040	2,011
84	2,612	3,336	2,663	1,060	2,053
85	2,652	3,386	2,703	1,075	2,083
86	2,691	3,436	2,743	1,092	2,114
87	2,730	3,488	2,784	1,108	2,146
88	2,771	3,540	2,825	1,124	2,179
89	2,814	3,592	2,869	1,141	2,211
90	2,855	3,647	2,911	1,159	2,244
91	2,898	3,701	2,955	1,177	2,278
92	2,943	3,758	2,999	1,195	2,311
93	2,985	3,814	3,043	1,211	2,347
94	3,030	3,872	3,089	1,229	2,381
95	3,076	3,928	3,135	1,248	2,416
96	3,122	3,987	3,183	1,267	2,453
97	3,168	4,049	3,229	1,286	2,489
98	3,215	4,109	3,278	1,305	2,527
99	3,263	4,171	3,327	1,325	2,565

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

Household Discount Factor 0.93

ACE PROPERTY & CASUALTY INSURANCE COMPANY

KENTUCKY Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: ALL EXCEPT 402, 410, 416-418

	Preferred				
				HD Plan	
Attained Age	Plan A	Plan F	Plan G	G	Plan N
0-64	1,586	1,962	1,617	643	1,246
65	1,467	1,731	1,495	595	1,152
66	1,467	1,731	1,495	595	1,152
67	1,467	1,731	1,495	595	1,152
68	1,467	1,801	1,495	595	1,152
69	1,467	1,873	1,495	595	1,152
70	1,525	1,947	1,555	619	1,199
71	1,579	2,016	1,609	640	1,240
72	1,618	2,066	1,650	656	1,271
73	1,658	2,117	1,691	672	1,303
74	1,700	2,170	1,733	689	1,335
75	1,742	2,224	1,776	707	1,369
76	1,786	2,279	1,820	725	1,403
77	1,830	2,337	1,866	743	1,439
78	1,876	2,396	1,912	762	1,474
79	1,923	2,456	1,960	781	1,511
80	1,961	2,505	2,000	796	1,541
81	2,001	2,555	2,040	811	1,572
82	2,041	2,607	2,080	828	1,603
83	2,081	2,658	2,122	845	1,635
84	2,123	2,711	2,164	861	1,668
85	2,155	2,752	2,197	874	1,693
86	2,186	2,792	2,229	887	1,718
87	2,219	2,834	2,263	901	1,744
88	2,252	2,876	2,296	914	1,770
89	2,287	2,920	2,331	928	1,796
90	2,320	2,964	2,366	942	1,824
91	2,356	3,008	2,402	956	1,851
92	2,391	3,054	2,438	971	1,878
93	2,426	3,099	2,474	985	1,907
94	2,463	3,146	2,511	999	1,935
95	2,500	3,193	2,548	1,015	1,964
96	2,536	3,241	2,586	1,030	1,993
97	2,574	3,290	2,625	1,045	2,023
98	2,614	3,339	2,664	1,061	2,054
99	2,652	3,390	2,704	1,076	2,085

	Standard				
				HD Plan	
Attained Age	Plan A	Plan F	Plan G	G	Plan N
0-64	1,824	2,256	1,859	740	1,433
65	1,687	1,992	1,719	684	1,326
66	1,687	1,992	1,719	684	1,326
67	1,687	1,992	1,719	684	1,326
68	1,687	2,071	1,719	684	1,326
69	1,687	2,153	1,719	684	1,326
70	1,755	2,240	1,789	712	1,378
71	1,815	2,318	1,850	737	1,427
72	1,860	2,375	1,897	754	1,462
73	1,908	2,435	1,945	773	1,499
74	1,954	2,496	1,993	792	1,536
75	2,003	2,557	2,042	813	1,574
76	2,054	2,621	2,093	834	1,613
77	2,104	2,687	2,145	854	1,655
78	2,157	2,755	2,199	876	1,695
79	2,211	2,824	2,254	898	1,738
80	2,256	2,880	2,300	916	1,773
81	2,300	2,939	2,345	933	1,807
82	2,346	2,998	2,392	953	1,843
83	2,395	3,057	2,441	972	1,879
84	2,441	3,117	2,489	991	1,919
85	2,478	3,164	2,526	1,005	1,947
86	2,515	3,211	2,563	1,020	1,976
87	2,552	3,260	2,602	1,036	2,005
88	2,590	3,308	2,640	1,050	2,036
89	2,630	3,357	2,681	1,067	2,066
90	2,668	3,409	2,721	1,083	2,097
91	2,709	3,459	2,761	1,100	2,129
92	2,750	3,512	2,803	1,117	2,160
93	2,789	3,565	2,844	1,132	2,193
94	2,832	3,619	2,887	1,149	2,225
95	2,875	3,671	2,930	1,167	2,258
96	2,918	3,726	2,975	1,184	2,293
97	2,961	3,784	3,018	1,202	2,326
98	3,004	3,840	3,063	1,220	2,362
99	3,050	3,898	3,109	1,238	2,397

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

Household Discount Factor 0.93

PREMIUM INFORMATION

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

There is a one-time $25 policy fee.

Household Discount: You are eligible for a household premium discount if 1) you are currently married and residing with your spouse or 2) you have been residing with a person for at least the last 12 months. If you qualify for this discount it will remain in effect for the life of the policy.

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY

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

RIGHT TO RETURN POLICY

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

POLICY REPLACEMENT

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

NOTICE

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

COMPLETE ANSWERS ARE VERY IMPORTANT

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

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

PLAN A

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1676	$0	$1676 (Part A deductible)
61st thru 90th day	All but $419 a day	$419 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $838 a day	$838 a day	$0
— Once lifetime reserve days are used:			
— Additional 365 days	$0	100% of Medicare eligible expenses	$0**
— Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $209.50 a day	$0	Up to $209.50 a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

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

PLAN A

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

*Once you have been billed $257 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

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

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES — Medically necessary skilled care services and medical supplies — Durable medical equipment First $257 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% $0 80%	$0 $0 20%	$0 $257 (Part B deductible) $0

PLAN F

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1676	$1676 (Part A deductible)	$0
61st thru 90th day	All but $419 a day	$419 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $838 a day	$838 a day	$0
— Once lifetime reserve days are used:			
— Additional 365 days	$0	100% of Medicare eligible expenses	$0**
— Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $209.50 a day	Up to $209.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

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

PLAN F

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

*Once you have been billed $257 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

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

(continued)

PLAN F

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies Durable medical equipment	100%	$0	$0
- First $257 of Medicare Approved Amounts*	$0	$257 (Part B deductible)	$0
- Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

PLAN G

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1676	$1676 (Part A deductible)	$0
61st thru 90th day	All but $419 a day	$419 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $838 a day	$838 a day	$0
— Once lifetime reserve days are used:			
— Additional 365 days	$0	100% of Medicare eligible expenses	$0**
— Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $209.50 a day	Up to $209.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

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

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

*Once you have been billed $257 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

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

(continued)

PLAN G

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment - First $257 of Medicare Approved Amounts*	$0	$0	$257 (Unless Part B deductible has been met)
- Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

HIGH DEDUCTIBLE PLAN G
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row. **This high deductible plan pays the same benefits as Plan G after you have paid a calendar year $2870 deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are $2870. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2870 DEDUCTIBLE ** PLAN PAYS	IN ADDITION TO $2870 DEDUCTIBLE ** YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1676	$1676 (Part A deductible)	$0
61st thru 90th day	All but $419 a day	$419 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $838 a day	$838 a day	$0
— Once lifetime reserve days are used:			
— Additional 365 days	$0	100% of Medicare eligible expenses	$0***
— Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $209.50 a day	Up to $209.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

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

HIGH DEDUCTIBLE PLAN G

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

*Once you have been billed $257 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

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

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

(continued)

HIGH DEDUCTIBLE PLAN G

PARTS A & B

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2870 DEDUCTIBLE ** PLAN PAYS	IN ADDITION TO $2870 DEDUCTIBLE ** YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment - First $257 of Medicare Approved Amounts*	$0	$0	$257 (Unless Part B deductible has been met)
- Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2870 DEDUCTIBLE ** PLAN PAYS	IN ADDITION TO $2870 DEDUCTIBLE ** YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN N

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1676	$1676 (Part A deductible)	$0
61st thru 90th day	All but $419 a day	$419 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $838 a day	$838 a day	$0
— Once lifetime reserve days are used:			
— Additional 365 days	$0	100% of Medicare eligible expenses	$0**
— Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $209.50 a day	Up to $209.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

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

PLAN N

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

*Once you have been billed $257 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $257 of Medicare Approved Amounts*	$0	$0	$257 (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Balance, other than up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $257 of Medicare Approved Amounts*	$0	$0	$257 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

PLAN N

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies Durable medical equipment - First $257 of Medicare Approved Amounts* - Remainder of Medicare Approved Amounts	100% $0 80%	$0 $0 20%	$0 $257 (Part B deductible) $0

OTHER BENEFITS – NOT COVERED BY MEDICARE

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