

ACE PROPERTY & CASUALTY INSURANCE COMPANY
Outline of Medicare Supplement Coverage
Benefit Plans A, F, G, N and High Deductible Plan G

Benefit Chart of Medicare Supplement Plans Sold on or after January 1, 2020

This chart shows the benefits included in each of the standard Medicare supplement plans. Some plans may not be available in your state. Only applicants' **first** eligible for Medicare before 2020 may purchase Plans C, F, and high deductible F.

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

Benefits	Plans Available to All Applicants									Medicare first eligible before 2020 only		
	A	B	D	G	G ¹	K	L	M	N	C	F	F ¹
Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	
Medicare Part B coinsurance or copayment	✓	✓	✓	✓		50%	75%	✓	✓ copays apply ³	✓	✓	
Blood (first three pints)	✓	✓	✓	✓		50%	75%	✓	✓	✓	✓	
Part A hospice care coinsurance or copayment	✓	✓	✓	✓		50%	75%	✓	✓	✓	✓	
Skilled nursing facility coinsurance			✓	✓		50%	75%	✓	✓	✓	✓	
Medicare Part A deductible		✓	✓	✓		50%	75%	50%	✓	✓	✓	
Medicare Part B deductible										✓	✓	
Medicare Part B excess charges				✓							✓	
Foreign travel emergency (up to plan limits)			✓	✓				✓	✓	✓	✓	
Out-of-pocket limit in 2024 ²						\$7060 ²	\$3530 ²					

¹Plans F and G also have a high deductible option which requires first paying a plan deductible of \$2800 before the plan begins to pay. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High deductible plan G does not cover the Medicare Part B deductible. However, high deductible plans F and G count your payment of the Medicare Part B deductible toward meeting the plan deductible.

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

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

ACE PROPERTY & CASUALTY INSURANCE COMPANY**TENNESSEE Standard Plans MALE Rates - ANNUAL**

FOR USE IN ZIP CODES: ALL OF STATE

Attained Age	Preferred					Attained Age	Standard				
	Plan A	Plan F	Plan G	HD Plan G	Plan N		Plan A	Plan F	Plan G	HD Plan G	Plan N
0-64	5,596	6,366	5,653	2,240	4,241	0-64	6,439	7,324	6,500	2,576	4,876
65	1,399	1,591	1,413	560	1,060	65	1,610	1,831	1,625	644	1,219
66	1,399	1,591	1,413	560	1,060	66	1,610	1,831	1,625	644	1,219
67	1,399	1,591	1,413	560	1,060	67	1,610	1,831	1,625	644	1,219
68	1,399	1,640	1,413	560	1,070	68	1,610	1,886	1,625	644	1,231
69	1,407	1,689	1,421	563	1,091	69	1,619	1,942	1,634	648	1,256
70	1,421	1,740	1,434	569	1,114	70	1,634	2,001	1,650	654	1,281
71	1,463	1,792	1,478	586	1,147	71	1,681	2,061	1,699	674	1,319
72	1,514	1,854	1,529	606	1,187	72	1,742	2,134	1,759	697	1,366
73	1,567	1,920	1,583	627	1,229	73	1,801	2,207	1,819	722	1,413
74	1,623	1,987	1,639	649	1,272	74	1,866	2,284	1,885	747	1,462
75	1,687	2,066	1,705	675	1,323	75	1,940	2,377	1,960	776	1,521
76	1,754	2,150	1,773	703	1,376	76	2,017	2,471	2,039	808	1,581
77	1,825	2,235	1,844	730	1,431	77	2,100	2,570	2,120	840	1,645
78	1,898	2,324	1,917	760	1,488	78	2,182	2,673	2,206	874	1,711
79	1,974	2,416	1,994	790	1,548	79	2,269	2,780	2,293	908	1,779
80	2,052	2,514	2,073	822	1,608	80	2,361	2,890	2,385	944	1,851
81	2,145	2,627	2,166	859	1,681	81	2,467	3,020	2,492	987	1,933
82	2,242	2,745	2,264	898	1,757	82	2,577	3,155	2,604	1,031	2,021
83	2,343	2,867	2,367	937	1,836	83	2,693	3,298	2,722	1,078	2,111
84	2,447	2,996	2,473	979	1,919	84	2,814	3,445	2,844	1,127	2,206
85	2,558	3,131	2,584	1,023	2,005	85	2,942	3,601	2,972	1,176	2,305
86	2,672	3,273	2,700	1,069	2,095	86	3,074	3,764	3,105	1,230	2,409
87	2,793	3,420	2,821	1,118	2,189	87	3,211	3,934	3,244	1,286	2,518
88	2,918	3,574	2,947	1,168	2,288	88	3,357	4,109	3,390	1,344	2,632
89	3,049	3,734	3,080	1,221	2,391	89	3,507	4,295	3,543	1,403	2,751
90	3,186	3,903	3,220	1,275	2,499	90	3,665	4,489	3,701	1,468	2,873
91	3,330	4,078	3,364	1,333	2,611	91	3,830	4,690	3,869	1,533	3,003
92	3,480	4,261	3,516	1,393	2,730	92	4,001	4,902	4,042	1,601	3,138
93	3,637	4,454	3,673	1,455	2,853	93	4,181	5,122	4,224	1,673	3,281
94	3,800	4,654	3,838	1,521	2,981	94	4,370	5,352	4,414	1,749	3,429
95	3,972	4,863	4,011	1,589	3,115	95	4,567	5,593	4,613	1,827	3,582
96	4,149	5,083	4,191	1,660	3,256	96	4,772	5,844	4,820	1,909	3,743
97	4,336	5,311	4,380	1,735	3,402	97	4,987	6,107	5,037	1,996	3,912
98	4,532	5,550	4,577	1,813	3,555	98	5,210	6,383	5,264	2,085	4,088
99	4,736	5,800	4,783	1,895	3,716	99	5,445	6,670	5,502	2,179	4,273

During open enrollment and guarantee issue periods only the best rates apply. These rates will continue upon each renewal.

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

TENNESSEE Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: ALL OF STATE

Attained Age	Preferred					Attained Age	Standard				
	Plan A	Plan F	Plan G	HD Plan G	Plan N		Plan A	Plan F	Plan G	HD Plan G	Plan N
0-64	4,975	5,659	5,024	1,993	3,766	0-64	5,721	6,510	5,782	2,288	4,333
65	1,244	1,415	1,256	498	941	65	1,430	1,627	1,445	572	1,083
66	1,244	1,415	1,256	498	941	66	1,430	1,627	1,445	572	1,083
67	1,244	1,415	1,256	498	941	67	1,430	1,627	1,445	572	1,083
68	1,244	1,458	1,256	498	951	68	1,430	1,676	1,445	572	1,094
69	1,251	1,502	1,263	501	970	69	1,438	1,726	1,453	576	1,116
70	1,263	1,547	1,275	505	990	70	1,453	1,779	1,467	581	1,138
71	1,300	1,592	1,313	520	1,019	71	1,495	1,832	1,511	599	1,172
72	1,346	1,648	1,359	538	1,055	72	1,548	1,896	1,563	620	1,214
73	1,393	1,706	1,407	557	1,092	73	1,602	1,962	1,618	641	1,256
74	1,442	1,766	1,457	577	1,130	74	1,659	2,030	1,675	664	1,299
75	1,499	1,836	1,515	600	1,175	75	1,725	2,113	1,742	690	1,352
76	1,559	1,910	1,576	624	1,222	76	1,793	2,196	1,812	718	1,406
77	1,623	1,987	1,639	649	1,272	77	1,866	2,284	1,885	747	1,463
78	1,687	2,066	1,705	676	1,323	78	1,940	2,376	1,961	777	1,521
79	1,754	2,149	1,772	702	1,376	79	2,017	2,470	2,038	807	1,581
80	1,824	2,234	1,843	730	1,431	80	2,099	2,570	2,120	840	1,644
81	1,907	2,334	1,925	764	1,495	81	2,192	2,685	2,215	878	1,718
82	1,993	2,439	2,013	798	1,561	82	2,291	2,805	2,315	918	1,796
83	2,083	2,549	2,103	834	1,631	83	2,394	2,931	2,419	957	1,876
84	2,175	2,663	2,197	871	1,705	84	2,502	3,063	2,528	1,001	1,961
85	2,274	2,784	2,297	910	1,782	85	2,616	3,201	2,641	1,045	2,049
86	2,376	2,908	2,400	950	1,862	86	2,733	3,346	2,759	1,093	2,142
87	2,483	3,040	2,508	993	1,946	87	2,855	3,496	2,883	1,143	2,238
88	2,595	3,177	2,620	1,038	2,034	88	2,984	3,653	3,013	1,194	2,339
89	2,711	3,320	2,739	1,084	2,126	89	3,117	3,818	3,149	1,247	2,445
90	2,832	3,469	2,862	1,133	2,221	90	3,258	3,990	3,291	1,304	2,555
91	2,960	3,625	2,990	1,185	2,321	91	3,405	4,169	3,438	1,362	2,670
92	3,094	3,788	3,125	1,238	2,426	92	3,557	4,357	3,593	1,424	2,790
93	3,233	3,959	3,265	1,293	2,536	93	3,716	4,553	3,754	1,487	2,916
94	3,378	4,137	3,412	1,352	2,650	94	3,884	4,757	3,924	1,556	3,048
95	3,530	4,323	3,565	1,413	2,769	95	4,059	4,971	4,101	1,624	3,185
96	3,688	4,518	3,726	1,476	2,893	96	4,242	5,195	4,284	1,696	3,328
97	3,855	4,720	3,894	1,543	3,024	97	4,432	5,429	4,478	1,774	3,477
98	4,028	4,933	4,069	1,611	3,160	98	4,632	5,673	4,679	1,854	3,634
99	4,209	5,156	4,252	1,684	3,303	99	4,840	5,929	4,890	1,937	3,798

During open enrollment and guarantee issue periods only the best rates apply. These rates will continue upon each renewal.

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

PREMIUM INFORMATION

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

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY

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

RIGHT TO RETURN POLICY

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

POLICY REPLACEMENT

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

NOTICE

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

COMPLETE ANSWERS ARE VERY IMPORTANT

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

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

PLAN A

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 st thru 90 th day 91 st day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the additional 365 days	All but \$1632 All but \$408 a day All but \$816 a day \$0 \$0	\$0 \$408 a day \$816 a day 100% of Medicare eligible expenses \$0	\$1632 (Part A deductible) \$0 \$0 \$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21 st thru 100 th day 101 st day and after	All approved amounts All but \$204 a day \$0	\$0 \$0 \$0	\$0 Up to \$204 a day All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

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

PLAN A

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

*Once you have been billed \$240 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

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

PARTS A & B

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

PLAN F

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 st thru 90 th day 91 st day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the additional 365 days	All but \$1632 All but \$408 a day All but \$816 a day \$0 \$0	\$1632 (Part A deductible) \$408 a day \$816 a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$0 \$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21 st thru 100 th day 101 st day and after	All approved amounts All but \$204 a day \$0	\$0 Up to \$204 a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

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

PLAN F

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

*Once you have been billed \$240 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

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

(continued)

PLAN F
PARTS A & B

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

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

PLAN G

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 st thru 90 th day 91 st day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the additional 365 days	All but \$1632 All but \$408 a day All but \$816 a day \$0 \$0	\$1632 (Part A deductible) \$408 a day \$816 a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$0 \$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21 st thru 100 th day 101 st day and after	All approved amounts All but \$204 a day \$0	\$0 Up to \$204 a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

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

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

*Once you have been billed \$240 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

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

(continued)

PLAN G
PARTS A & B

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

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

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

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row. **This high deductible plan pays the same benefits as Plan G after you have paid a calendar year \$2800 deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are \$2800. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$2800 DEDUCTIBLE ** PLAN PAYS	IN ADDITION TO \$2800 DEDUCTIBLE ** YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 st thru 90 th day 91 st day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the additional 365 days	All but \$1632 All but \$408 a day All but \$816 a day \$0 \$0	\$1632 (Part A deductible) \$408 a day \$816 a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$0 \$0*** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21 st thru 100 th day 101 st day and after	All approved amounts All but \$204 a day \$0	\$0 Up to \$204 a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

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

HIGH DEDUCTIBLE PLAN G

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

*Once you have been billed \$240 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

**This high deductible plan pays the same benefits as Plan G after you have paid a calendar year \$2800 deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are \$2800. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$2800 DEDUCTIBLE ** PLAN PAYS	IN ADDITION TO \$2800 DEDUCTIBLE ** YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$240 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 Generally 80%	\$0 Generally 20%	\$240 (Unless Part B deductible has been met) \$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	\$0	100%	\$0
BLOOD First 3 pints Next \$240 of Medicare Approved amounts* Remainder of Medicare Approved amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$240 (Unless Part B deductible has been met) \$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

(continued)

HIGH DEDUCTIBLE PLAN G

PARTS A & B

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$2800 DEDUCTIBLE ** PLAN PAYS	IN ADDITION TO \$2800 DEDUCTIBLE ** YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies Durable medical equipment	100%	\$0	\$0
- First \$240 of Medicare Approved Amounts*	\$0	\$0	\$240 (Unless Part B deductible has been met)
- Remainder of Medicare Approved Amounts	80%	20%	\$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	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 61 st thru 90 th day 91 st day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the additional 365 days	All but \$1632 All but \$408 a day All but \$816 a day \$0 \$0	\$1632 (Part A deductible) \$408 a day \$816 a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$0 \$0** All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21 st thru 100 th day 101 st day and after	All approved amounts All but \$204 a day \$0	\$0 Up to \$204 a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

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

PLAN N

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

*Once you have been billed \$240 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$240 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 Generally 80%	\$0 Balance, other than up to \$20 per office visit and up to \$50 per emergency room visit. The copayment of up to \$50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	\$240 (Part B deductible) Up to \$20 per office visit and up to \$50 per emergency room visit. The copayment of up to \$50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD First 3 pints Next \$240 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$240 (Part B deductible) \$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

(continued)

PLAN N
PARTS A & B

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

OTHER BENEFITS – NOT COVERED BY MEDICARE

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