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

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

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

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

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

[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 8-1-2024

ACE PROPERTY & CASUALTY INSURANCE COMPANY

Policy Fee $25

ILLINOIS Standard Plans MALE Rates - ANNUAL

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

	Preferred				
				HD Plan	
Attained Age	Plan A	Plan F	Plan G	G	Plan N
0-64	5,668	7,162	5,936	2,268	4,424
65	1,667	1,965	1,745	667	1,263
66	1,667	1,965	1,745	667	1,263
67	1,667	1,965	1,745	667	1,263
68	1,667	2,025	1,745	667	1,274
69	1,675	2,086	1,755	671	1,299
70	1,700	2,149	1,781	681	1,326
71	1,750	2,213	1,834	701	1,366
72	1,811	2,291	1,897	725	1,414
73	1,874	2,370	1,964	751	1,463
74	1,941	2,453	2,032	778	1,514
75	2,016	2,551	2,112	808	1,575
76	2,098	2,654	2,199	841	1,638
77	2,184	2,760	2,286	872	1,703
78	2,269	2,869	2,378	909	1,772
79	2,360	2,984	2,472	944	1,843
80	2,456	3,105	2,572	983	1,915
81	2,566	3,243	2,687	1,026	2,002
82	2,681	3,389	2,807	1,074	2,093
83	2,801	3,540	2,934	1,121	2,186
84	2,926	3,700	3,066	1,172	2,284
85	3,058	3,866	3,204	1,224	2,387
86	3,198	4,041	3,348	1,279	2,494
87	3,341	4,223	3,499	1,336	2,608
88	3,492	4,413	3,657	1,397	2,725
89	3,648	4,612	3,822	1,461	2,847
90	3,813	4,818	3,993	1,526	2,976
91	3,985	5,037	4,173	1,595	3,109
92	4,164	5,262	4,363	1,667	3,250
93	4,351	5,500	4,558	1,741	3,398
94	4,547	5,745	4,763	1,821	3,551
95	4,752	6,006	4,977	1,902	3,708
96	4,967	6,276	5,202	1,987	3,876
97	5,190	6,559	5,437	2,077	4,050
98	5,423	6,853	5,682	2,169	4,234
99	5,668	7,162	5,936	2,268	4,424

	Standard				
				HD Plan	
Attained Age	Plan A	Plan F	Plan G	G	Plan N
0-64	6,518	8,237	6,828	2,609	5,089
65	1,917	2,261	2,007	767	1,451
66	1,917	2,261	2,007	767	1,451
67	1,917	2,261	2,007	767	1,451
68	1,917	2,329	2,007	767	1,465
69	1,928	2,398	2,018	772	1,494
70	1,956	2,471	2,047	782	1,526
71	2,015	2,544	2,110	807	1,570
72	2,083	2,634	2,182	833	1,627
73	2,156	2,726	2,258	864	1,681
74	2,231	2,822	2,337	893	1,740
75	2,320	2,935	2,430	929	1,811
76	2,413	3,052	2,529	968	1,884
77	2,511	3,174	2,628	1,004	1,959
78	2,609	3,300	2,734	1,044	2,038
79	2,714	3,432	2,844	1,086	2,118
80	2,823	3,570	2,958	1,129	2,204
81	2,950	3,730	3,091	1,182	2,301
82	3,084	3,896	3,230	1,234	2,405
83	3,221	4,072	3,373	1,289	2,512
84	3,367	4,254	3,526	1,348	2,627
85	3,517	4,447	3,685	1,407	2,744
86	3,675	4,647	3,851	1,471	2,869
87	3,842	4,858	4,025	1,537	2,999
88	4,015	5,075	4,207	1,607	3,133
89	4,193	5,302	4,394	1,679	3,276
90	4,386	5,543	4,593	1,755	3,422
91	4,582	5,792	4,800	1,833	3,576
92	4,790	6,053	5,017	1,917	3,737
93	5,005	6,324	5,242	2,002	3,907
94	5,230	6,609	5,478	2,094	4,082
95	5,465	6,906	5,726	2,187	4,265
96	5,711	7,216	5,981	2,285	4,457
97	5,968	7,542	6,251	2,389	4,658
98	6,237	7,881	6,533	2,496	4,868
99	6,518	8,237	6,828	2,609	5,089

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

ACE PROPERTY & CASUALTY INSURANCE COMPANY

ILLINOIS Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: 601, 605

	Preferred				
				HD Plan	
Attained Age	Plan A	Plan F	Plan G	G	Plan N
0-64	5,458	6,896	5,716	2,184	4,260
65	1,605	1,892	1,680	642	1,216
66	1,605	1,892	1,680	642	1,216
67	1,605	1,892	1,680	642	1,216
68	1,605	1,950	1,680	642	1,227
69	1,613	2,008	1,690	646	1,251
70	1,637	2,069	1,715	655	1,277
71	1,685	2,131	1,766	675	1,315
72	1,744	2,206	1,827	699	1,362
73	1,804	2,282	1,891	723	1,409
74	1,869	2,362	1,957	749	1,458
75	1,941	2,457	2,034	778	1,516
76	2,020	2,556	2,117	810	1,577
77	2,103	2,658	2,201	840	1,640
78	2,185	2,763	2,290	875	1,707
79	2,273	2,873	2,380	909	1,774
80	2,365	2,990	2,477	946	1,844
81	2,471	3,123	2,588	988	1,927
82	2,582	3,263	2,703	1,034	2,015
83	2,697	3,409	2,825	1,079	2,105
84	2,817	3,563	2,952	1,128	2,200
85	2,945	3,723	3,086	1,179	2,299
86	3,079	3,891	3,224	1,231	2,402
87	3,217	4,067	3,369	1,286	2,511
88	3,362	4,250	3,521	1,346	2,624
89	3,513	4,441	3,680	1,406	2,742
90	3,671	4,640	3,845	1,470	2,865
91	3,838	4,850	4,019	1,536	2,994
92	4,010	5,067	4,201	1,605	3,129
93	4,190	5,296	4,389	1,676	3,272
94	4,379	5,532	4,586	1,753	3,419
95	4,576	5,783	4,793	1,832	3,571
96	4,783	6,044	5,010	1,913	3,732
97	4,998	6,316	5,236	2,000	3,900
98	5,222	6,600	5,472	2,089	4,077
99	5,458	6,896	5,716	2,184	4,260

	Standard				
				HD Plan	
Attained Age	Plan A	Plan F	Plan G	G	Plan N
0-64	6,277	7,932	6,575	2,513	4,900
65	1,846	2,177	1,932	738	1,397
66	1,846	2,177	1,932	738	1,397
67	1,846	2,177	1,932	738	1,397
68	1,846	2,242	1,932	738	1,411
69	1,856	2,309	1,943	743	1,439
70	1,883	2,379	1,972	753	1,470
71	1,940	2,449	2,031	777	1,512
72	2,006	2,537	2,101	803	1,566
73	2,076	2,625	2,175	832	1,619
74	2,149	2,717	2,250	860	1,675
75	2,234	2,826	2,340	895	1,744
76	2,323	2,939	2,435	932	1,814
77	2,418	3,056	2,530	967	1,887
78	2,512	3,177	2,633	1,006	1,962
79	2,613	3,305	2,738	1,045	2,040
80	2,718	3,438	2,848	1,088	2,122
81	2,841	3,592	2,977	1,138	2,216
82	2,970	3,752	3,110	1,188	2,316
83	3,102	3,921	3,248	1,242	2,419
84	3,242	4,097	3,395	1,298	2,530
85	3,387	4,282	3,548	1,355	2,642
86	3,539	4,475	3,708	1,417	2,763
87	3,700	4,678	3,876	1,480	2,888
88	3,866	4,887	4,051	1,548	3,017
89	4,038	5,106	4,232	1,617	3,155
90	4,223	5,337	4,423	1,690	3,295
91	4,412	5,577	4,622	1,765	3,444
92	4,612	5,829	4,831	1,846	3,599
93	4,820	6,090	5,047	1,927	3,763
94	5,036	6,365	5,275	2,016	3,931
95	5,262	6,651	5,513	2,106	4,107
96	5,499	6,949	5,759	2,201	4,292
97	5,747	7,262	6,020	2,300	4,486
98	6,006	7,589	6,291	2,404	4,688
99	6,277	7,932	6,575	2,513	4,900

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

Household Discount Factor 0.93

ACE PROPERTY & CASUALTY INSURANCE COMPANY

ILLINOIS Standard Plans MALE Rates - ANNUAL

FOR USE IN ZIP CODES: ALL EXCEPT 600-608

	Preferred				
				HD Plan	
Attained Age	Plan A	Plan F	Plan G	G	Plan N
0-64	4,986	6,300	5,222	1,995	3,891
65	1,466	1,728	1,535	587	1,111
66	1,466	1,728	1,535	587	1,111
67	1,466	1,728	1,535	587	1,111
68	1,466	1,782	1,535	587	1,120
69	1,474	1,835	1,544	590	1,143
70	1,495	1,890	1,566	599	1,166
71	1,539	1,946	1,613	617	1,201
72	1,593	2,015	1,669	638	1,244
73	1,648	2,085	1,727	660	1,287
74	1,708	2,158	1,788	684	1,332
75	1,773	2,244	1,858	711	1,385
76	1,845	2,335	1,934	739	1,441
77	1,921	2,428	2,011	767	1,498
78	1,996	2,524	2,091	799	1,559
79	2,076	2,625	2,174	830	1,621
80	2,160	2,731	2,262	864	1,685
81	2,257	2,853	2,364	903	1,761
82	2,358	2,981	2,469	944	1,841
83	2,464	3,114	2,581	986	1,923
84	2,574	3,254	2,697	1,031	2,009
85	2,690	3,400	2,819	1,077	2,100
86	2,813	3,554	2,945	1,125	2,194
87	2,939	3,715	3,078	1,175	2,294
88	3,071	3,882	3,216	1,229	2,397
89	3,209	4,057	3,362	1,285	2,504
90	3,354	4,238	3,512	1,342	2,617
91	3,506	4,431	3,671	1,403	2,735
92	3,663	4,629	3,838	1,466	2,859
93	3,828	4,838	4,010	1,531	2,989
94	4,000	5,054	4,190	1,602	3,123
95	4,180	5,283	4,378	1,673	3,262
96	4,370	5,521	4,576	1,748	3,409
97	4,566	5,770	4,783	1,827	3,563
98	4,770	6,029	4,998	1,908	3,724
99	4,986	6,300	5,222	1,995	3,891

	Standard				
				HD Plan	
Attained Age	Plan A	Plan F	Plan G	G	Plan N
0-64	5,733	7,246	6,006	2,295	4,476
65	1,686	1,988	1,765	674	1,276
66	1,686	1,988	1,765	674	1,276
67	1,686	1,988	1,765	674	1,276
68	1,686	2,048	1,765	674	1,289
69	1,696	2,109	1,775	679	1,315
70	1,720	2,173	1,801	688	1,342
71	1,772	2,237	1,856	710	1,381
72	1,832	2,317	1,919	733	1,431
73	1,896	2,398	1,986	760	1,479
74	1,963	2,482	2,056	785	1,530
75	2,040	2,582	2,137	817	1,593
76	2,122	2,685	2,224	851	1,657
77	2,208	2,792	2,311	884	1,723
78	2,295	2,903	2,405	919	1,793
79	2,387	3,019	2,501	955	1,863
80	2,483	3,140	2,602	993	1,939
81	2,595	3,281	2,719	1,039	2,024
82	2,713	3,427	2,841	1,085	2,116
83	2,833	3,582	2,967	1,134	2,210
84	2,962	3,742	3,101	1,185	2,311
85	3,094	3,912	3,241	1,238	2,414
86	3,233	4,088	3,387	1,294	2,524
87	3,379	4,274	3,540	1,352	2,638
88	3,531	4,464	3,700	1,414	2,756
89	3,689	4,664	3,866	1,477	2,882
90	3,858	4,876	4,040	1,544	3,010
91	4,030	5,095	4,222	1,612	3,146
92	4,213	5,325	4,413	1,686	3,288
93	4,403	5,563	4,611	1,761	3,437
94	4,600	5,814	4,818	1,842	3,591
95	4,807	6,075	5,036	1,924	3,752
96	5,023	6,347	5,261	2,010	3,920
97	5,250	6,634	5,499	2,101	4,097
98	5,487	6,933	5,747	2,196	4,282
99	5,733	7,246	6,006	2,295	4,476

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

Household Discount Factor 0.93

ACE PROPERTY & CASUALTY INSURANCE COMPANY

ILLINOIS Standard Plans FEMALE Rates - ANNUAL

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

	Preferred						Standard					
Attained Age	Plan A	Plan F	Plan G	HD Plan G	Plan N	Attained Age	Plan A	Plan F	Plan G	HD Plan G	Plan N
0-64	5,037	6,365	5,277	2,016	3,933	0-64	5,793	7,320	6,068	2,318	4,522
65	1,481	1,747	1,552	592	1,121	65	1,704	2,010	1,784	682	1,291
66	1,481	1,747	1,552	592	1,121	66	1,704	2,010	1,784	682	1,291
67	1,481	1,747	1,552	592	1,121	67	1,704	2,010	1,784	682	1,291
68	1,481	1,800	1,552	592	1,133	68	1,704	2,071	1,784	682	1,303
69	1,489	1,853	1,560	596	1,155	69	1,713	2,131	1,795	687	1,328
70	1,511	1,910	1,583	605	1,179	70	1,738	2,196	1,821	696	1,356
71	1,557	1,966	1,630	624	1,213	71	1,789	2,262	1,875	716	1,396
72	1,611	2,035	1,687	645	1,257	72	1,852	2,341	1,939	741	1,445
73	1,667	2,107	1,745	667	1,300	73	1,915	2,423	2,007	767	1,494
74	1,726	2,181	1,806	691	1,345	74	1,984	2,507	2,078	795	1,548
75	1,793	2,268	1,878	717	1,399	75	2,062	2,608	2,159	825	1,610
76	1,864	2,359	1,955	747	1,456	76	2,144	2,712	2,247	860	1,674
77	1,940	2,453	2,032	776	1,514	77	2,231	2,822	2,336	893	1,741
78	2,016	2,551	2,112	808	1,575	78	2,318	2,934	2,430	929	1,811
79	2,098	2,653	2,199	839	1,638	79	2,413	3,051	2,527	966	1,884
80	2,184	2,759	2,286	872	1,703	80	2,511	3,174	2,628	1,003	1,958
81	2,280	2,883	2,388	912	1,780	81	2,622	3,315	2,746	1,049	2,046
82	2,382	3,012	2,496	953	1,860	82	2,741	3,464	2,870	1,098	2,139
83	2,490	3,147	2,607	996	1,942	83	2,863	3,620	2,999	1,146	2,233
84	2,601	3,288	2,726	1,041	2,031	84	2,992	3,782	3,135	1,198	2,335
85	2,719	3,437	2,849	1,088	2,122	85	3,127	3,953	3,274	1,251	2,441
86	2,841	3,592	2,976	1,138	2,217	86	3,266	4,130	3,423	1,309	2,551
87	2,970	3,754	3,110	1,188	2,317	87	3,416	4,317	3,577	1,366	2,665
88	3,102	3,924	3,251	1,242	2,422	88	3,568	4,511	3,739	1,429	2,785
89	3,243	4,100	3,396	1,298	2,530	89	3,728	4,714	3,907	1,492	2,911
90	3,389	4,285	3,550	1,356	2,644	90	3,897	4,926	4,082	1,560	3,042
91	3,543	4,476	3,710	1,418	2,765	91	4,073	5,148	4,267	1,630	3,178
92	3,701	4,678	3,878	1,482	2,889	92	4,257	5,380	4,459	1,704	3,321
93	3,869	4,887	4,052	1,548	3,019	93	4,449	5,622	4,660	1,780	3,472
94	4,042	5,107	4,234	1,617	3,155	94	4,648	5,875	4,868	1,861	3,628
95	4,224	5,338	4,425	1,691	3,297	95	4,857	6,139	5,089	1,943	3,792
96	4,414	5,578	4,623	1,766	3,446	96	5,076	6,414	5,318	2,032	3,962
97	4,614	5,829	4,833	1,846	3,600	97	5,305	6,704	5,557	2,123	4,140
98	4,820	6,092	5,050	1,930	3,763	98	5,544	7,006	5,807	2,219	4,327
99	5,037	6,365	5,277	2,016	3,933	99	5,793	7,320	6,068	2,318	4,522

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

Household Discount Factor 0.93

ACE PROPERTY & CASUALTY INSURANCE COMPANY

ILLINOIS Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: 601, 605

	Preferred						Standard				
Attained Age	Plan A	Plan F	Plan G	HD Plan G	Plan N	Attained Age	Plan A	Plan F	Plan G	HD Plan G	Plan N
0-64	4,851	6,130	5,082	1,941	3,787	0-64	5,578	7,049	5,844	2,232	4,355
65	1,426	1,683	1,495	570	1,079	65	1,640	1,936	1,718	656	1,243
66	1,426	1,683	1,495	570	1,079	66	1,640	1,936	1,718	656	1,243
67	1,426	1,683	1,495	570	1,079	67	1,640	1,936	1,718	656	1,243
68	1,426	1,734	1,495	570	1,091	68	1,640	1,994	1,718	656	1,255
69	1,434	1,784	1,502	574	1,112	69	1,650	2,052	1,728	661	1,279
70	1,455	1,839	1,524	583	1,135	70	1,674	2,115	1,754	671	1,306
71	1,499	1,893	1,569	600	1,168	71	1,723	2,178	1,805	689	1,345
72	1,551	1,960	1,624	621	1,210	72	1,783	2,254	1,868	714	1,391
73	1,605	2,029	1,680	642	1,252	73	1,845	2,333	1,932	738	1,439
74	1,662	2,101	1,739	666	1,295	74	1,911	2,414	2,001	765	1,491
75	1,727	2,184	1,809	690	1,347	75	1,986	2,511	2,079	794	1,550
76	1,795	2,271	1,882	720	1,402	76	2,065	2,612	2,164	828	1,612
77	1,868	2,362	1,957	748	1,458	77	2,149	2,717	2,249	860	1,676
78	1,941	2,457	2,034	778	1,516	78	2,233	2,825	2,340	895	1,744
79	2,020	2,555	2,117	808	1,577	79	2,323	2,938	2,434	930	1,814
80	2,103	2,657	2,201	840	1,640	80	2,418	3,056	2,530	966	1,885
81	2,196	2,777	2,299	878	1,714	81	2,525	3,192	2,644	1,010	1,971
82	2,294	2,900	2,403	918	1,791	82	2,639	3,336	2,764	1,057	2,059
83	2,398	3,031	2,511	959	1,870	83	2,757	3,486	2,888	1,104	2,151
84	2,505	3,167	2,625	1,002	1,955	84	2,881	3,641	3,018	1,154	2,249
85	2,618	3,310	2,743	1,048	2,043	85	3,011	3,806	3,153	1,204	2,350
86	2,736	3,459	2,866	1,096	2,135	86	3,145	3,977	3,296	1,260	2,457
87	2,860	3,615	2,995	1,144	2,231	87	3,289	4,157	3,444	1,315	2,566
88	2,987	3,778	3,131	1,196	2,333	88	3,435	4,344	3,601	1,376	2,682
89	3,123	3,948	3,270	1,250	2,437	89	3,590	4,539	3,762	1,437	2,804
90	3,263	4,126	3,418	1,306	2,547	90	3,753	4,744	3,931	1,502	2,930
91	3,412	4,310	3,573	1,366	2,662	91	3,923	4,957	4,109	1,570	3,060
92	3,564	4,505	3,734	1,427	2,782	92	4,099	5,181	4,294	1,641	3,198
93	3,726	4,706	3,901	1,491	2,907	93	4,285	5,414	4,487	1,714	3,343
94	3,892	4,918	4,078	1,557	3,038	94	4,476	5,657	4,688	1,792	3,494
95	4,068	5,140	4,261	1,628	3,175	95	4,677	5,912	4,901	1,871	3,652
96	4,250	5,371	4,452	1,701	3,319	96	4,888	6,177	5,121	1,957	3,815
97	4,443	5,614	4,654	1,778	3,467	97	5,109	6,456	5,351	2,044	3,987
98	4,642	5,867	4,863	1,858	3,624	98	5,339	6,746	5,592	2,137	4,167
99	4,851	6,130	5,082	1,941	3,787	99	5,578	7,049	5,844	2,232	4,355

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

Household Discount Factor 0.93

ACE PROPERTY & CASUALTY INSURANCE COMPANY

ILLINOIS Standard Plans FEMALE Rates - ANNUAL

FOR USE IN ZIP CODES: ALL EXCEPT 600-608

	Preferred						Standard					
				HD Plan						HD Plan		
Attained Age	Plan A	Plan F	Plan G	G	Plan N	Attained Age	Plan A	Plan F	Plan G	G	Plan N
0-64	4,431	5,599	4,642	1,773	3,459	0-64	5,096	6,439	5,338	2,039	3,978
65	1,302	1,537	1,365	521	986	65	1,499	1,768	1,570	600	1,135
66	1,302	1,537	1,365	521	986	66	1,499	1,768	1,570	600	1,135
67	1,302	1,537	1,365	521	986	67	1,499	1,768	1,570	600	1,135
68	1,302	1,583	1,365	521	997	68	1,499	1,821	1,570	600	1,146
69	1,310	1,630	1,372	524	1,016	69	1,507	1,875	1,579	604	1,168
70	1,329	1,680	1,392	532	1,037	70	1,529	1,932	1,602	612	1,193
71	1,369	1,730	1,433	548	1,067	71	1,574	1,990	1,649	630	1,228
72	1,417	1,790	1,484	568	1,105	72	1,629	2,059	1,706	652	1,271
73	1,466	1,853	1,535	587	1,144	73	1,685	2,131	1,765	674	1,315
74	1,518	1,919	1,589	608	1,183	74	1,745	2,205	1,828	699	1,362
75	1,577	1,995	1,652	631	1,230	75	1,814	2,294	1,899	726	1,416
76	1,640	2,075	1,719	657	1,280	76	1,886	2,386	1,976	757	1,473
77	1,706	2,158	1,788	683	1,332	77	1,963	2,482	2,055	785	1,531
78	1,773	2,244	1,858	711	1,385	78	2,039	2,580	2,137	817	1,593
79	1,845	2,334	1,934	738	1,441	79	2,122	2,683	2,223	849	1,657
80	1,921	2,427	2,011	767	1,498	80	2,208	2,792	2,311	882	1,722
81	2,006	2,536	2,100	802	1,565	81	2,306	2,916	2,415	923	1,800
82	2,095	2,649	2,195	839	1,636	82	2,411	3,047	2,525	966	1,881
83	2,190	2,769	2,294	876	1,708	83	2,519	3,185	2,638	1,008	1,964
84	2,288	2,893	2,398	916	1,786	84	2,632	3,326	2,757	1,054	2,054
85	2,392	3,023	2,506	957	1,866	85	2,750	3,477	2,880	1,100	2,147
86	2,499	3,159	2,618	1,001	1,951	86	2,873	3,633	3,011	1,151	2,244
87	2,612	3,302	2,736	1,045	2,038	87	3,005	3,798	3,146	1,201	2,344
88	2,729	3,451	2,860	1,093	2,131	88	3,138	3,968	3,289	1,257	2,450
89	2,853	3,606	2,987	1,142	2,226	89	3,279	4,146	3,437	1,312	2,561
90	2,981	3,769	3,123	1,193	2,326	90	3,428	4,333	3,591	1,372	2,676
91	3,117	3,937	3,263	1,247	2,432	91	3,583	4,528	3,754	1,434	2,796
92	3,256	4,115	3,411	1,304	2,542	92	3,745	4,733	3,922	1,499	2,922
93	3,403	4,299	3,564	1,362	2,656	93	3,914	4,945	4,099	1,565	3,054
94	3,555	4,493	3,725	1,422	2,775	94	4,088	5,168	4,282	1,637	3,192
95	3,716	4,695	3,892	1,487	2,900	95	4,273	5,400	4,477	1,709	3,336
96	3,883	4,906	4,067	1,554	3,031	96	4,465	5,642	4,678	1,787	3,485
97	4,058	5,128	4,251	1,624	3,167	97	4,667	5,897	4,888	1,867	3,642
98	4,240	5,359	4,442	1,698	3,310	98	4,877	6,162	5,108	1,952	3,806
99	4,431	5,599	4,642	1,773	3,459	99	5,096	6,439	5,338	2,039	3,978

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.

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.