

THESE RATES ARE EFFECTIVE 1-1-2026



2025 ProCare[®] Rates – New York

Plans C, F and F+ are only available to applicants first eligible for Medicare Part A before January 1, 2020.

Community Rates policy rates are the same for all ages. Community rates increase with medical care cost increases.

Area Rate policy rates vary by geographic location based on the applicant's current residence address as designated by three digit ZIP codes, indicated at the right.

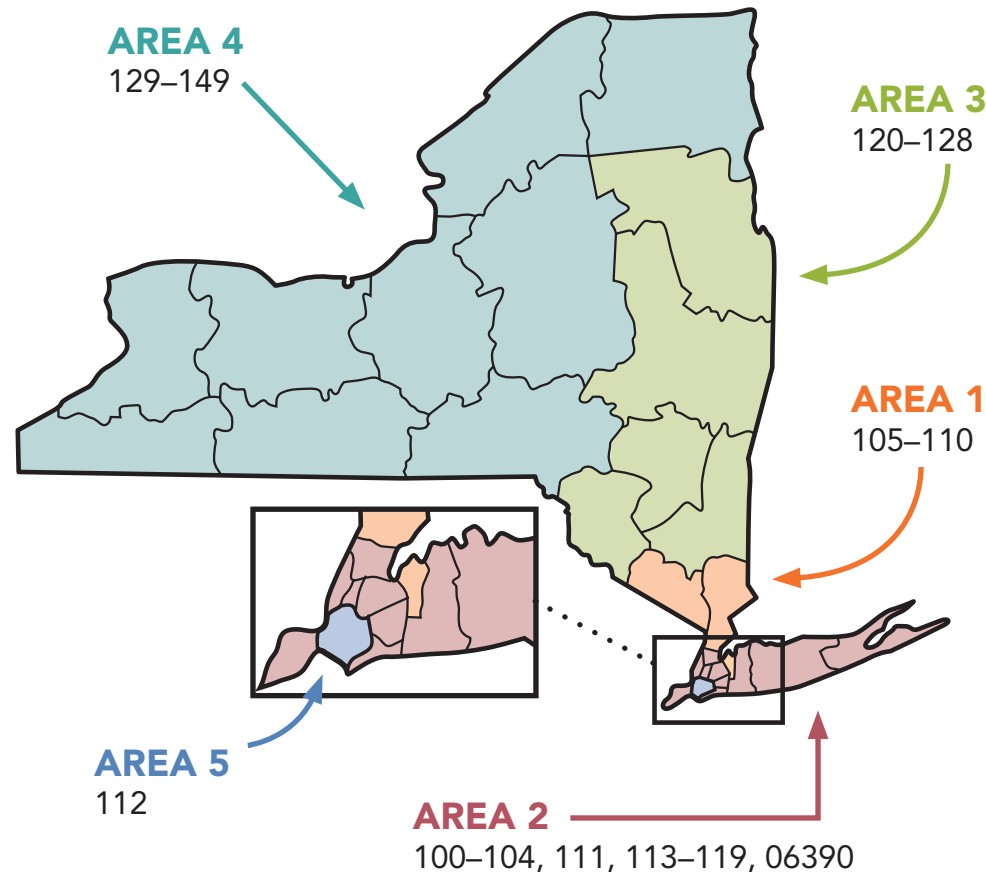
Renewal Rates are based on the geographic rating area in which the policyholder currently resides.

When moving out of NY: In New York, premium rates change based on the current residence of the policyholder. When moving out of New York, GLNY Medicare Supplement insurance policyholders may see their premium rates change according to where their new **OUT-OF-STATE residence** is located.

Policyholders moving **from NY to FLORIDA** will be charged **Area 6** rates (currently equal to Area 5 rates) on their next premium due date or on the next available date after the Company has given the policyholder proper notice of the change.

Policyholders moving **from NY to ANY STATE OTHER THAN FLORIDA** will be charged **Area 7** rates (currently equal to Area 1 & 2 rates) on their next premium due date or on the next available date after the Company has given the policyholder proper notice of the change.

When moving to a different area within NY: GLNY policyholders may see their premium rates change based on where their new NY residence is located. The change will occur on their next premium due date or on the next available date after the Company has given the policyholder proper notice of the change.



THESE RATES ARE EFFECTIVE 1-1-2026

NEW YORK 2025

Globe Life Insurance Company of New York – ProCare® Rate Sheets

PCRC-31 NY25 010126

Area 1 (ZIP 105-110) and Area 2 (ZIP 100-104, 111,113-119, 06390)							
Plan	A	SA	Q	M	Plan Code		Effective Date
					Under Age 65	Age 65 and over	
A	4015	2008	1004	335	N9E	N45	01/01/2026
B	5387	2694	1347	449	N9F	N46	01/01/2026
C	5990	2995	1498	500	N9G	N47	01/01/2026
D	5904	2952	1476	492	N9H	N48	01/01/2026
F	6789	3395	1698	566	N9I	N49	01/01/2026
F+	1642	821	411	137	N9K	N51	01/01/2026
G	5523	2762	1381	461	N9J	N50	01/01/2026
G+	1089	545	273	91	NCL	NCK	01/01/2026
K	2091	1046	523	175	N9C	N43	01/01/2026
L	3724	1862	931	311	N9D	N44	01/01/2026
N	5394	2697	1349	450	N9L	N52	01/01/2026

Area 3 (ZIP 120-128) and Area 4 (ZIP 129-149)							
Plan	A	SA	Q	M	Plan Code		Effective Date
					Under Age 65	Age 65 and over	
A	3345	1673	837	279	N9E	N45	01/01/26
B	4490	2245	1123	375	N9F	N46	01/01/26
C	4992	2496	1248	416	N9G	N47	01/01/26
D	4919	2460	1230	410	N9H	N48	01/01/26
F	5658	2829	1415	472	N9I	N49	01/01/26
F+	1369	685	343	115	N9K	N51	01/01/26
G	4602	2301	1151	384	N9J	N50	01/01/26
G+	908	454	227	76	NCL	NCK	01/01/26
K	1742	871	436	146	N9C	N43	01/01/26
L	3104	1552	776	259	N9D	N44	01/01/26
N	4496	2248	1124	375	N9L	N52	01/01/26

Area 5 (ZIP 112)							
Plan	A	SA	Q	M	Plan Code		Effective Date
					Under Age 65	Age 65 and over	
A	4497	2249	1125	375	N9E	N45	01/01/26
B	6035	3018	1509	503	N9F	N46	01/01/26
C	6711	3356	1678	560	N9G	N47	01/01/26
D	6614	3307	1654	552	N9H	N48	01/01/26
F	7607	3804	1902	634	N9I	N49	01/01/26
F+	1840	920	460	154	N9K	N51	01/01/26
G	6187	3094	1547	516	N9J	N50	01/01/26
G+	1220	610	305	102	NCL	NCK	01/01/26
K	2342	1171	586	196	N9C	N43	01/01/26
L	4173	2087	1044	348	N9D	N44	01/01/26
N	6045	3023	1512	504	N9L	N52	01/01/26

Only applicants first eligible for Medicare Part A before 2020 may purchase plans C, F, and High Deductible Plan F.

COMMISSIONABLE PREMIUM

Area 1 (ZIP 105-110) and Area 2 (ZIP 100-104, 111,113-119, 06390)					Area 3 (ZIP 120-128) and Area 4 (ZIP 129-149)					Area 5 (ZIP 112)				
Plan*	A	SA	Q	M	Plan*	A	SA	Q	M	Plan*	A	SA	Q	M
A	3,963.00	1,982.00	991.00	330.00	A	3,302.00	1,651.00	826.00	275.00	A	4,439.00	2,220.00	1,110.00	370.00
B	5,318.00	2,659.00	1,329.00	443.00	B	4,432.00	2,216.00	1,108.00	370.00	B	5,958.00	2,979.00	1,489.00	496.00
C	5,657.00	2,828.00	1,414.00	472.00	C	4,672.00	2,336.00	1,168.00	389.00	C	6,369.00	3,185.00	1,592.00	531.00
D	5,828.00	2,914.00	1,457.00	485.00	D	4,856.00	2,428.00	1,214.00	404.00	D	6,529.00	3,264.00	1,632.00	544.00
F	6,446.00	3,223.00	1,612.00	537.00	F	5,329.00	2,664.00	1,332.00	444.00	F	7,253.00	3,627.00	1,813.00	604.00
F+	1,621.00	810.00	405.00	135.00	F+	1,351.00	676.00	338.00	113.00	F+	1,816.00	908.00	454.00	152.00
G	5,452.00	2,726.00	1,363.00	455.00	G	4,543.00	2,271.00	1,136.00	379.00	G	6,108.00	3,054.00	1,527.00	509.00
G+	1,075.00	538.00	269.00	89.00	G+	896.00	448.00	224.00	75.00	G+	1,204.00	602.00	301.00	100.00
K	2,064.00	1,032.00	516.00	172.00	K	1,720.00	860.00	430.00	144.00	K	2,312.00	1,156.00	578.00	193.00
L	3,676.00	1,838.00	919.00	307.00	L	3,064.00	1,532.00	766.00	255.00	L	4,119.00	2,060.00	1,030.00	343.00
N	5,325.00	2,662.00	1,331.00	444.00	N	4,438.00	2,219.00	1,109.00	370.00	N	5,967.00	2,984.00	1,492.00	497.00

*The premium portions for the Market Stabilization Pool for all plans and Part B Deductible for plans C and F (only) have been subtracted from the appropriate mode to calculate commission



ProCare[®]

Medicare Supplement Insurance Policies

Help to reduce out-of-pocket costs that Medicare does not pay.

Globe Life Insurance Company of New York's ProCare Plans are a smart choice...

Freedom to Choose Your Own Healthcare Providers

There is neither a designated physician list nor an approval process to see a specialist.

Nationwide Acceptance

ProCare Medicare Supplement plans from Globe Life Insurance Company of New York are recognized and accepted nationwide.

Your Satisfaction Is Guaranteed

You have 30 days to review your policy. If after receiving your ProCare policy you want to cancel for any reason, simply return your policy and I.D. card to Globe Life Insurance Company of New York within the 30-day period. Any premium, less any claims paid, is refunded.

The purpose of this communication is the solicitation of insurance. Globe Life Insurance Company of New York is not connected with, endorsed by, or sponsored by the U.S. government, federal Medicare program, Social Security Administration, or the Department of Health and Human Services. Medicare Supplement insurance **POLICY FORMS GNYMSA10, GNYMSB10, GNYMSC10, GNYMSD10, GNYMSF10, GNYMSHDF10, GNYMSG10, GNYMSHDG, GNYMSK06, GNYMSL06, and GNYMSN10** are available from our Company. NY requires that these plans be available to persons under age 65 eligible for Medicare due to disability or End Stage Renal disease (ESRD). Only Applicants first eligible for Medicare before 2020 may purchase Plans C, F, and F+. You may be contacted by an Agent representing Globe Life Insurance Company of New York. A licensed Agent will provide additional information upon request. These policies meet the minimum standards for MEDICARE SUPPLEMENT INSURANCE as defined by the New York State Department of Financial Services. The expected benefit ratio for this policy is 65%. This ratio is the portion of future premiums which the Company expects to return as benefits, when averaged over all people with this policy. **IMPORTANT NOTICE - A CONSUMER'S GUIDE TO HEALTH INSURANCE FOR PEOPLE ELIGIBLE FOR MEDICARE MAY BE OBTAINED FROM YOUR LOCAL SOCIAL SECURITY OFFICE OR FROM THIS INSURER.**

Globe Life Insurance Company of New York: The Right Coverage, The Right Company

Do I need a Medicare Supplement?

Medicare is an essential part of every Senior's health planning, but it was never intended to provide for all your healthcare expenses. Escalating healthcare costs continue to leave many expenses that Medicare does not cover. Unless you have supplemental insurance coverage, these expenses come out of your pocket.

Choosing a Medicare Supplement:

Medicare Supplement insurance policies are the same by law. Depending on the plan you select, coverages pay various Medicare deductibles, coinsurances, and other medical expenses not covered by Medicare. However, insurers' rates and services vary, which makes it very important for Seniors to shop carefully to get the best value for their dollars.

Globe Life Insurance Company of New York offers 11 of the 12 standardized plans: A, B, C, D, F, F+, G, G+, K, L and N. A Globe Life Insurance Company of New York representative can help you choose which plan best suits your needs for the long term.

Who's eligible for coverage?

If you are age 65 or older and enrolled in Medicare Parts A and B, you are eligible for Medicare Supplement coverage. You are also eligible if you are under age 65 and qualify for Medicare due to disability.

When to purchase:

If you are 65 or older and still working, you may want to wait to enroll in Medicare Part B if you have health coverage through an employer or union based on your (or your spouse's) current or active employment.

What does each Medicare Supplement plan pay?

All Medicare Supplement standardized plans include the following basic benefits:

- **Hospitalization:** Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
- **Medical Expenses:** Part B coinsurance (generally 20% of Medicare-approved expenses) or, copayments for hospital outpatient services. Plans K, L, and N require insureds to pay a portion of the Part B coinsurance or copayments.
- **Blood:** First three pints of blood each calendar year.
- **Hospice:** Part A coinsurance for eligible hospice/respite care expenses.

The Medicare Supplement Plan Benefit chart on the next page shows the benefits included in each plan. In New York, all Medicare Supplement insurers must offer Plans A and B, and either Plan D or Plan G.

Use your answers from the Healthcare Services Worksheet at the bottom right to help determine which plan is right for you.

Medicare Supplement Plan Benefits

Only applicants first eligible for Medicare Part A before 2020 may purchase Plans C, F, and High Deductible Plan F.

MEDICARE PLANS / BENEFITS*	Plans Available to All Applicants							Medicare First Eligible Before 2020 Only	
	A	B	D	G▼	K■	L■	N●	C	F▼
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●	✓	✓
Blood (first three pints)	✓	✓	✓	✓	50%	75%	✓	✓	✓
Hospice	✓	✓	✓	✓	50%	75%	✓	✓	✓
Skilled Nursing Facility Coinsurance			✓	✓	50%	75%	✓	✓	✓
Medicare Part A Deductible		✓	✓	✓	50%	75%	✓	✓	✓
Medicare Part B Deductible								✓	✓
Medicare Part B Excess Charges				100%					100%
Foreign Travel Emergency (up to plan limits)			✓	✓			✓	✓	✓
Out-of-Pocket Annual Limit■					\$8,000	\$4,000			

- Plans F and G also have a high deductible option which requires first paying a plan deductible of (\$2,950 in 2026) 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 Plan G counts your payment of the Medicare Part B deductible toward meeting the plan deductible.
- 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 (\$8,000) for Plan K, \$4,000 for Plan L in 2026). The out-of-pocket annual limit does NOT include the charges from your provider that exceed Medicare-approved amounts, called 'excess charges'. You will be responsible for paying excess charges. The out-of-pocket annual limit may increase each year for inflation.
- Plan N pays 100% of Medical Expenses (Part B Coinsurance) except for a copayment of up to \$20 for some office visits and up to \$50 copayment for emergency room visits that do not result in an inpatient admission. The emergency room copayment is waived if the insured is admitted to any hospital, and the emergency visit is covered as a Medicare Part A expense.

* Denotes plans available by Globe Life Insurance Company of New York

Healthcare Services Worksheet

In making your choice, you will want to consider your future healthcare needs. It may help to take into account your past expenses in these areas to determine which plan makes sense for you.

Last year, what did you spend on...

1. **Skilled Nursing Facility Coinsurance?** Consider a plan with this benefit if you may go to a skilled nursing facility and stay there for more than 20 days. **Benefit pays up to \$217 per day for days 21-100 in a skilled nursing facility.**

\$ ☐

2. **Medicare Part A Hospital Deductible?** Consider a ProCare plan with this benefit if you may stay in the hospital multiple times. **Benefit pays \$1,736 for days 1-60 of a hospital stay.**

\$ ☐

3. **Medicare Part B Deductible?** If you have Medicare Part B, you must pay this deductible (\$283 in 2026) before Medicare starts to pay its share. High deductible Plans F and G count your payment of the Medicare Part B deductible toward meeting the plan deductible.

\$ ☐

4. **Medicare Part B Excess Doctor Charges (limited to 5% in New York)?** Consider a plan with this benefit if your doctor doesn't accept Medicare assignment, or if during a hospital stay you cannot choose your doctors. **Benefit pays the difference between your doctor's actual charge and Medicare's approved amount.**

\$ ☐

5. **A Foreign-Travel Emergency?** Consider a ProCare plan with this benefit if you travel outside the U.S. and may need emergency healthcare. **Benefit covers emergency healthcare you receive outside the U.S.**

\$ ☐

Do you need this benefit?
(Check box)

Why Choose Globe Life Insurance Company of New York for Your Medicare Supplement?

The reason customers purchase our products and Agents want to represent us is we're not the same old story. At Globe Life Insurance Company of New York responding to the insurance needs of the people of New York isn't just about business. It's about responsibility. We care about our commitment to you.



Policy issue and claims processing
— averaging less than a week



Freedom to choose providers
and hospitals



A (Excellent) or higher Financial Strength
Rating from A.M. Best Company
for more than 35 consecutive years
(Rating as of 11/25)*

*This rating refers only to the financial strength of the company and is not a recommendation of the specific policy provisions, rates, or practices of the insurance company.



Globe Life
Insurance Co. of New York

Effective Date Of Coverage

The policy becomes effective as of the date of the application (or a later date if requested by the applicant), if the applicant, as of the date of the application, is eligible for said insurance, and the required premium has been paid. If for any reason the policy is not issued, payment is refunded in full.

Limitations And Exclusions

No benefits are payable for: any expense which you are not legally obligated to pay; or, any services that are not medically necessary as determined by Medicare or are not furnished at the direction of and under the supervision of a physician; or, any portion of any expense for which payment is made by Medicare; or, any type of expense not eligible for coverage under Medicare.

Preexisting Conditions

Loss due to injury or sickness for which medical advice or treatment was recommended or given by a physician within six months prior to policy effective date is not covered unless the loss is incurred more than 60 days after the effective date. If you have a preexisting condition and have had a continuous period of creditable coverage for at least 63 days prior to the enrollment date of the new coverage, we cannot exclude coverage based on the preexisting condition. If the period of creditable coverage is less than 60 days, we will reduce the pre-existing condition exclusion period by the amount of time you have had creditable coverage.

PO Box 3125
Syracuse, NY 13220-3125
GlobeLifeOfNewYork.com

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APPLICATION FOR INSURANCE

GLOBE LIFE INSURANCE COMPANY OF NEW YORK * A NEW YORK STOCK CO. * HOME OFFICE: SYRACUSE, NY

PART I: APPLICANT INFORMATION

Plan Code 		Advanced Effective Date Requested 		Mode of Premium ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly (APP only)		Method of Payment ☐ Send Premium Notices ☐ Automatic Payment Plan		Draft Date Day (01-28) of the Month to Draft Bank Account 	
Medicare first eligible before 2020 only				Select Plan Applying for ☐ A ☐ B ☐ C ☐ D ☐ F* ☐ F+* ☐ G ☐ G+ ☐ K ☐ L ☐ N					

[illegible]**Applicant's Mailing Address:**[illegible]

If Applicant's Residence Address is different from Mailing Address, show below:

Street or Route																								
City																			State					
Zip Code						County																		

[illegible]

(as shown on your Medicare card omitting dashes)

Date of Birth (mm-dd-yyyy) - - Age Last Birthday Sex ☐ Male
☐ Female

E-mail Address of Proposed Insured	
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Application Verification Information	A recorded interview may be necessary to confirm information contained in your written application. The most convenient time and place for the interview is:	☐ 8 AM - Noon ☐ Noon - 6 PM ☐ 6 PM - 9 PM	Home Phone No. - - Work Phone No. - -
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THE SALE OF A MEDICARE SUPPLEMENT POLICY IS PROHIBITED WHERE AN INDIVIDUAL HAS A MEDICARE SUPPLEMENT POLICY IN FORCE AND DOES NOT DESIRE TO REPLACE THE EXISTING POLICY OR WHERE THE MEDICARE SUPPLEMENT POLICY WOULD DUPLICATE BENEFITS TO WHICH THE INDIVIDUAL IS ENTITLED UNDER A MEDICARE ADVANTAGE PLAN.

APPLICATION FOR INSURANCE

GLOBE LIFE INSURANCE COMPANY OF NEW YORK * A NEW YORK STOCK CO. * HOME OFFICE: SYRACUSE, NY

PART II: ELIGIBILITY QUESTIONS

PLEASE ANSWER ALL QUESTIONS.

TO THE BEST OF YOUR KNOWLEDGE AND BELIEF:

Yes No

1. (a) Did you turn age 65 in the last six (6) months? ☐ Yes ☐ No

(b) Did you enroll in Medicare Part B in the last six (6) months? ☐ Yes ☐ No

(c) If "YES", what is the effective date? (mm-dd-yyyy) - -

2. Are you covered for medical assistance through the state Medicaid program?

NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer "NO" to this question.

☐ Yes ☐ No

If YES,

(a) Will Medicaid pay your premiums for this Medicare Supplement policy? ☐ Yes ☐ No

(b) Do you receive any benefits from Medicaid OTHER THAN payment towards your Medicare Part B premium? ☐ Yes ☐ No

3. (a) If you had coverage from any Medicare Advantage plan other than original Medicare within the past 63 days (for example, a Medicare HMO, PPO or PFFS), fill in your start and end dates below. If you are still covered under the Medicare Advantage plan, leave "END DATE" blank.

START DATE (mm-dd-yyyy) - -

END DATE (mm-dd-yyyy) - -

Yes No

(b) If you are still covered under the Medicare Advantage plan, do you intend to replace your current coverage with this new Medicare Supplement policy? ☐ Yes ☐ No

(c) Was this your first time in this type of Medicare Advantage plan? ☐ Yes ☐ No

(d) Did you drop a Medicare Supplement policy to enroll in the Medicare Advantage plan? ☐ Yes ☐ No

4. (a) Do you have another Medicare Supplement or Medicare Select policy in force? ☐ Yes ☐ No

(b) If so, with what company, and what plan do you have? _____

(c) If so, do you intend to replace your current Medicare Supplement or Medicare Select policy with this policy? ☐ Yes ☐ No

5. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan) ☐ Yes ☐ No

(a) If so, with what company and what kind of policy?

(b) What are your dates of coverage under the other policy? (If you are still covered under the other policy, leave "END DATE" blank.)

START DATE (mm-dd-yyyy) - -

END DATE (mm-dd-yyyy) - -



APPLICATION FOR INSURANCE

PART III: APPLICANT AUTHORIZATION



THE SALE OF A MEDICARE SUPPLEMENT POLICY IS PROHIBITED WHERE AN INDIVIDUAL HAS A MEDICARE SUPPLEMENT POLICY IN FORCE AND DOES NOT DESIRE TO REPLACE THE EXISTING POLICY OR WHERE THE MEDICARE SUPPLEMENT POLICY WOULD DUPLICATE BENEFITS TO WHICH THE INDIVIDUAL IS ENTITLED UNDER A MEDICARE ADVANTAGE PLAN.

APPLICATION FOR INSURANCE

GLOBE LIFE INSURANCE COMPANY OF NEW YORK * A NEW YORK STOCK CO. * HOME OFFICE: SYRACUSE, NY

PART IV: AGENT CERTIFICATION

The undersigned Agent certifies that he/she has ☐ / has not ☐ personally met with the Applicant and that the Applicant has read, or had read to him/her, the completed application.

AGENT COMPLETES (Attach separate sheet, if necessary.)

1. List any other health insurance policy you have sold to the Applicant which is still in force:

2. List any other health insurance policy you have sold to the Applicant in the past five (5) years which is no longer in force:

I certify: (1) I have accurately recorded the information supplied by the Applicant, (2) I have given an outline of coverage for the policy applied for and a Medicare Supplement Buyers Guide to the Applicant, (3) I have reviewed the current health insurance coverage of the Applicant and find that additional coverage of the type and amount applied for is appropriate for the Applicant's needs.

Last Name

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Agent No.

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Agent's Signature

GNYMA15R

MAIL POLICY TO: ☐ Agent ☐ Insured



Instructions to Agent: This form is provided for the purpose of compliance with regulations regarding the replacement of Medicare Supplement insurance. When the replacement question on the application is answered YES, this form must be dated, signed by the applicant and by the Agent, and submitted with the application, AND a copy of this form must be left with the applicant.

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND HEALTH INSURANCE,
HMO COVERAGE OR EMPLOYER-PROVIDED HEALTH BENEFIT ARRANGEMENT

GLOBE LIFE INSURANCE COMPANY OF NEW YORK
A New York Stock Company * Home Office: Syracuse, New York

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to your application, you intend to terminate existing accident and health insurance, health maintenance organization coverage or employer-provided health benefit coverage and replace it with a policy to be issued by Globe Life Insurance Company of New York. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all health coverage you now have and evaluate the need for existing coverage that may duplicate this policy. Terminate your present policy only if, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision.

STATEMENT TO APPLICANT BY ISSUER OR AGENT:

I have reviewed your current medical or health insurance coverage. The replacement of insurance involved in this transaction does not duplicate coverage, to the best of my knowledge. The replacement policy is being purchased for the following reason(s) checked below:

- ☐ Additional benefits.
 - ☐ No change in benefits, but lower premiums.
 - ☐ Fewer benefits and lower premiums.
 - ☐ My plan has outpatient prescription drug coverage and I am enrolling in Part D.
 - ☐ Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment.
- _____
- _____

☐ Other. (please specify) _____

- (1) Health conditions which you may presently have may be considered pre-existing conditions and may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
- (2) State regulation provides that in applying a pre-existing condition limitation, a Medicare supplement issuer must credit the time the applicant was previously covered under creditable coverage (including Medicare supplement insurance, Medicare select coverage and Medicare Advantage plans) if the previous creditable coverage was continuous to a date not more than 63 days prior to the enrollment date of the new policy.
- (3) If you still wish to terminate your present policy and replace it with new coverage, review the application carefully to be certain that all information has been properly recorded.

DO NOT CANCEL YOUR PRESENT POLICY UNTIL YOU HAVE RECEIVED YOUR NEW POLICY AND ARE SURE THAT YOU WANT TO KEEP IT.

(Agent's Signature)
Type or print name & address of Agent or Broker:

(Applicant's Signature)

(Date)

GLOBE LIFE INSURANCE COMPANY OF NEW YORK

P.O. Box 3125, Syracuse, New York 13220-3125

NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE

Your application for the Medicare Supplement insurance policy (certificate) issued by this company indicates that you intended to terminate existing Medicare Supplement insurance coverage, Medicare Select coverage or health maintenance organization (HMO) issued Medicare risk or cost contract and replace it with the coverage applied for with this company. Duplicate Medicare Supplement insurance coverage is unnecessary and you should terminate one of your Medicare Supplement insurance, Medicare Select or HMO contract if more than one such contract is still in force.

Current Health or Medicare Policy

Name of Company: _____

Policy Number: _____

Premium: _____ Type: _____

Applicant's Name: _____

1. Does the insurer provide a service for an automatic filing of both assigned and unassigned Part B claims?

Current Policy

☐ Yes ☐ No

GLNY Policy

☐ Yes ☐ No

2. If the current policy is a standardized Medicare Supplement Plan under the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), identify the plan category as A, B, C, D, F, High Deductible F, G, High Deductible G, K, L, M, or N.

Current Plan

_____ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

ProCare Plan

A	B	C	D	F	F+	G	G+	K	L	N
---	---	---	---	---	----	---	----	---	---	---

There is no need to complete the rest of this form if the current policy is a standardized Plan.

3. If the current policy is not a standardized Plan, answer the following questions for the current policy only.

Current Policy

GLNY Policy

Y = Yes N = No

Part A

Pays Medicare Part A Deductible?

☐ Yes ☐ No

Pays all expenses after Medicare Part A is exhausted up to 365 days?

☐ Yes ☐ No

Has a Skilled Nursing Facility benefit?

☐ Yes ☐ No

Part B

Pays Medicare Part B Deductible?

☐ Yes ☐ No

Pays ALL Medicare Part B coinsurance amounts?

☐ Yes ☐ No

Pays 100% of excess charges (*amounts above Medicare approved*)?

☐ Yes ☐ No

Has a Foreign Travel Benefit?

☐ Yes ☐ No

Is Policy Guaranteed Renewable?

☐ Yes ☐ No

Prescription Drug Benefit?

☐ Yes ☐ No

Preventive Care Benefit?

☐ Yes ☐ No

Other Benefits or Services (itemize) _____

A	B	C▼	D	F▼	F+▼	G	G+	K	L	N
N	Y	Y	Y	Y	Y	Y	Y	50%	75%	Y
Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
N	N	Y	Y	Y	Y	Y	Y	50%	75%	Y
A	B	C▼	D	F▼	F+▼	G	G+	K	L	N
N	N	Y	N	Y	Y	N	N	N	N	N
Y	Y	Y	Y	Y	Y	Y	Y	*	*	**
N	N	N	N	Y	Y	Y	Y	N	N	N
N	N	Y	Y	Y	Y	Y	Y	N	N	Y
Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
N	N	N	N	N	N	N	N	N	N	N
N	N	N	N	N	N	N	N	N	N	N

* Once you meet out-of-pocket annual limit

** Subject to policy copayment for office visits and emergency room visits

▼ Only applicants first eligible for Medicare before 2020 may purchase plans C, F, and High Deductible F

The Applicant's actual current policy ☐ **was** ☐ **was not** made available to me for review.

The Applicant's current policy ☐ **is** ☐ **is not** a Medicare Advantage Plan.

The Applicant's current policy ☐ **is** ☐ **is not** employer-provided coverage.

Agent's Signature and Agent Number _____

Date _____

Applicant's Signature _____

Date _____

A copy of this form must be returned with the application when a replacement of any health policy is involved in the sale of a GLNY Medicare Supplement policy.



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Applicant Notice and Conditional Receipt

Instructions Complete this section and
to Agent: leave this receipt with the applicant.

I have purchased the following Medicare Supplement Plan:

- | | | |
|---------------------------------|----------------------------------|----------------------------------|
| ☐ Plan A | ☐ Plan B | ☐ Plan C |
| ☐ Plan D | ☐ Plan F | ☐ Plan F+ |
| ☐ Plan G | ☐ Plan G+ | ☐ Plan K |
| ☐ Plan L | ☐ Plan N | |

Congratulations on Your Good Judgement!

**Make Check Payable to
Globe Life Insurance Company of New York
not to an individual.**

Received of _____

the sum of \$ _____

for _____ months Medicare Supplement policy premium with application for insurance. Acting in reliance of the answers to the questions on the signed application, Globe Life Insurance Company of New York agrees that insurance shall become effective as of the date of the application (or a later date if so requested by the applicant), if the applicant, as of the date of the application, is insurable and acceptable for said insurance under its usual underwriting rules, and the required premium has been paid. If for any reason the policy is not issued, payment is to be refunded in full.

Date

Agent's Signature



_____, is a Sole Proprietorship
(Fill in Company name here)
and I am the owner of the company. I authorize my premium to be paid from the company account.

Signature of Owner

Printed Name of Owner

Note: If this policy is to be on bank draft, the bank draft authorization on the application **must** also be signed.

2026 MEDICARE PART A

Part A is Hospital Insurance for confinement in a hospital or skilled nursing facility per benefit period.

*A benefit period begins on the first day you receive service as an inpatient 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.

WHEN YOU ARE HOSPITALIZED* FOR:	MEDICARE COVERS	YOU PAY
1-60 DAYS	Most confinement costs <u>after</u> the required Medicare deductible	\$1,736 DEDUCTIBLE
61-90 DAYS	All eligible expenses <u>after</u> patient pays a per-day coinsurance	\$434 A DAY COINSURANCE as much as: \$13,020
91-150 DAYS	All eligible expenses <u>after</u> patient pays a per-day coinsurance (These are Lifetime Reserve Days that may never be used again)	\$868 A DAY COINSURANCE as much as: \$52,080
151 DAYS OR MORE	NOTHING	YOU PAY ALL COSTS
*SKILLED NURSING CONFINEMENT: Following an inpatient hospital stay of at least 3 days and enter a Medicare-approved skilled nursing facility within 30 days after hospital discharge and receive skilled nursing care	All eligible expenses for the first 20 days; then all eligible expenses for days 21-100 <u>after</u> patient pays a per-day coinsurance	After 20 days \$217 A DAY COINSURANCE as much as: \$17,360
HOSPICE CARE: Must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment for outpatient drugs and inpatient respite care	Medicare CO-PAYMENT
BLOOD	100% of approved amount <u>after</u> first 3 pints of blood.	First 3 pints

2026 MEDICARE PART B

Part B is Medical Insurance and covers physician services, outpatient care, tests, and supplies — per calendar year.

ON EXPENSES INCURRED FOR:	MEDICARE COVERS	YOU PAY
ANNUAL DEDUCTIBLE	Incurred Expenses after the required Medicare deductible	\$283 ANNUAL DEDUCTIBLE
MEDICAL EXPENSES Physicians' services for inpatient and outpatient medical/surgical services; physical/speech therapy; and diagnostic tests	80% of approved amount	20% of approved amount*
EXCESS DOCTOR CHARGES** (Above Medicare Approved Amounts)	0% above approved amount	ALL COSTS
CLINICAL LABORATORY SERVICES	Generally 100% of approved amount	Nothing for services
HOME HEALTHCARE	100% of approved amount; 80% of approved amount for durable medical equipment	Nothing for services; 20% of approved amount* for durable medical equipment
OUTPATIENT HOSPITAL TREATMENT	Medicare payment to hospital, based on outpatient procedure payment rates	Coinsurance based on outpatient payment rates
BLOOD	80% of approved amount <u>after</u> first 3 pints of blood.	First 3 pints plus 20% of approved amount for additional pints

*On all Medicare-covered expenses, a doctor or other healthcare provider may agree to accept Medicare assignment. This means the patient will not be required to pay any expense in excess of Medicare's approved charge. The patient pays only 20% of the approved charge.

**Physicians who do not accept assignment of a Medicare claim are limited as to the amount they can charge for a covered service. In 2026, the most a nonparticipating physician can charge for a service covered by Medicare is 115% of the approved amount (may vary by state). *Note: In New York, the most a nonparticipating physician can charge for services covered by Medicare is 105% of the approved amount. For routine office visits covered by Medicare, a nonparticipating New York physician can charge up to 115% of the fee schedule amount.*

Automatic Claims Filing Instructions...

This sheet tells you how Automatic Claims Filing works to eliminate the vast majority of your claims filing with the Company. It also explains what you do in those instances when your claims are not received automatically by us.

SECTION 1: Claims You Need NOT File With The Company

DOCTORS' CHARGES AND OTHER MEDICAL EXPENSES NOT PROVIDED BY A HOSPITAL... are the most commonly incurred health care claims and **come to us automatically after your doctor/provider has filed with Medicare.** These are claims you do not need to file with the Company.

Your Medicare Number: 111-11-1111A

Page 2 of 2
July 1, 2006

Notes Section:

- a This information is being sent to your private insurer. They will review it to see if additional benefits can be paid. Send any questions regarding your supplemental benefits to them.
- b This service is paid at 100% of the Medicare approved amount.
- c Your doctor did not accept assignment for this service. Under Federal law, your doctor cannot charge more than \$39.02. If you have already paid more than this amount, you are entitled to a refund from the provider.

Question:

How can I be sure you have received my claims from Medicare for doctors' charges and other medical expenses not provided by a hospital?

Answer:

Medicare will send you the **Medicare Summary Notice (MSN)** form shown here. The MSN shows all the services or supplies that providers and suppliers billed to Medicare during each 3-month period, what Medicare paid, and what you may owe the provider. **The MSN is not a bill.**

Look for a statement on the MSN form similar to the following...

"a. This information is being sent to your private insurer..."

...this means Medicare has already sent your claim to us — in other words, you do nothing. If this statement does not appear, send us a copy of all pages of the MSN form.

For a quicker review, you may visit www.MyMedicare.gov to track your Medicare claims online.

CMS Medicare Summary Notice Page 1 of 2
July 1, 2006

BENEFICIARY NAME
STREET ADDRESS
CITY, STATE ZIP CODE

CUSTOMER SERVICE INFORMATION

Your Medicare Number: 111-11-1111A

If you have questions, write or call:
Medicare (#12345)
555 Medicare Blvd., Suite 200
Medicare Building
Medicare, US XXXXX-XXXX

Call: 1-800-MEDICARE (1-800-633-4227)
Ask for Doctor Services
TTY for Hearing Impaired: 1-877-486-2048

BE INFORMED: Beware of telemarketers offering free or discounted Medicare items or services.

This is a summary of claims processed from 05/10/2006 through 08/10/2006.

PART B MEDICAL INSURANCE – ASSIGNED CLAIMS

Dates of Service	Services Provided	Amount Charged	Medicare Approved	Medicare Paid Provider	You May Be Billed	See Notes Section
Claim Number: 12435-84956-84556 Paul Jones, M.D., 123 West Street, Jacksonville, FL 33231-0024 Referred by: Scott Wilson, M.D.						
04/19/06	1 Influenza immunization (90724)	\$5.00	\$3.88	\$3.88	\$0.00	b
04/19/06	1 Admin. flu vac (G0008)	5.00	3.43	3.43	0.00	b
Claim Total		\$10.00	\$7.31	\$7.31	\$0.00	
Claim Number: 12435-84956-84557 ABC Ambulance, P.O. Box 2149, Jacksonville, FL 33231						
04/25/06	1 Ambulance, base rate (A0020)	\$289.00	\$249.78	\$199.82	\$49.96	
04/25/06	1 Ambulance, per mile (A0021)	21.00	16.96	13.57	3.39	
Claim Total		\$310.00	\$266.74	\$213.39	\$53.35	

PART B MEDICAL INSURANCE – UNASSIGNED CLAIMS

Dates of Service	Services Provided	Amount Charged	Medicare Approved	Medicare Paid You	You May Be Billed	See Notes Section
Claim Number: 12435-84956-84558 William Newman, M.D., 362 North Street Jacksonville, FL 33231-0024						
03/10/06	1 Office/Outpatient Visit, ES (99213)	\$47.00	\$33.93	\$27.15	\$39.02	c

THIS IS NOT A BILL – Keep this notice for your records.

SECTION 2: Hospital & Skilled Nursing Claims You Need To File

HOSPITAL CHARGES – BOTH OUTPATIENT AND INPATIENT – AND SKILLED NURSING FACILITY CHARGES... are less frequently incurred expenses which you or the facility must file with the Company for consideration of benefits due under your policy. In most cases for inpatient, and often for outpatient services, hospitals will file the claim with both Medicare and the Company on the policyholder's behalf. Here is what to do if you need to file your claim:

1. Outpatient Hospital Charges:

[Charges for services you receive from the hospital even though you are not confined overnight.] Ask the hospital to send us a copy of the REMITTANCE ADVISE the hospital receives from Medicare.

2. Inpatient Hospital Charges:

[Charges associated with overnight confinement in a hospital.] Ask the hospital to send us a copy of the same form the hospital sends to Medicare – the **UB-04 (CMS 1450)**. This is the fastest and simplest way to receive benefits... Or...

Another way to file your inpatient hospital claim is to wait until you receive the Medicare Summary Notice shown here and send us a copy of the section entitled **PART A HOSPITAL INSURANCE - INPATIENT CLAIMS**.

Note: You may also visit www.MyMedicare.gov to track your Medicare claims online and mail us a copy once Medicare pays the claim.

3. Skilled Nursing Facility Charges:

Medicare will send you the **Medicare Summary Notice** shown here; send us a copy.

Question:

What if I am confined in a skilled nursing facility for which Medicare pays no benefits?

Answer:

In these cases, we do not always provide benefits either. If you are uncertain whether benefits would be available under your coverage, you should send us copies of your bills from the nursing facility so that we can determine if benefits are due.

**Medicare Summary Notice**

Page 1 of 2
July 1, 2006

BENEFICIARY NAME
STREET ADDRESS
CITY, STATE ZIP CODE

CUSTOMER SERVICE INFORMATION

Your Medicare Number: 111-11-1111A

If you have questions, write or call:
Medicare (#12345)
555 Medicare Blvd., Suite 200
Medicare Building
Medicare, US XXXXX-XXXX

Call: 1-800-MEDICARE (1-800-633-4227)
Ask for Hospital Services
TTY for Hearing Impaired: 1-877-486-2048

BE INFORMED: Beware of "free" medical services or products. If it sounds too good to be true, it probably is.

This is a summary of claims processed from 05/15/2006 through 08/10/2006.

PART A HOSPITAL INSURANCE – INPATIENT CLAIMS

Dates of Service	Benefit Days Used	Non-Covered Charges	Deductible and Coinsurance	You May Be Billed	See Notes Section
Claim Number: 12435-84956-84556-45621 Cure Hospital, 213 Sick Lane, Dallas, TX 75555 Referred by: Paul Jones, M.D. 04/25/06 – 05/09/06					a
	14 days	\$0.00	\$876.00	\$876.00	b, c
Claim Number: 12435-84956-84556-45622 Continued Care Hospital, 124 Sick Lane, Dallas, TX 75555 Referred by: Paul Jones, M.D. 05/09/06 – 06/20/06					
	11 days	\$0.00	\$0.00	\$0.00	

PART B MEDICAL INSURANCE – OUTPATIENT FACILITY CLAIMS

Dates of Service	Services Provided	Amount Charged	Non-Covered Charges	Deductible and Coinsurance	You May Be Billed	See Notes Section
Claim Number: 12435-8956-8458 Medicare Hospital, 123 Medicare Lane, Dallas, TX 75209 Referred by: Paul Jones, M.D. 04/02/06					d	
	L.V. Therapy (Q0081)	\$33.00	\$0.00	\$6.60	\$6.60	
	Lab (3810)	1,140.50	0.00	228.10	228.10	
	Operating Room (31628)	786.50	0.00	157.30	157.30	
	Observation Room (99201)	293.00	0.00	58.60	58.60	
	Claim Total	\$2,253.00	\$0.00	\$450.60	\$450.60	(continued)

THIS IS NOT A BILL – Keep this notice for your records.

GLOBE LIFE INSURANCE COMPANY OF NEW YORK

301 Plainfield Road, Suite 150, Syracuse, New York 13212 | P.O. Box 3125, Syracuse, New York 13220-3125

A New York Stock Company * Home Office: Syracuse, New York

Benefit Chart of Medicare Supplement Plans Sold on or After January 1, 2020 Including Revisions Effective January 1, 2020

Benefit Plans A, B, C, D, F, F+, G, G+, K, L, and N

This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plan “A” and “B” and either Plan “D” or “G” available. 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.

* Denotes plans available by Globe Life Insurance Company of New York in New York State.

Benefits	Plans Available to All Applicants								Medicare First Eligible Before 2020 Only	
	A*	B*	D*	G*1*	K*	L*	M	N*	C*	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 2026 ²					8,000 ²	4,000 ²				

¹ Plans F and G also have a high deductible option which requires first paying a plan deductible of \$2,950 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. (The calendar year high deductible for high deductible Plan “F” and high deductible Plan “G” shall be adjusted annually by the Secretary of the United States of Health and Human Services. The cover page must specify the applicable deductible amount.)

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.

PREMIUM INFORMATION

We, Globe Life Insurance Company of New York, can only raise your premium if we raise the premium for all policies like yours in this state.

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 your insurance company.

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to Globe Life Insurance Company of New York, P.O. Box 3125, Syracuse, New York 13220-3125. 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.

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 your medical cost.

Neither Globe Life Insurance Company of New York 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

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

Globe Life of New York Medicare Supplement Rates

Area 1 (ZIP 105-110) and Area 2 (ZIP 100-104, 111,113-119, 06390)							
Plan	A	SA	Q	M	Plan Code		Effective Date
					Under Age 65	Age 65 and over	
A	4015	2008	1004	335	N9E	N45	01/01/2026
B	5387	2694	1347	449	N9F	N46	01/01/2026
C	5990	2995	1498	500	N9G	N47	01/01/2026
D	5904	2952	1476	492	N9H	N48	01/01/2026
F	6789	3395	1698	566	N9I	N49	01/01/2026
F+	1642	821	411	137	N9K	N51	01/01/2026
G	5523	2762	1381	461	N9J	N50	01/01/2026
G+	1089	545	273	91	NCL	NCK	01/01/2026
K	2091	1046	523	175	N9C	N43	01/01/2026
L	3724	1862	931	311	N9D	N44	01/01/2026
N	5394	2697	1349	450	N9L	N52	01/01/2026

Area 3 (ZIP 120-128) and Area 4 (ZIP 129-149)							
Plan	A	SA	Q	M	Plan Code		Effective Date
					Under Age 65	Age 65 and over	
A	3345	1673	837	279	N9E	N45	01/01/26
B	4490	2245	1123	375	N9F	N46	01/01/26
C	4992	2496	1248	416	N9G	N47	01/01/26
D	4919	2460	1230	410	N9H	N48	01/01/26
F	5658	2829	1415	472	N9I	N49	01/01/26
F+	1369	685	343	115	N9K	N51	01/01/26
G	4602	2301	1151	384	N9J	N50	01/01/26
G+	908	454	227	76	NCL	NCK	01/01/26
K	1742	871	436	146	N9C	N43	01/01/26
L	3104	1552	776	259	N9D	N44	01/01/26
N	4496	2248	1124	375	N9L	N52	01/01/26

Area 5 (ZIP 112)							
Plan	A	SA	Q	M	Plan Code		Effective Date
					Under Age 65	Age 65 and over	
A	4497	2249	1125	375	N9E	N45	01/01/26
B	6035	3018	1509	503	N9F	N46	01/01/26
C	6711	3356	1678	560	N9G	N47	01/01/26
D	6614	3307	1654	552	N9H	N48	01/01/26
F	7607	3804	1902	634	N9I	N49	01/01/26
F+	1840	920	460	154	N9K	N51	01/01/26
G	6187	3094	1547	516	N9J	N50	01/01/26
G+	1220	610	305	102	NCL	NCK	01/01/26
K	2342	1171	586	196	N9C	N43	01/01/26
L	4173	2087	1044	348	N9D	N44	01/01/26
N	6045	3023	1512	504	N9L	N52	01/01/26

Only applicants first eligible for Medicare Part A before 2020 may purchase plans C, F, and High Deductible Plan F.

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 \$1736	\$0	\$1736 (Part A Deductible)
61st thru 90th day	All but \$434 a day	\$434 a day	\$0
91st day and after:			
– While using 60 lifetime reserve days	All but \$868 a day	\$868 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 \$217 a day	\$0	Up to \$217 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 copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

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

- * Once you have been billed \$283 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 \$283 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	\$0 Generally 80%	\$0 Generally 20%	\$283 (Part B Deductible) \$0
Part B Excess Charges (Above Medicare-Approved Amounts)	\$0	\$0	All Costs
BLOOD First 3 pints Next \$283 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	\$0 \$0 80%	All Costs \$0 20%	\$0 \$283 (Part B Deductible) \$0
CLINICAL LABORATORY SERVICES – Tests for diagnostic services	100%	\$0	\$0

PARTS A & B

HOME HEALTH CARE – MEDICARE-APPROVED SERVICES – Medically necessary skilled care services and medical supplies – Durable medical equipment First \$283 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$283 (Part B Deductible) \$0
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PLAN B
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 \$1736	\$1736 (Part A Deductible)	\$0
61st thru 90th day	All but \$434 a day	\$434 a day	\$0
91st day and after:			
– While using 60 lifetime reserve days	All but \$868 a day	\$868 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 \$217 a day	\$0	Up to \$217 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 copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

PLAN B

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

- * Once you have been billed \$283 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 \$283 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	\$0 Generally 80%	\$0 Generally 20%	\$283 (Part B Deductible) \$0
Part B Excess Charges (Above Medicare-Approved Amounts)	\$0	\$0	All Costs
BLOOD First 3 pints Next \$283 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	\$0 \$0 80%	All Costs \$0 20%	\$0 \$283 (Part B Deductible) \$0
CLINICAL LABORATORY SERVICES – Tests for diagnostic services	100%	\$0	\$0

PARTS A & B

HOME HEALTH CARE – MEDICARE-APPROVED SERVICES – Medically necessary skilled care services and medical supplies – Durable medical equipment First \$283 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$283 (Part B Deductible) \$0
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PLAN C
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 \$1736	\$1736 (Part A Deductible)	\$0
61st thru 90th day	All but \$434 a day	\$434 a day	\$0
91st day and after:			
– While using 60 lifetime reserve days	All but \$868 a day	\$868 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 \$217 a day	Up to \$217 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

PLAN C

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

- * Once you have been billed \$283 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 \$283 of Medicare-Approved Amounts*	\$0	\$283 (Part B Deductible)	\$0
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (Above Medicare-Approved Amounts)	\$0	\$0	All Costs
BLOOD			
First 3 pints	\$0	All Costs	\$0
Next \$283 of Medicare-Approved Amounts*	\$0	\$283 (Part B Deductible)	\$0
Remainder of Medicare-Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES			
– Tests for diagnostic services	100%	\$0	\$0

PARTS A & B

HOME HEALTH CARE – MEDICARE-APPROVED SERVICES			
– Medically necessary skilled care services and medical supplies	100%	\$0	\$0
– Durable medical equipment			
First \$283 of Medicare-Approved Amounts*	\$0	\$283 (Part B Deductible)	\$0
Remainder of Medicare-Approved Amounts	80%	20%	\$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

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 D
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 \$1736	\$1736 (Part A Deductible)	\$0
61st thru 90th day	All but \$434 a day	\$434 a day	\$0
91st day and after:			
– While using 60 lifetime reserve days	All but \$868 a day	\$868 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 \$217 a day	Up to \$217 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 coinsurance, coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

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

- * Once you have been billed \$283 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 \$283 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	\$0 Generally 80%	\$0 Generally 20%	\$283 (Part B Deductible) \$0
Part B Excess Charges (Above Medicare-Approved Amounts)	\$0	\$0	All Costs
BLOOD First 3 pints Next \$283 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	\$0 \$0 80%	All Costs \$0 20%	\$0 \$283 (Part B Deductible) \$0
CLINICAL LABORATORY SERVICES – Tests for diagnostic services	100%	\$0	\$0

PARTS A & B

HOME HEALTH CARE – MEDICARE-APPROVED SERVICES – Medically necessary skilled care services and medical supplies – Durable medical equipment First \$283 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$283 (Part B Deductible) \$0
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OTHER BENEFITS – NOT COVERED BY MEDICARE

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
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PLAN F or HIGH DEDUCTIBLE 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.
- ** This high deductible plan pays the same benefits as Plan F after one has paid a calendar year \$2950 deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are \$2950. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$2950 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO \$2950 DEDUCTIBLE,** YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st 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 \$1736 All but \$434 a day All but \$868 a day \$0 \$0	\$1736 (Part A Deductible) \$434 a day \$868 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 21st thru 100th day 101st day and after	All approved amounts All but \$217 a day \$0	\$0 Up to \$217 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

PLAN F or HIGH DEDUCTIBLE PLAN F
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

- * Once you have been billed \$283 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 F after one has paid a calendar year \$2950 deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are \$2950. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$2950 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO \$2950 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 \$283 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	\$0 Generally 80%	\$283 (Part B Deductible) Generally 20%	\$0 \$0
Part B Excess Charges (Above Medicare-Approved Amounts)	\$0	100%	\$0
BLOOD First 3 pints Next \$283 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	\$0 \$0 80%	All Costs \$283 (Part B Deductible) 20%	\$0 \$0 \$0
CLINICAL LABORATORY SERVICES – Tests for diagnostic services	100%	\$0	\$0

PARTS A & B

HOME HEALTH CARE – MEDICARE-APPROVED SERVICES – Medically necessary skilled care services and medical supplies – Durable medical equipment First \$283 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	100% \$0 80%	\$0 \$283 (Part B Deductible) 20%	\$0 \$0 \$0
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OTHER BENEFITS – NOT COVERED BY MEDICARE

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
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PLAN G or 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 one has paid a calendar year \$2950 deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are \$2950. 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 \$2950 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO \$2950 DEDUCTIBLE,** YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st 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 \$1736 All but \$434 a day All but \$868 a day \$0 \$0	\$1736 (Part A Deductible) \$434 a day \$868 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 21st thru 100th day 101st day and after	All approved amounts All but \$217 a day \$0	\$0 Up to \$217 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

PLAN G or HIGH DEDUCTIBLE PLAN G
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

- * Once you have been billed \$283 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 one has paid a calendar year \$2950 deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are \$2950. 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 \$2950 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO \$2950 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 \$283 of Medicare-Approved Amounts*	\$0	\$0	\$283 (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 Next \$283 of Medicare-Approved Amounts*	\$0 \$0	All Costs \$0	\$0 \$283 (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

PARTS A & B

HOME HEALTH CARE – MEDICARE-APPROVED SERVICES – Medically necessary skilled care services and medical supplies – Durable medical equipment First \$283 of Medicare-Approved Amounts*	100% \$0	\$0 \$0	\$0 \$283 (Unless Part B Deductible has been met)
Remainder of Medicare-Approved Amounts	80%	20%	\$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

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
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PLAN K

- * You will pay half the cost-sharing of some covered services until you reach the annual out-of-pocket limit of \$8000 each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. **However, this limit DOES NOT include charges from your provider that exceed Medicare-approved amounts (these are called “Excess Charges”) and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

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 \$1736	\$868 (50% of Part A Deductible)	\$868 (50% of Part A Deductible) ♦
61st thru 90th day	All but \$434 a day	\$434 a day	\$0
91st day and after:			
– While using 60 lifetime reserve days	All but \$868 a day	\$868 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 \$217 a day	Up to \$108.50 a day (50% of Part A Coinsurance)	Up to \$108.50 a day (50% of Part A Coinsurance) ♦
101st day and after	\$0	\$0	All Costs
BLOOD			
First 3 pints	\$0	50%	50% ♦
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	50% of copayment/coinsurance	50% of copayment/coinsurance ♦

PLAN K

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

**** Once you have been billed \$283 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 \$283 of Medicare-Approved Amounts **** Preventive Benefits for Medicare-Covered Services Remainder of Medicare-Approved Amounts	\$0 Generally 80% or more of Medicare-approved amounts Generally 80%	\$0 Remainder of Medicare-approved amounts Generally 10%	\$283 (Part B Deductible) **** ♦ All costs above Medicare-approved amounts Generally 10% ♦
Part B Excess Charges (Above Medicare-Approved Amounts)	\$0	\$0	All Costs (and they do not count toward annual out-of-pocket limit of \$8000)*
BLOOD First 3 pints Next \$283 of Medicare-Approved Amounts **** Remainder of Medicare-Approved Amounts	\$0 \$0 Generally 80%	50% \$0 Generally 10%	50% ♦ \$283 (Part B Deductible) **** ♦ Generally 10% ♦
CLINICAL LABORATORY SERVICES – Tests for diagnostic services	100%	\$0	\$0

PARTS A & B

HOME HEALTH CARE – MEDICARE-APPROVED SERVICES – Medically necessary skilled care services and medical supplies – Durable medical equipment First \$283 of Medicare-Approved Amounts ***** Remainder of Medicare-Approved Amounts	100% \$0 80%	\$0 \$0 10%	\$0 \$283 (Part B Deductible) ♦ 10% ♦
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* This plan limits your annual out-of-pocket payment for Medicare-approved amounts \$8000 per year. **However, this limit DOES NOT include charges from your provider that exceed Medicare-approved amounts (these are called “Excess Charges”) and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

***** Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

PLAN L

- * You will pay one-fourth of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of \$4000 each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. **However, this limit DOES NOT include charges from your provider that exceed Medicare-approved amounts (these are called “Excess Charges”) and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

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 \$1736	\$1302 (75% of Part A Deductible)	\$434 (25% of Part A Deductible) ♦
61st thru 90th day	All but \$434 a day	\$434 a day	\$0
91st day and after:			
– While using 60 lifetime reserve days	All but \$868 a day	\$868 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 \$217 a day	Up to \$162.75 a day (75% of Part A Coinsurance)	Up to \$54.25 a day (25% of Part A Coinsurance) ♦
101st day and after	\$0	\$0	All Costs
BLOOD			
First 3 pints	\$0	75%	25% ♦
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	75% of copayment/coinsurance	25% of copayment/coinsurance ♦

PLAN L

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

**** Once you have been billed \$283 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 \$283 of Medicare-Approved Amounts **** Preventive Benefits for Medicare-Covered Services Remainder of Medicare-Approved Amounts	\$0 Generally 80% or more of Medicare-approved amounts Generally 80%	\$0 Remainder of Medicare-approved amounts Generally 15%	\$283 (Part B Deductible) **** ♦ All costs above Medicare-approved amounts Generally 5% ♦
Part B Excess Charges (Above Medicare-Approved Amounts)	\$0	\$0	All Costs (and they do not count toward annual out-of-pocket limit of \$4000)*
BLOOD First 3 pints Next \$283 of Medicare-Approved Amounts **** Remainder of Medicare-Approved Amounts	\$0 \$0 Generally 80%	75% \$0 Generally 15%	25% ♦ \$283 (Part B Deductible) **** ♦ Generally 5% ♦
CLINICAL LABORATORY SERVICES – Tests for diagnostic services	100%	\$0	\$0

PARTS A & B

HOME HEALTH CARE – MEDICARE-APPROVED SERVICES – Medically necessary skilled care services and medical supplies – Durable medical equipment First \$283 of Medicare-Approved Amounts ***** Remainder of Medicare-Approved Amounts	100% \$0 80%	\$0 \$0 15%	\$0 \$283 (Part B Deductible) ♦ 5% ♦
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* This plan limits your annual out-of-pocket payment for Medicare-approved amounts \$4000 per year. **However, this limit DOES NOT include charges from your provider that exceed Medicare-approved amounts (these are called “Excess Charges”) and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

***** Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

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 \$1736	\$1736 (Part A Deductible)	\$0
61st thru 90th day	All but \$434 a day	\$434 a day	\$0
91st day and after:			
– While using 60 lifetime reserve days	All but \$868 a day	\$868 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 \$217 a day	Up to \$217 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

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

- * Once you have been billed \$283 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 \$283 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.	 \$283 (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 \$283 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	 \$0 \$0 80%	 All Costs \$0 20%	 \$0 \$283 (Part B Deductible) \$0
CLINICAL LABORATORY SERVICES – Tests for diagnostic services	100%	\$0	\$0

PARTS A & B

HOME HEALTH CARE – MEDICARE-APPROVED SERVICES – Medically necessary skilled care services and medical supplies – Durable medical equipment First \$283 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	 100% \$0 80%	 \$0 \$0 20%	 \$0 \$283 (Part B Deductible) \$0
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OTHER BENEFITS – NOT COVERED BY MEDICARE

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
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