NEW YORK

GLOBE LIFE INSURANCE COMPANY OF NEW YORK

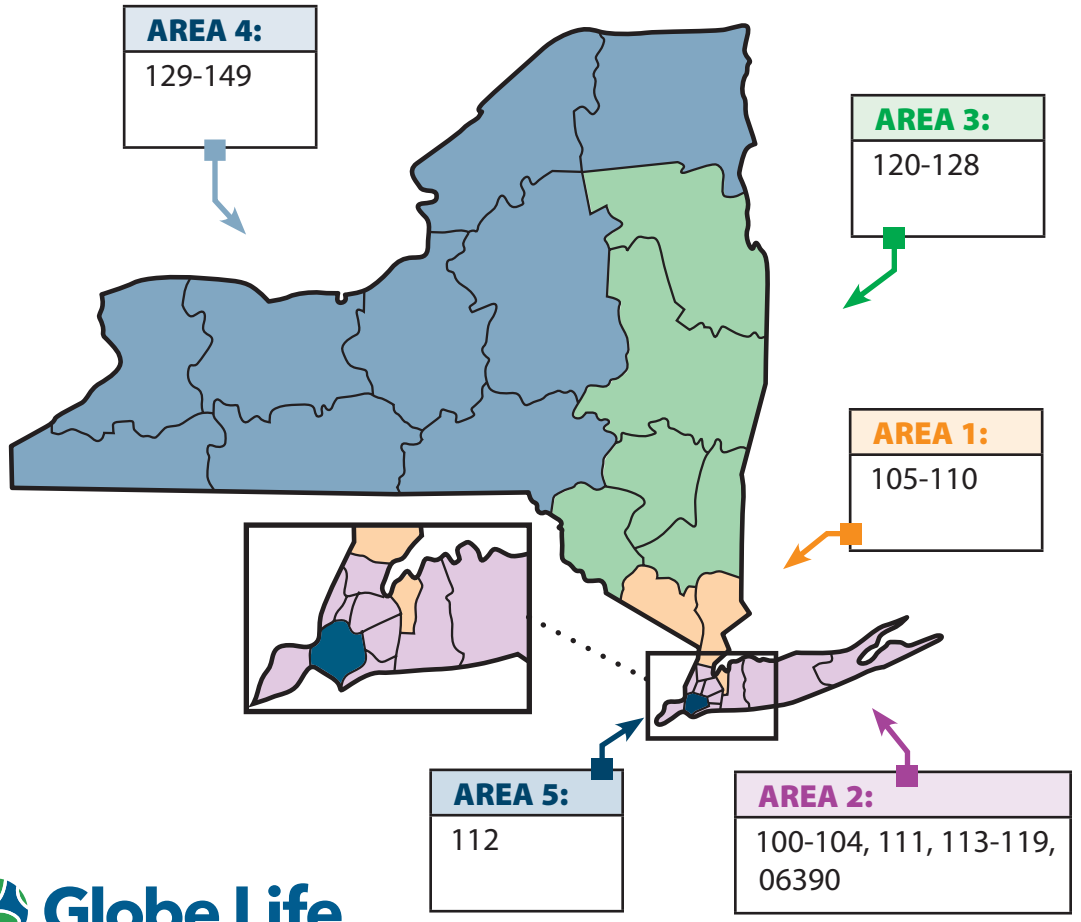
2023 ProCare® RATE SHEETS

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.



Globe Life
Insurance Co. of New York

AREA 1 *(ZIP 105-110)*
AREA 2 *(ZIP 100-104, 111, 113-119, 06390)*

PLAN	A	SA	Q	M	Plan Code Under Age 65	Plan Code Age 65 and over	Effective Date
A	3199	1600	800	267	N9E	N45	02-01-24
B	3936	1968	984	328	N9F	N46	02-01-22
C	4753	2377	1189	397	N9G	N47	02-01-22
D	4685	2343	1172	391	N9H	N48	02-01-22
F	4663	2332	1166	389	N9I	N49	02-01-24
F+	1077	539	270	90	N9K	N51	02-01-24
G	4174	2087	1044	348	N9J	N50	02-01-22
G+	864	432	216	72	NCL	NCK	02-01-22
K	1642	821	411	137	N9C	N43	02-01-22
L	2801	1401	701	234	N9D	N44	02-01-24
N	3944	1972	986	329	N9L	N52	02-01-24

AREA 3 *(ZIP 120-128)*
AREA 4 *(ZIP 129-149)*

PLAN	A	SA	Q	M	Plan Code Under Age 65	Plan Code Age 65 and over	Effective Date
A	2666	1333	667	223	N9E	N45	02-01-24
B	3280	1640	820	274	N9F	N46	02-01-22
C	3961	1981	991	331	N9G	N47	02-01-22
D	3904	1952	976	326	N9H	N48	02-01-22
F	3886	1943	972	324	N9I	N49	02-01-24
F+	897	449	225	75	N9K	N51	02-01-24
G	3479	1740	870	290	N9J	N50	02-01-22
G+	720	360	180	60	NCL	NCK	02-01-22
K	1368	684	342	114	N9C	N43	02-01-22
L	2333	1167	584	195	N9D	N44	02-01-24
N	3287	1644	822	274	N9L	N52	02-01-24

AREA 5 *(ZIP 112)*

PLAN	A	SA	Q	M	Plan Code Under Age 65	Plan Code Age 65 and over	Effective Date
A	3583	1792	896	299	N9E	N45	02-01-24
B	4409	2205	1103	368	N9F	N46	02-01-22
C	5325	2663	1332	444	N9G	N47	02-01-22
D	5249	2625	1313	438	N9H	N48	02-01-22
F	5224	2612	1306	436	N9I	N49	02-01-24
F+	1206	603	302	101	N9K	N51	02-01-24
G	4677	2339	1170	390	N9J	N50	02-01-22
G+	968	484	242	81	NCL	NCK	02-01-22
K	1839	920	460	154	N9C	N43	02-01-22
L	3137	1569	785	262	N9D	N44	02-01-24
N	4419	2210	1105	369	N9L	N52	02-01-24

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

Globe Life
Insurance Co. of New York

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								✓	✓
Medciare Part B Excess Charges				100%					100%
Foreign Travel Emergency (up to plan limits)			✓	✓			✓	✓	✓
Out-of-Pocket Annual Limit■					$7,060	$3,530			

▼ Plans F and G also have a high deductible option which requires first paying a plan deductible of ($2,800 in 2024) 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 ($7,060 for Plan K, $3,530 for Plan L in 2024). 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.

Do you need this benefit? *(Check box)*

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 $204 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 $1,632 for days 1-60 of a hospital stay.*** $ ☐
3. **Medicare Part B Deductible?** If you have Medicare Part B, you must pay this deductible ($240 in 2024) 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.*** $ ☐

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 30 consecutive years (Rating as of 8/23)*

**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

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 I: APPLICANT INFORMATION

Plan Code

Advanced Effective Date Requested

*Medicare first eligible before 2020 only

Select Plan Applying for ○ A ○ B ○ C* ○ D ○ F* ○ F+* ○ G ○ G+ ○ K ○ L ○ N

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

Applicant's First Name

M.I.

Last Name

Applicant's Mailing Address:

Street or Route

City State

Zip Code County

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

Street or Route

City State

Zip Code County

Social Security Number - -

Medicare Claim Number

(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

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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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? ○ ○

   (b) Did you enroll in Medicare Part B in the last six (6) months? ○ ○

   (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. ○ ○
   If YES,

   (a) Will Medicaid pay your premiums for this Medicare Supplement policy? ○ ○

   (b) Do you receive any benefits from Medicaid OTHER THAN payment towards your Medicare Part B premium? ○ ○

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? ○ ○

   (c) Was this your first time in this type of Medicare Advantage plan? ○ ○

   (d) Did you drop a Medicare Supplement policy to enroll in the Medicare Advantage plan? ○ ○

4. (a) Do you have another Medicare Supplement or Medicare Select policy in force? ○ ○

   (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? ○ ○

5. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan) ○ ○

   (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) ☐☐ - ☐☐ - ☐☐☐☐

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 III: APPLICANT AUTHORIZATION

(1) You do not need more than one Medicare Supplement policy or certificate.

(2) If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

(3) You may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy.

(4) If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement policy may be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing Medicaid eligibility. If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

(5) If you are eligible for, and have enrolled in a Medicare Supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare Supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.

(6) Counseling services may be available in your state to provide advice concerning your purchase of Medicare Supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

I hereby apply to Globe Life Insurance Company of New York for a policy to be issued in reliance on my written answers to the above questions. The answers are, to the best of my knowledge and belief, true. I agree the policy shall not be effective unless it has actually been issued. I have received an outline of coverage for the policy applied for and a Medicare Supplement Buyers Guide.

I hereby request that the coverage applied for under this application becomes effective on _____. I understand that I may be waiving certain rights and guarantees under the conditional receipt by making this request. I understand that I have the right to apply for a policy which provides only the minimum requirements for Medicare Supplement insurance in the State of New York.

I understand that loss due to injury or sickness for which medical advice was given or treatment was recommended by or received from a physician within 6 months prior to the policy effective date is not covered unless the loss is incurred more than 60 days after the policy effective date. This exclusion will be waived if I am replacing another accident and health insurance policy, a Medicare Supplement insurance policy, health maintenance organization contract or employer-provided health benefit arrangement and the previous coverage was continuous to a date more than 63 days prior to the effective date of this policy.

I, HEREBY AUTHORIZE MIB, Inc. ("MIB"), any insurance company, hospital, physician, or other practitioner that possesses any records of me or my physical or mental health and/or treatment, and any pharmacy or any pharmacy benefits manager that possesses prescription history about me, to give any and all such information to Globe Life Insurance Company of New York, or its reinsurers, for the purpose of determining my eligibility for benefits under this policy. Health information obtained will not be re-disclosed without my authorization unless permitted by law, in which case it may not be protected under federal privacy rules. I authorize Globe Life Insurance Company of New York, or its reinsurers, to make a brief report of my personal health information to MIB. This authorization shall be valid for two years from this date and may be revoked by sending written notice to Globe Life Insurance Company of New York at P.O. Box 8080 McKinney, TX 75070. I understand that I may request a copy of this authorization from Globe Life Insurance Company of New York or request a copy of the information in MIB's files by writing to MIB at MIB, Inc. 50 Braintree Hill, Suite 400, Braintree, MA 02184-8734 or calling (866) 692-6901. I acknowledge receipt of the MIB Pre-Notice. A photographic copy of this authorization will be as valid as the original.

No agent may bind, alter, change or waive any underwriting requirements or other provisions of the application or policy. Final acceptance is made by the Underwriting Department of the Company.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

Application Signed at City | **State** | **On this Date (mm-dd-yyyy)**

Amount paid with application: $, .

Applicant's Signature

for first months premiums.

(Application Continued)

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

Agent No.

_____

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)

MKT0013

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.

GLOBE LIFE INSURANCE COMPANY OF NEW YORK

P.O. Box 3125 • Syracuse, NY • 13220

REPLACEMENT FORM

Health Insurance Policy – Comparison Form

Current Health or Medicare Policy

Name of Company: _____

Policy Number: _____

Premium: _____ Type: _____

Proposed GLNY Medicare Supplement Policy

Name of Company: **Globe Life Insurance Company of New York**

Application 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.

ProCare Plan

Current 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		A	B	C▼	D	F▼	F+▼	G	G+	K	L	N
Pays Medicare Part A Deductible?	☐ Yes ☐ No	ℕ	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	50%	75%	**Y**
Pays all expenses after Medicare Part A is exhausted up to 365 days?	☐ Yes ☐ No	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**
Has a Skilled Nursing Facility benefit?	☐ Yes ☐ No	ℕ	ℕ	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	50%	75%	**Y**
Part B		A	B	C▼	D	F▼	F+▼	G	G+	K	L	N
Pays Medicare Part B Deductible?	☐ Yes ☐ No	ℕ	ℕ	**Y**	ℕ	**Y**	**Y**	ℕ	ℕ	ℕ	ℕ	ℕ
Pays ALL Medicare Part B coinsurance amounts?	☐ Yes ☐ No	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	*	*	**
Pays 100% of excess charges *(amounts above Medicare approved)*?	☐ Yes ☐ No	ℕ	ℕ	ℕ	ℕ	**Y**	**Y**	**Y**	**Y**	ℕ	ℕ	ℕ
Has a Foreign Travel Benefit?	☐ Yes ☐ No	ℕ	ℕ	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	ℕ	ℕ	**Y**
Is Policy Guaranteed Renewable?	☐ Yes ☐ No	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**	**Y**
Prescription Drug Benefit?	☐ Yes ☐ No	ℕ	ℕ	ℕ	ℕ	ℕ	ℕ	ℕ	ℕ	ℕ	ℕ	ℕ
Preventive Care Benefit?	☐ Yes ☐ No	ℕ	ℕ	ℕ	ℕ	ℕ	ℕ	ℕ	ℕ	ℕ	ℕ	ℕ

Other Benefits or Services (itemize) _____

* 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.

Globe Life
Insurance Co. of New York

Bank Draft Authorization

Draft date cannot be the 29th, 30th or 31st.

Proposed Insured's Social Security Number

[ ][ ][ ] - [ ][ ] - [ ][ ][ ][ ]

Requested Bank Draft Day (dd)

[ ][ ]

Payor's First Name

M.I.

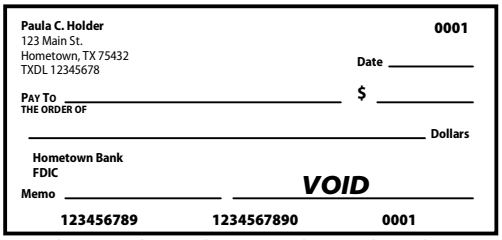
Payor's Last Name

Bank ABA Routing Number

Account Number

Bank Name

Account information fields above must be complete if voided check is not attached.
See the example check below for the location of the Bank Routing Number and Account Number.



Helpful Information for Social Security Recipients		
Social Security Benefits Paid On	Birth Date On	Draft Date
Second Wednesday	1st – 10th	14th
Third Wednesday	11th – 20th	21st
Fourth Wednesday	21st – 31st	28th

As a convenience to me, I hereby request and authorize you, Globe Life Insurance Company of New York, Syracuse, New York, to initiate debit entries to my bank account, as recorded above, for insurance premiums and/or non-insurance product fees, as applicable, and the bank named above to debit the same to such account. I agree that your rights and treatment of such debits shall be the same as if they were checks personally signed by me. I further agree that if any such debits are dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever, even if such dishonor results in the forfeiture of insurance. This authorization will remain in effect until revoked by me in writing to you, provided that you and the bank shall have a reasonable opportunity to act on such notification. All premiums and/or fees may be automatically withdrawn from my account on MONTHLY mode, unless a different mode has been selected on the application(s).

NOTE - <u>Business</u> accounts are permitted only in relation to sole proprietorships, in which case a voided check and a completed Sole Proprietor form (SP 9-01) are required.

Payor's Signature (as it appears on bank records)

Applicant Notice and Conditional Receipt

Instructions to Agent: Complete this section and 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

GLOBE LIFE®
INSURANCE CO.
OF NEW YORK

_____, 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.

2024 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 after the required Medicare deductible	**$1,632** DEDUCTIBLE
61-90 DAYS	All eligible expenses after patient pays a per-day coinsurance	**$408** A DAY COINSURANCE as much as: **$12,240**
91-150 DAYS	All eligible expenses after patient pays a per-day coinsurance (These are Lifetime Reserve Days that may never be used again)	**$816** A DAY COINSURANCE as much as: **$48,960**
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 after patient pays a per-day coinsurance	After 20 days **$204** A DAY COINSURANCE as much as: **$16,320**
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 after first 3 pints of blood.	First 3 pints

F3095
UAI0136 **1023**

2024 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	**$240** 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 after 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 2024, 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.*

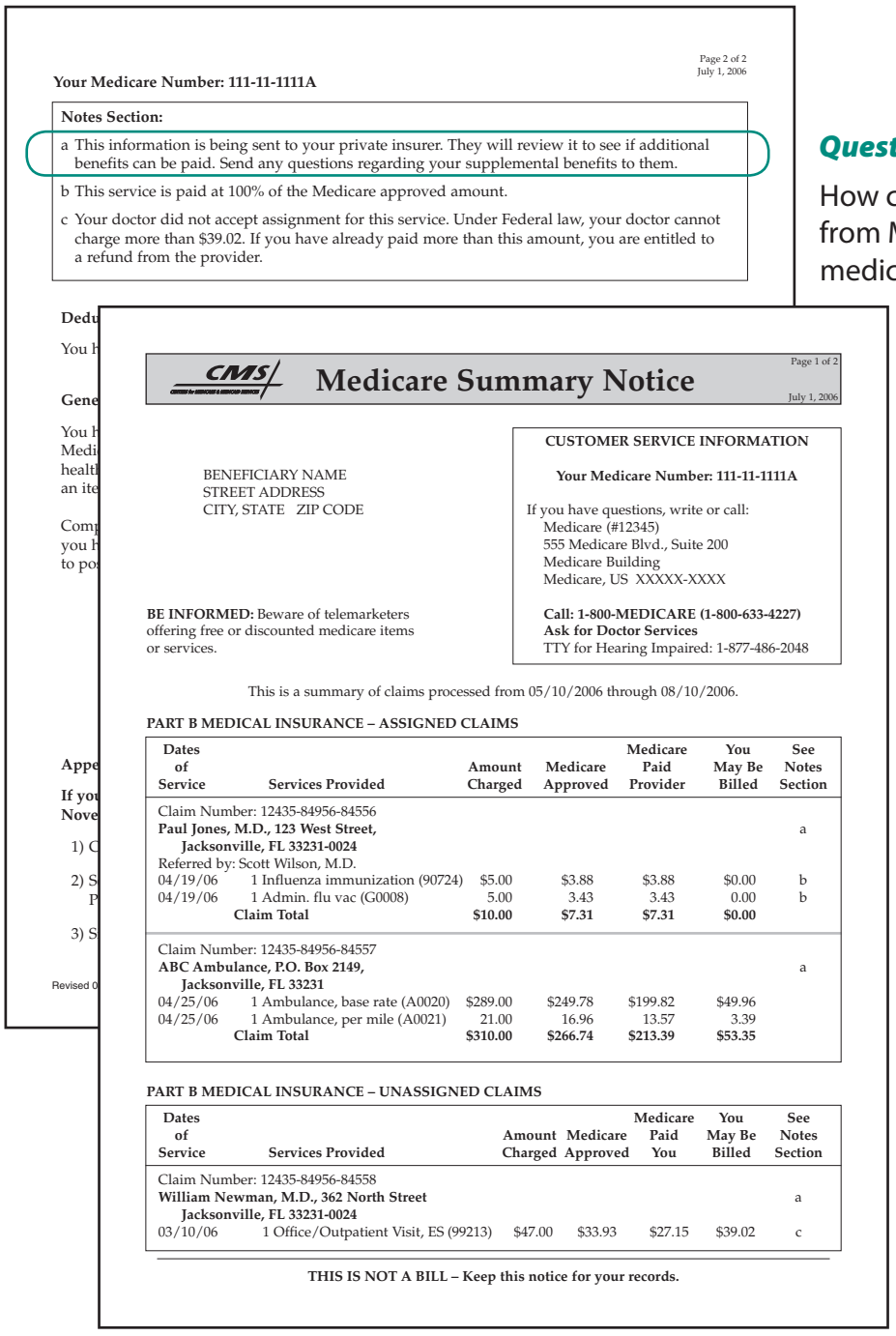
F3095
UAI0136 **1023**

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.



Page 2 of 2
July 1, 2006

Your Medicare Number: 111-11-1111A

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.

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						a
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						a
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						a
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.

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.

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 ADVICE 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.

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 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.					a
04/25/06 – 05/09/06	14 days	$0.00	$876.00	$876.00	b, c
Claim Number: 12435-84956-845556-45622 **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.						d
04/02/06	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.

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.

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 2024[2]					7,060[2]	3,530[2]				

[1] Plans F and G also have a high deductible option which requires first paying a plan deductible of $2,800 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)*
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	3199	1600	800	267	N9E	N45	02-01-24
B	3936	1968	984	328	N9F	N46	02-01-22
C	4753	2377	1189	397	N9G	N47	02-01-22
D	4685	2343	1172	391	N9H	N48	02-01-22
F	4663	2332	1166	389	N9I	N49	02-01-24
F+	1077	539	270	90	N9K	N51	02-01-24
G	4174	2087	1044	348	N9J	N50	02-01-22
G+	864	432	216	72	NCL	NCK	02-01-22
K	1642	821	411	137	N9C	N43	02-01-22
L	2801	1401	701	234	N9D	N44	02-01-24
N	3944	1972	986	329	N9L	N52	02-01-24

AREA 3 *(ZIP 120-128)*
AREA 4 *(ZIP 129-149)*

PLAN	A	SA	Q	M	Plan Code		Effective Date
					Under Age 65	Age 65 and over	
A	2666	1333	667	223	N9E	N45	02-01-24
B	3280	1640	820	274	N9F	N46	02-01-22
C	3961	1981	991	331	N9G	N47	02-01-22
D	3904	1952	976	326	N9H	N48	02-01-22
F	3886	1943	972	324	N9I	N49	02-01-24
F+	897	449	225	75	N9K	N51	02-01-24
G	3479	1740	870	290	N9J	N50	02-01-22
G+	720	360	180	60	NCL	NCK	02-01-22
K	1368	684	342	114	N9C	N43	02-01-22
L	2333	1167	584	195	N9D	N44	02-01-24
N	3287	1644	822	274	N9L	N52	02-01-24

AREA 5 *(ZIP 112)*

PLAN	A	SA	Q	M	Plan Code		Effective Date
					Under Age 65	Age 65 and over	
A	3583	1792	896	299	N9E	N45	02-01-24
B	4409	2205	1103	368	N9F	N46	02-01-22
C	5325	2663	1332	444	N9G	N47	02-01-22
D	5249	2625	1313	438	N9H	N48	02-01-22
F	5224	2612	1306	436	N9I	N49	02-01-24
F+	1206	603	302	101	N9K	N51	02-01-24
G	4677	2339	1170	390	N9J	N50	02-01-22
G+	968	484	242	81	NCL	NCK	02-01-22
K	1839	920	460	154	N9C	N43	02-01-22
L	3137	1569	785	262	N9D	N44	02-01-24
N	4419	2210	1105	369	N9L	N52	02-01-24

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 $1632	$0	$1632 (Part A Deductible)
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $816 a day	$816 a day	$0
Once lifetime reserve days are used:			
– Additional 365 days	$0	100% of Medicare-Eligible Expenses	$0
– Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $204 a day	$0	Up to $204 a day
101st day and after	$0	$0	All Costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional Amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited 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 $240 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

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

PARTS A & B

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

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 $1632	$1632 (Part A Deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $816 a day	$816 a day	$0
Once lifetime reserve days are used:			
– Additional 365 days	$0	100% of Medicare-Eligible Expenses	$0
– Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $204 a day	$0	Up to $204 a day
101st day and after	$0	$0	All Costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional Amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited 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 $240 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

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

PARTS A & B

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

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

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

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

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

OTHER BENEFITS – NOT COVERED BY MEDICARE

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 $1632	$1632 (Part A Deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $816 a day	$816 a day	$0
Once lifetime reserve days are used:			
– Additional 365 days	$0	100% of Medicare-Eligible Expenses	$0
– Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $204 a day	Up to $204 a day	$0
101st day and after	$0	$0	All Costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional Amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited 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 $240 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

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

PARTS A & B

HOME HEALTH CARE – MEDICARE-APPROVED SERVICES			
– Medically necessary skilled care services and medical supplies	100%	$0	$0
– Durable medical equipment			
First $240 of Medicare-Approved Amounts*	$0	$0	$240 (Part B Deductible)
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 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 $2800 deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are $2800. 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 $2800 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO $2800 DEDUCTIBLE,** YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1632	$1632 (Part A Deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $816 a day	$816 a day	$0
Once lifetime reserve days are used:			
– Additional 365 days	$0	100% of Medicare-Eligible Expenses	$0
– Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $204 a day	Up to $204 a day	$0
101st day and after	$0	$0	All Costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional Amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

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

** This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2800 deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are $2800. 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 $2800 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO $2800 DEDUCTIBLE,** YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as			
Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $240 of Medicare-Approved Amounts*	$0	$240 (Part B Deductible)	$0
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 $240 of Medicare-Approved Amounts*	$0	$240 (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 $240 of Medicare-Approved Amounts*	$0	$240 (Part B Deductible)	$0
Remainder of Medicare-Approved Amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

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 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 $2800 deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are $2800. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.

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

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

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

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

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2800 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO $2800 DEDUCTIBLE,** YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as			
Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $240 of Medicare-Approved Amounts*	$0	$0	$240 (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 $240 of Medicare-Approved Amounts*	$0	$0	$240 (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	100%	$0	$0
– Durable medical equipment			
First $240 of Medicare-Approved Amounts*	$0	$0	$240 (Unless Part B Deductible has been met)
Remainder of Medicare-Approved Amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

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 K

* You will pay half the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $7060 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 $1632	$816 (50% of Part A Deductible)	$816 (50% of Part A Deductible)♦
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $816 a day	$816 a day	$0
Once lifetime reserve days are used:			
– Additional 365 days	$0	100% of Medicare-Eligible Expenses	$0
– Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE**			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $204 a day	Up to $102 a day (50% of Part A Coinsurance)	Up to $102 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 $240 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as			
Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $240 of Medicare-Approved Amounts ****	$0	$0	$240 (Part B Deductible) ****♦
Preventive Benefits for Medicare-Covered Services	Generally 80% or more of Medicare-approved amounts	Remainder of Medicare-approved amounts	All costs above Medicare-approved amounts
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 10%	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 $2940)*
BLOOD			
First 3 pints	$0	50%	50%♦
Next $240 of Medicare-Approved Amounts ****	$0	$0	$240 (Part B Deductible) ****♦
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 10%	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	100%	$0	$0
– Durable medical equipment			
First $240 of Medicare-Approved Amounts *****	$0	$0	$240 (Part B Deductible)♦
Remainder of Medicare-Approved Amounts	80%	10%	10%♦

* This plan limits your annual out-of-pocket payment for Medicare-approved amounts $7060 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 $3530 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 $1632	$1224 (75% of Part A Deductible)	$408 (25% of Part A Deductible) ♦
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $816 a day	$816 a day	$0
Once lifetime reserve days are used:			
– Additional 365 days	$0	100% of Medicare-Eligible Expenses	$0
– Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE**			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $204 a day	Up to $153 a day (75% of Part A Coinsurance)	Up to $51 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 $240 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as			
Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $240 of Medicare-Approved Amounts ****	$0	$0	$240 (Part B Deductible) **** ♦
Preventive Benefits for Medicare-Covered Services	Generally 80% or more of Medicare-approved amounts	Remainder of Medicare-approved amounts	All costs above Medicare-approved amounts
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 15%	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 $3470)*
BLOOD			
First 3 pints	$0	75%	25% ♦
Next $240 of Medicare-Approved Amounts ****	$0	$0	$240 (Part B Deductible) **** ♦
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 15%	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	100%	$0	$0
– Durable medical equipment			
First $240 of Medicare-Approved Amounts *****	$0	$0	$240 (Part B Deductible) ♦
Remainder of Medicare-Approved Amounts	80%	15%	5% ♦

* This plan limits your annual out-of-pocket payment for Medicare-approved amounts $3530 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 $1632	$1632 (Part A Deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $816 a day	$816 a day	$0
Once lifetime reserve days are used:			
– Additional 365 days	$0	100% of Medicare-Eligible Expenses	$0
– Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $204 a day	Up to $204 a day	$0
101st day and after	$0	$0	All Costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional Amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

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

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

PARTS A & B

HOME HEALTH CARE – MEDICARE-APPROVED SERVICES			
– Medically necessary skilled care services and medical supplies	100%	$0	$0
– Durable medical equipment			
First $240 of Medicare-Approved Amounts*	$0	$0	$240 (Part B Deductible)
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