

GLOBE LIFE INSURANCE COMPANY OF NEW YORK

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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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