

# 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 <sup>3</sup>	✓	✓
Blood (first three pints)	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Part A hospice care coinsurance or copayment	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Skilled nursing facility coinsurance			✓	✓	50%	75%	✓	✓	✓	✓
Medicare Part A deductible		✓	✓	✓	50%	75%	50%	✓	✓	✓
Medicare Part B deductible									✓	✓
Medicare Part B excess charges				✓						✓
Foreign travel emergency (up to plan limits)			✓	✓			✓	✓	✓	✓
Out-of-pocket limit in 2025 <sup>2</sup>					7,220 <sup>2</sup>	3,610 <sup>2</sup>				

<sup>1</sup> Plans F and G also have a high deductible option which requires first paying a plan deductible of \$2,870 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.)

<sup>2</sup> 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.

<sup>3</sup> 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	3199	1600	800	267	N9E	N45	02/01/24
B	4285	2143	1072	358	N9F	N46	02/01/25
C	4753	2377	1189	397	N9G	N47	02/01/22
D	4685	2343	1172	391	N9H	N48	02/01/22
F	5428	2714	1357	453	N9I	N49	02/01/25
F+	1307	654	327	109	N9K	N51	02/01/25
G	4383	2192	1096	366	N9J	N50	02/01/25
G+	864	432	216	72	NCL	NCK	02/01/22
K	1663	832	416	139	N9C	N43	02/01/25
L	2968	1484	742	248	N9D	N44	02/01/25
N	4299	2150	1075	359	N9L	N52	02/01/25

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	2666	1333	667	223	N9E	N45	02/01/24
B	3571	1786	893	298	N9F	N46	02/01/25
C	3961	1981	991	331	N9G	N47	02/01/22
D	3904	1952	976	326	N9H	N48	02/01/22
F	4523	2262	1131	377	N9I	N49	02/01/25
F+	1089	545	273	91	N9K	N51	02/01/25
G	3652	1826	913	305	N9J	N50	02/01/25
G+	720	360	180	60	NCL	NCK	02/01/22
K	1386	693	347	116	N9C	N43	02/01/25
L	2473	1237	619	207	N9D	N44	02/01/25
N	3582	1791	896	299	N9L	N52	02/01/25

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	4802	2401	1201	401	N9F	N46	02/01/25
C	5325	2663	1332	444	N9G	N47	02/01/22
D	5249	2625	1313	438	N9H	N48	02/01/22
F	6081	3041	1521	507	N9I	N49	02/01/25
F+	1464	732	366	122	N9K	N51	02/01/25
G	4910	2455	1228	410	N9J	N50	02/01/25
G+	968	484	242	81	NCL	NCK	02/01/22
K	1863	932	466	156	N9C	N43	02/01/25
L	3325	1663	832	278	N9D	N44	02/01/25
N	4817	2409	1205	402	N9L	N52	02/01/25

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
<b>HOSPITALIZATION*</b>			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$1676	\$0	\$1676 (Part A Deductible)
61st thru 90th day	All but \$419 a day	\$419 a day	\$0
91st day and after:			
– While using 60 lifetime reserve days	All but \$838 a day	\$838 a day	\$0
Once lifetime reserve days are used:			
– Additional 365 days	\$0	100% of Medicare-Eligible Expenses	\$0
– Beyond the Additional 365 days	\$0	\$0	All Costs
<b>SKILLED NURSING FACILITY CARE*</b>			
You must meet Medicare’s requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$209.50 a day	\$0	Up to \$209.50 a day
101st day and after	\$0	\$0	All Costs
<b>BLOOD</b>			
First 3 pints	\$0	3 pints	\$0
Additional Amounts	100%	\$0	\$0
<b>HOSPICE CARE</b>			
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 \$257 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as</b> Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First \$257 of Medicare-Approved Amounts*	\$0	\$0	\$257 (Part B Deductible)
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	\$0
<b>Part B Excess Charges</b> (Above Medicare-Approved Amounts)	\$0	\$0	All Costs
<b>BLOOD</b>			
First 3 pints	\$0	All Costs	\$0
Next \$257 of Medicare-Approved Amounts*	\$0	\$0	\$257 (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	\$0
<b>CLINICAL LABORATORY SERVICES</b>			
– Tests for diagnostic services	100%	\$0	\$0

**PARTS A & B**

<b>HOME HEALTH CARE – MEDICARE-APPROVED SERVICES</b>			
– Medically necessary skilled care services and medical supplies	100%	\$0	\$0
– Durable medical equipment			
First \$257 of Medicare-Approved Amounts*	\$0	\$0	\$257 (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
<b>HOSPITALIZATION*</b>			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$1676	\$1676 (Part A Deductible)	\$0
61st thru 90th day	All but \$419 a day	\$419 a day	\$0
91st day and after:			
– While using 60 lifetime reserve days	All but \$838 a day	\$838 a day	\$0
Once lifetime reserve days are used:			
– Additional 365 days	\$0	100% of Medicare-Eligible Expenses	\$0
– Beyond the Additional 365 days	\$0	\$0	All Costs
<b>SKILLED NURSING FACILITY CARE*</b>			
You must meet Medicare’s requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$209.50 a day	\$0	Up to \$209.50 a day
101st day and after	\$0	\$0	All Costs
<b>BLOOD</b>			
First 3 pints	\$0	3 pints	\$0
Additional Amounts	100%	\$0	\$0
<b>HOSPICE CARE</b>			
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 \$257 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as</b> Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First \$257 of Medicare-Approved Amounts*	\$0	\$0	\$257 (Part B Deductible)
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	\$0
<b>Part B Excess Charges</b> (Above Medicare-Approved Amounts)	\$0	\$0	All Costs
<b>BLOOD</b>			
First 3 pints	\$0	All Costs	\$0
Next \$257 of Medicare-Approved Amounts*	\$0	\$0	\$257 (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	\$0
<b>CLINICAL LABORATORY SERVICES</b>			
– Tests for diagnostic services	100%	\$0	\$0

**PARTS A & B**

<b>HOME HEALTH CARE – MEDICARE-APPROVED SERVICES</b>			
– Medically necessary skilled care services and medical supplies	100%	\$0	\$0
– Durable medical equipment			
First \$257 of Medicare-Approved Amounts*	\$0	\$0	\$257 (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
<b>HOSPITALIZATION*</b>			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$1676	\$1676 (Part A Deductible)	\$0
61st thru 90th day	All but \$419 a day	\$419 a day	\$0
91st day and after:			
– While using 60 lifetime reserve days	All but \$838 a day	\$838 a day	\$0
Once lifetime reserve days are used:			
– Additional 365 days	\$0	100% of Medicare-Eligible Expenses	\$0
– Beyond the Additional 365 days	\$0	\$0	All Costs
<b>SKILLED NURSING FACILITY CARE*</b>			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$209.50 a day	Up to \$209.50 a day	\$0
101st day and after	\$0	\$0	All Costs
<b>BLOOD</b>			
First 3 pints	\$0	3 pints	\$0
Additional Amounts	100%	\$0	\$0
<b>HOSPICE CARE</b>			
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 \$257 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as</b> Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First \$257 of Medicare-Approved Amounts*	\$0	\$257 (Part B Deductible)	\$0
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	\$0
<b>Part B Excess Charges</b> (Above Medicare-Approved Amounts)	\$0	\$0	All Costs
<b>BLOOD</b>			
First 3 pints	\$0	All Costs	\$0
Next \$257 of Medicare-Approved Amounts*	\$0	\$257 (Part B Deductible)	\$0
Remainder of Medicare-Approved Amounts	80%	20%	\$0
<b>CLINICAL LABORATORY SERVICES</b>			
– Tests for diagnostic services	100%	\$0	\$0

**PARTS A & B**

<b>HOME HEALTH CARE – MEDICARE-APPROVED SERVICES</b>			
– Medically necessary skilled care services and medical supplies	100%	\$0	\$0
– Durable medical equipment			
First \$257 of Medicare-Approved Amounts*	\$0	\$257 (Part B Deductible)	\$0
Remainder of Medicare-Approved Amounts	80%	20%	\$0

**OTHER BENEFITS – NOT COVERED BY MEDICARE**

<b>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</b>			
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
<b>HOSPITALIZATION*</b>			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$1676	\$1676 (Part A Deductible)	\$0
61st thru 90th day	All but \$419 a day	\$419 a day	\$0
91st day and after:			
– While using 60 lifetime reserve days	All but \$838 a day	\$838 a day	\$0
Once lifetime reserve days are used:			
– Additional 365 days	\$0	100% of Medicare-Eligible Expenses	\$0
– Beyond the Additional 365 days	\$0	\$0	All Costs
<b>SKILLED NURSING FACILITY CARE*</b>			
You must meet Medicare’s requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$209.50 a day	Up to \$209.50 a day	\$0
101st day and after	\$0	\$0	All Costs
<b>BLOOD</b>			
First 3 pints	\$0	3 pints	\$0
Additional Amounts	100%	\$0	\$0
<b>HOSPICE CARE</b>			
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 \$257 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as</b> Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First \$257 of Medicare-Approved Amounts*	\$0	\$0	\$257 (Part B Deductible)
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	\$0
<b>Part B Excess Charges</b> (Above Medicare-Approved Amounts)	\$0	\$0	All Costs
<b>BLOOD</b>			
First 3 pints	\$0	All Costs	\$0
Next \$257 of Medicare-Approved Amounts*	\$0	\$0	\$257 (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	\$0
<b>CLINICAL LABORATORY SERVICES</b>			
– Tests for diagnostic services	100%	\$0	\$0

**PARTS A & B**

<b>HOME HEALTH CARE – MEDICARE-APPROVED SERVICES</b>			
– Medically necessary skilled care services and medical supplies	100%	\$0	\$0
– Durable medical equipment			
First \$257 of Medicare-Approved Amounts*	\$0	\$0	\$257 (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	\$0

**OTHER BENEFITS – NOT COVERED BY MEDICARE**

<b>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</b>			
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 \$2870 deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are \$2870. 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 \$2870 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO \$2870 DEDUCTIBLE,** YOU PAY
<b>HOSPITALIZATION*</b>			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$1676	\$1676 (Part A Deductible)	\$0
61st thru 90th day	All but \$419 a day	\$419 a day	\$0
91st day and after:			
– While using 60 lifetime reserve days	All but \$838 a day	\$838 a day	\$0
Once lifetime reserve days are used:			
– Additional 365 days	\$0	100% of Medicare-Eligible Expenses	\$0
– Beyond the Additional 365 days	\$0	\$0	All Costs
<b>SKILLED NURSING FACILITY CARE*</b>			
You must meet Medicare’s requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$209.50 a day	Up to \$209.50 a day	\$0
101st day and after	\$0	\$0	All Costs
<b>BLOOD</b>			
First 3 pints	\$0	3 pints	\$0
Additional Amounts	100%	\$0	\$0
<b>HOSPICE CARE</b>			
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 \$257 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.
- \*\* This high deductible plan pays the same benefits as Plan F after one has paid a calendar year \$2870 deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are \$2870. 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 \$2870 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO \$2870 DEDUCTIBLE,** YOU PAY
<b>MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as</b> Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First \$257 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	\$0 Generally 80%	\$257 (Part B Deductible) Generally 20%	\$0 \$0
<b>Part B Excess Charges</b> (Above Medicare-Approved Amounts)	\$0	100%	\$0
<b>BLOOD</b> First 3 pints Next \$257 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	\$0 \$0 80%	All Costs \$257 (Part B Deductible) 20%	\$0 \$0 \$0
<b>CLINICAL LABORATORY SERVICES</b> – Tests for diagnostic services	100%	\$0	\$0

**PARTS A & B**

<b>HOME HEALTH CARE – MEDICARE-APPROVED SERVICES</b> – Medically necessary skilled care services and medical supplies – Durable medical equipment First \$257 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	100%   \$0 80%	\$0  \$257 (Part B Deductible) 20%	\$0  \$0 \$0
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**OTHER BENEFITS – NOT COVERED BY MEDICARE**

<b>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</b> 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 \$2870 deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are \$2870. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$2870 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO \$2870 DEDUCTIBLE,** YOU PAY
<b>HOSPITALIZATION*</b>			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$1676	\$1676 (Part A Deductible)	\$0
61st thru 90th day	All but \$419 a day	\$419 a day	\$0
91st day and after:			
– While using 60 lifetime reserve days	All but \$838 a day	\$838 a day	\$0
Once lifetime reserve days are used:			
– Additional 365 days	\$0	100% of Medicare-Eligible Expenses	\$0
– Beyond the Additional 365 days	\$0	\$0	All Costs
<b>SKILLED NURSING FACILITY CARE*</b>			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$209.50 a day	Up to \$209.50 a day	\$0
101st day and after	\$0	\$0	All Costs
<b>BLOOD</b>			
First 3 pints	\$0	3 pints	\$0
Additional Amounts	100%	\$0	\$0
<b>HOSPICE CARE</b>			
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 \$257 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.
- \*\* This high deductible plan pays the same benefits as Plan G after one has paid a calendar year \$2870 deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are \$2870. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$2870 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO \$2870 DEDUCTIBLE,** YOU PAY
<b>MEDICAL EXPENSES</b> – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First \$257 of Medicare-Approved Amounts*	\$0	\$0	\$257 (Unless Part B Deductible has been met)
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	\$0
<b>Part B Excess Charges</b> (Above Medicare Approved Amounts)	\$0	100%	\$0
<b>BLOOD</b> First 3 pints Next \$257 of Medicare-Approved Amounts*	\$0 \$0	All Costs \$0	\$0 \$257 (Unless Part B Deductible has been met)
Remainder of Medicare-Approved Amounts	80%	20%	\$0
<b>CLINICAL LABORATORY SERVICES</b> – Tests for diagnostic services	100%	\$0	\$0

**PARTS A & B**

<b>HOME HEALTH CARE</b> – MEDICARE-APPROVED SERVICES – Medically necessary skilled care services and medical supplies – Durable medical equipment First \$257 of Medicare-Approved Amounts*	100% \$0	\$0 \$0	\$0 \$257 (Unless Part B Deductible has been met)
Remainder of Medicare-Approved Amounts	80%	20%	\$0

**OTHER BENEFITS – NOT COVERED BY MEDICARE**

<b>FOREIGN TRAVEL</b> – 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 \$7220 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 *
<b>HOSPITALIZATION**</b>			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$1676	\$838 (50% of Part A Deductible)	\$838 (50% of Part A Deductible) ♦
61st thru 90th day	All but \$419 a day	\$419 a day	\$0
91st day and after:			
– While using 60 lifetime reserve days	All but \$838 a day	\$838 a day	\$0
Once lifetime reserve days are used:			
– Additional 365 days	\$0	100% of Medicare-Eligible Expenses	\$0
– Beyond the Additional 365 days	\$0	\$0	All Costs
<b>SKILLED NURSING FACILITY CARE**</b>			
You must meet Medicare’s requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$209.50 a day	Up to \$104.75 a day (50% of Part A Coinsurance)	Up to \$104.75 a day (50% of Part A Coinsurance) ♦
101st day and after	\$0	\$0	All Costs
<b>BLOOD</b>			
First 3 pints	\$0	50%	50% ♦
Additional Amounts	100%	\$0	\$0
<b>HOSPICE CARE</b>			
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 \$257 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , such as Physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First \$257 of Medicare-Approved Amounts **** 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%	\$257 (Part B Deductible) **** ♦ All costs above Medicare-approved amounts Generally 10% ♦
<b>Part B Excess Charges</b> (Above Medicare-Approved Amounts)	\$0	\$0	All Costs (and they do not count toward annual out-of-pocket limit of \$7220)*
<b>BLOOD</b> First 3 pints Next \$257 of Medicare-Approved Amounts **** Remainder of Medicare-Approved Amounts	\$0 \$0 Generally 80%	50% \$0 Generally 10%	50% ♦ \$257 (Part B Deductible) **** ♦ Generally 10% ♦
<b>CLINICAL LABORATORY SERVICES</b> – Tests for diagnostic services	100%	\$0	\$0

**PARTS A & B**

<b>HOME HEALTH CARE – MEDICARE-APPROVED SERVICES</b> – Medically necessary skilled care services and medical supplies – Durable medical equipment First \$257 of Medicare-Approved Amounts ***** Remainder of Medicare-Approved Amounts	100% \$0 80%	\$0 \$0 10%	\$0 \$257 (Part B Deductible) ♦ 10% ♦
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\* This plan limits your annual out-of-pocket payment for Medicare-approved amounts \$7220 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 \$3610 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 *
<b>HOSPITALIZATION**</b>			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$1676	\$1257 (75% of Part A Deductible)	\$419 (25% of Part A Deductible) ♦
61st thru 90th day	All but \$419 a day	\$419 a day	\$0
91st day and after:			
– While using 60 lifetime reserve days	All but \$838 a day	\$838 a day	\$0
Once lifetime reserve days are used:			
– Additional 365 days	\$0	100% of Medicare-Eligible Expenses	\$0
– Beyond the Additional 365 days	\$0	\$0	All Costs
<b>SKILLED NURSING FACILITY CARE**</b>			
You must meet Medicare’s requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$209.50 a day	Up to \$157.12 a day (75% of Part A Coinsurance)	Up to \$52.38 a day (25% of Part A Coinsurance) ♦
101st day and after	\$0	\$0	All Costs
<b>BLOOD</b>			
First 3 pints	\$0	75%	25% ♦
Additional Amounts	100%	\$0	\$0
<b>HOSPICE CARE</b>			
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 \$257 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>MEDICAL EXPENSES</b> – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First \$257 of Medicare-Approved Amounts **** 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%	\$257 (Part B Deductible) **** ♦ All costs above Medicare-approved amounts Generally 5% ♦
<b>Part B Excess Charges</b> (Above Medicare-Approved Amounts)	\$0	\$0	All Costs (and they do not count toward annual out-of-pocket limit of \$3610)*
<b>BLOOD</b> First 3 pints Next \$257 of Medicare-Approved Amounts **** Remainder of Medicare-Approved Amounts	\$0 \$0 Generally 80%	75% \$0 Generally 15%	25% ♦ \$257 (Part B Deductible) **** ♦ Generally 5% ♦
<b>CLINICAL LABORATORY SERVICES</b> – Tests for diagnostic services	100%	\$0	\$0

**PARTS A & B**

<b>HOME HEALTH CARE</b> – MEDICARE-APPROVED SERVICES – Medically necessary skilled care services and medical supplies – Durable medical equipment First \$257 of Medicare-Approved Amounts ***** Remainder of Medicare-Approved Amounts	100% \$0 80%	\$0 \$0 15%	\$0 \$257 (Part B Deductible) ♦ 5% ♦
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\* This plan limits your annual out-of-pocket payment for Medicare-approved amounts \$3610 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
<b>HOSPITALIZATION*</b>			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$1676	\$1676 (Part A Deductible)	\$0
61st thru 90th day	All but \$419 a day	\$419 a day	\$0
91st day and after:			
– While using 60 lifetime reserve days	All but \$838 a day	\$838 a day	\$0
Once lifetime reserve days are used:			
– Additional 365 days	\$0	100% of Medicare-Eligible Expenses	\$0
– Beyond the Additional 365 days	\$0	\$0	All Costs
<b>SKILLED NURSING FACILITY CARE*</b>			
You must meet Medicare’s requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st thru 100th day	All but \$209.50 a day	Up to \$209.50 a day	\$0
101st day and after	\$0	\$0	All Costs
<b>BLOOD</b>			
First 3 pints	\$0	3 pints	\$0
Additional Amounts	100%	\$0	\$0
<b>HOSPICE CARE</b>			
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 \$257 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as:</b> Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First \$257 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	\$0 Generally 80%	\$0 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.	\$257 (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.
<b>Part B Excess Charges</b> (Above Medicare-Approved Amounts)	\$0	\$0	All costs
<b>BLOOD</b> First 3 pints Next \$257 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	\$0 \$0 80%	All Costs \$0 20%	\$0 \$257 (Part B Deductible) \$0
<b>CLINICAL LABORATORY SERVICES</b> – Tests for diagnostic services	100%	\$0	\$0

**PARTS A & B**

<b>HOME HEALTH CARE – MEDICARE-APPROVED SERVICES</b> – Medically necessary skilled care services and medical supplies – Durable medical equipment First \$257 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$257 (Part B Deductible) \$0
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**OTHER BENEFITS – NOT COVERED BY MEDICARE**

<b>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</b> 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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