

# **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 <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 2020 <sup>2</sup>					\$5,880 <sup>2</sup>	\$2,940 <sup>2</sup>				

<sup>1</sup> Plans F and G also have a high deductible option which requires first paying a plan deductible of \$2,340 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

<b>AREA 1 (ZIP 105-110)</b> <b>AREA 2 (ZIP 100-104, 111, 113-119, 00501, 00544, 06390)</b>							
PLAN	A	SA	Q	M	Plan Code		Effective Date
					Under Age 65	Age 65 and over	
<b>A</b>	2871	1436	718	240	N9E	N45	09-01-19
<b>B</b>	3936	1968	984	328	N9F	N46	09-01-19
<b>C</b>	4753	2377	1189	397	N9G	N47	09-01-19
<b>D</b>	4685	2343	1172	391	N9H	N48	09-01-19
<b>F</b>	4484	2242	1121	374	N9I	N49	09-01-19
<b>F+</b>	821	411	206	69	N9K	N51	09-01-19
<b>G</b>	4174	2087	1044	348	N9J	N50	09-01-19
<b>G+</b>	821	411	206	69	NCL	NCK	01-01-20
<b>K</b>	1642	821	411	137	N9C	N43	09-01-19
<b>L</b>	2472	1236	618	206	N9D	N44	09-01-19
<b>N</b>	3104	1552	776	259	N9L	N52	09-01-19

<b>AREA 3 (ZIP 120-128)</b> <b>AREA 4 (ZIP 129-149)</b>							
PLAN	A	SA	Q	M	Plan Code		Effective Date
					Under Age 65	Age 65 and over	
<b>A</b>	2392	1196	598	200	N9E	N45	09-01-19
<b>B</b>	3280	1640	820	274	N9F	N46	09-01-19
<b>C</b>	3961	1981	991	331	N9G	N47	09-01-19
<b>D</b>	3904	1952	976	326	N9H	N48	09-01-19
<b>F</b>	3737	1869	935	312	N9I	N49	09-01-19
<b>F+</b>	684	342	171	57	N9K	N51	09-01-19
<b>G</b>	3479	1740	870	290	N9J	N50	09-01-19
<b>G+</b>	684	342	171	57	NCL	NCK	01-01-20
<b>K</b>	1368	684	342	114	N9C	N43	09-01-19
<b>L</b>	2060	1030	515	172	N9D	N44	09-01-19
<b>N</b>	2587	1294	647	216	N9L	N52	09-01-19

<b>AREA 5 (ZIP 112)</b>							
PLAN	A	SA	Q	M	Plan Code		Effective Date
					Under Age 65	Age 65 and over	
<b>A</b>	3216	1608	804	268	N9E	N45	09-01-19
<b>B</b>	4409	2205	1103	368	N9F	N46	09-01-19
<b>C</b>	5325	2663	1332	444	N9G	N47	09-01-19
<b>D</b>	5249	2625	1313	438	N9H	N48	09-01-19
<b>F</b>	5024	2512	1256	419	N9I	N49	09-01-19
<b>F+</b>	920	460	230	77	N9K	N51	09-01-19
<b>G</b>	4677	2339	1170	390	N9J	N50	09-01-19
<b>G+</b>	920	460	230	77	NCL	NCK	01-01-20
<b>K</b>	1839	920	460	154	N9C	N43	09-01-19
<b>L</b>	2770	1385	693	231	N9D	N44	09-01-19
<b>N</b>	3478	1739	870	290	N9L	N52	09-01-19

Only applicants first eligible for Medicare Part A before 2020 may purchase Plans C, F and High Deductible Plan F. The G+ Plan is only available with a policy effective date of 1/1/2020 or later.

**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 \$1408	\$0	\$1408 (Part A Deductible)
61st thru 90th day	All but \$352 a day	\$352 a day	\$0
91st day and after:			
– While using 60 lifetime reserve days	All but \$704 a day	\$704 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 \$176 a day	\$0	Up to \$176 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 \$198 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 \$198 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	\$0 Generally 80%	\$0 Generally 20%	\$198 (Part B Deductible) \$0
<b>Part B Excess Charges</b> (Above Medicare-Approved Amounts)	\$0	\$0	All Costs
<b>BLOOD</b> First 3 pints Next \$198 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	\$0 \$0 80%	All Costs \$0 20%	\$0 \$198 (Part B Deductible) \$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 \$198 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	100%   \$0 80%	\$0   \$0 20%	\$0   \$198 (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
<b>HOSPITALIZATION*</b>			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$1408	\$1408 (Part A Deductible)	\$0
61st thru 90th day	All but \$352 a day	\$352 a day	\$0
91st day and after:			
– While using 60 lifetime reserve days	All but \$704 a day	\$704 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 \$176 a day	\$0	Up to \$176 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 \$198 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 \$198 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	\$0 Generally 80%	\$0 Generally 20%	\$198 (Part B Deductible) \$0
<b>Part B Excess Charges</b> (Above Medicare-Approved Amounts)	\$0	\$0	All Costs
<b>BLOOD</b> First 3 pints Next \$198 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	\$0 \$0 80%	All Costs \$0 20%	\$0 \$198 (Part B Deductible) \$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 \$198 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	100%   \$0 80%	\$0   \$0 20%	\$0   \$198 (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
<b>HOSPITALIZATION*</b>			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$1408	\$1408 (Part A Deductible)	\$0
61st thru 90th day	All but \$352 a day	\$352 a day	\$0
91st day and after:			
– While using 60 lifetime reserve days	All but \$704 a day	\$704 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 \$176 a day	Up to \$176 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 \$198 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 \$198 of Medicare-Approved Amounts*	\$0	\$198 (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 \$198 of Medicare-Approved Amounts*	\$0	\$198 (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</b> – MEDICARE-APPROVED SERVICES			
– Medically necessary skilled care services and medical supplies	100%	\$0	\$0
– Durable medical equipment			
First \$198 of Medicare-Approved Amounts*	\$0	\$198 (Part B Deductible)	\$0
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	\$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 \$1408	\$1408 (Part A Deductible)	\$0
61st thru 90th day	All but \$352 a day	\$352 a day	\$0
91st day and after:			
– While using 60 lifetime reserve days	All but \$704 a day	\$704 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 \$176 a day	Up to \$176 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 \$198 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 \$198 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	\$0 Generally 80%	\$0 Generally 20%	\$198 (Part B Deductible) \$0
<b>Part B Excess Charges</b> (Above Medicare-Approved Amounts)	\$0	\$0	All Costs
<b>BLOOD</b> First 3 pints Next \$198 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	\$0 \$0 80%	All Costs \$0 20%	\$0 \$198 (Part B Deductible) \$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 \$198 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$198 (Part B Deductible) \$0
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**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 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 \$2340 deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are \$2340. 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 \$2340 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO \$2340 DEDUCTIBLE,** YOU PAY
<b>HOSPITALIZATION*</b> 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 \$1408 All but \$352 a day  All but \$704 a day  \$0 \$0	\$1408 (Part A Deductible) \$352 a day  \$704 a day  100% of Medicare-Eligible Expenses \$0	\$0 \$0  \$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 21st thru 100th day 101st day and after	All approved amounts All but \$176 a day \$0	\$0 Up to \$176 a day \$0	\$0 \$0 All Costs
<b>BLOOD</b> First 3 pints Additional Amounts	\$0 100%	3 pints \$0	\$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 \$198 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 \$2340 deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are \$2340. 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 \$2340 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO \$2340 DEDUCTIBLE,** 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 \$198 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	\$0 Generally 80%	\$198 (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 \$198 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	\$0 \$0 80%	All Costs \$198 (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 \$198 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	100%   \$0 80%	\$0  \$198 (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 \$2340 deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are \$2340. 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 \$2340 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO \$2340 DEDUCTIBLE,** YOU PAY
<b>HOSPITALIZATION*</b> 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 \$1408 All but \$352 a day  All but \$704 a day  \$0 \$0	\$1408 (Part A Deductible) \$352 a day  \$704 a day  100% of Medicare-Eligible Expenses \$0	\$0 \$0  \$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 21st thru 100th day 101st day and after	All approved amounts All but \$176 a day \$0	\$0 Up to \$176 a day \$0	\$0 \$0 All Costs
<b>BLOOD</b> First 3 pints Additional Amounts	\$0 100%	3 pints \$0	\$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 \$198 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 \$2340 deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are \$2340. 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 \$2340 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO \$2340 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 \$198 of Medicare-Approved Amounts*	\$0	\$0	\$198 (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 \$198 of Medicare-Approved Amounts*	\$0 \$0	All Costs \$0	\$0 \$198 (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 \$198 of Medicare-Approved Amounts*	100% \$0	\$0 \$0	\$0 \$198 (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 \$5880 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 \$1408	\$704 (50% of Part A Deductible)	\$704 (50% of Part A Deductible) ♦
61st thru 90th day	All but \$352 a day	\$352 a day	\$0
91st day and after:			
– While using 60 lifetime reserve days	All but \$704 a day	\$704 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 \$176 a day	Up to \$88 a day (50% of Part A Coinsurance)	Up to \$88 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 \$198 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 \$198 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%	\$198 (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 \$5880)*
<b>BLOOD</b> First 3 pints Next \$198 of Medicare-Approved Amounts **** Remainder of Medicare-Approved Amounts	\$0 \$0 Generally 80%	50% \$0 Generally 10%	50% ♦ \$198 (Part B Deductible) **** ♦ Generally 10% ♦
<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 \$198 of Medicare-Approved Amounts ***** Remainder of Medicare-Approved Amounts	100%   \$0 80%	\$0   \$0 10%	\$0   \$198 (Part B Deductible) ♦ 10% ♦
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\* This plan limits your annual out-of-pocket payment for Medicare-approved amounts \$5880 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 \$2940 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 \$1408	\$1056 (75% of Part A Deductible)	\$352 (25% of Part A Deductible) ♦
61st thru 90th day	All but \$352 a day	\$352 a day	\$0
91st day and after:			
– While using 60 lifetime reserve days	All but \$704 a day	\$704 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 \$176 a day	Up to \$132 a day (75% of Part A Coinsurance)	Up to \$44 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 \$198 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 \$198 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%	\$198 (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 \$2940)*
<b>BLOOD</b> First 3 pints Next \$198 of Medicare-Approved Amounts **** Remainder of Medicare-Approved Amounts	\$0 \$0 Generally 80%	75% \$0 Generally 15%	25% ♦ \$198 (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 \$198 of Medicare-Approved Amounts ***** Remainder of Medicare-Approved Amounts	100%   \$0 80%	\$0   \$0 15%	\$0   \$198 (Part B Deductible) ♦ 5% ♦
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\* This plan limits your annual out-of-pocket payment for Medicare-approved amounts \$2940 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 \$1408	\$1408 (Part A Deductible)	\$0
61st thru 90th day	All but \$352 a day	\$352 a day	\$0
91st day and after:			
– While using 60 lifetime reserve days	All but \$704 a day	\$704 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 \$176 a day	Up to \$176 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 \$198 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 \$198 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.	\$198 (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 \$198 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	\$0 \$0 80%	All Costs \$0 20%	\$0 \$198 (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 \$198 of Medicare-Approved Amounts* Remainder of Medicare-Approved Amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$198 (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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