MONITOR LIFE INSURANCE COMPANY OF NEW YORK
Outline of Medicare Supplement Coverage
Benefit Plans A, F, G, N and High Deductible Plan G

Benefit Chart of Medicare Supplement Plans Sold on or after January 1, 2020

This chart shows the benefits included in each of the standard Medicare supplement plans. Some plans may not be available. 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.

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 2023[2]					$6940[2]	$3470[2]				

[1]Plans F and G also have a high deductible option which requires first paying a plan deductible of $2700 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.

[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.

MONITOR LIFE INSURANCE COMPANY OF NEW YORK

OHIO Standard Plans - ANNUAL

FOR USE IN ZIP CODES: 430-435, 437-439, 446-449, 455-458

	MALE										FEMALE									
	Preferred					Standard					Preferred					Standard				
Attained Age	Plan A	Plan F	Plan G	Plan HDG	Plan N	Plan A	Plan F	Plan G	Plan HDG	Plan N	Plan A	Plan F	Plan G	Plan HDG	Plan N	Plan A	Plan F	Plan G	Plan HDG	Plan N
65	1,502.13	1,878.03	1,509.68	550.68	1,166.55	1,727.45	2,159.74	1,736.13	633.29	1,341.53	1,306.20	1,633.07	1,312.77	478.86	1,014.39	1,502.13	1,878.03	1,509.68	550.68	1,166.55
66	1,502.13	1,878.03	1,509.68	550.68	1,166.55	1,727.45	2,159.74	1,736.13	633.29	1,341.53	1,306.20	1,633.07	1,312.77	478.86	1,014.39	1,502.13	1,878.03	1,509.68	550.68	1,166.55
67	1,502.13	1,878.03	1,509.68	550.68	1,166.55	1,727.45	2,159.74	1,736.13	633.29	1,341.53	1,306.20	1,633.07	1,312.77	478.86	1,014.39	1,502.13	1,878.03	1,509.68	550.68	1,166.55
68	1,502.13	1,878.03	1,509.68	550.68	1,166.55	1,727.45	2,159.74	1,736.13	633.29	1,341.53	1,306.20	1,633.07	1,312.77	478.86	1,014.39	1,502.13	1,878.03	1,509.68	550.68	1,166.55
69	1,502.13	1,878.03	1,509.68	550.68	1,166.55	1,727.45	2,159.74	1,736.13	633.29	1,341.53	1,306.20	1,633.07	1,312.77	478.86	1,014.39	1,502.13	1,878.03	1,509.68	550.68	1,166.55
70	1,502.13	1,878.03	1,509.68	550.68	1,166.55	1,727.45	2,159.74	1,736.13	633.29	1,341.53	1,306.20	1,633.07	1,312.77	478.86	1,014.39	1,502.13	1,878.03	1,509.68	550.68	1,166.55
71	1,550.29	1,936.13	1,558.08	568.22	1,214.80	1,782.83	2,226.56	1,791.79	653.45	1,397.02	1,348.07	1,683.60	1,354.86	494.10	1,056.34	1,550.29	1,936.13	1,558.08	568.22	1,214.80
72	1,598.30	1,994.22	1,606.33	585.70	1,263.03	1,838.05	2,293.35	1,847.28	673.55	1,452.49	1,389.82	1,734.10	1,396.81	509.30	1,098.29	1,598.30	1,994.22	1,606.33	585.70	1,263.03
73	1,646.15	2,052.26	1,654.42	603.13	1,324.39	1,893.07	2,360.10	1,902.59	693.59	1,523.05	1,431.43	1,784.57	1,438.63	524.46	1,151.64	1,646.15	2,052.26	1,654.42	603.13	1,324.39
74	1,693.85	2,110.28	1,702.37	620.52	1,386.84	1,947.93	2,426.83	1,957.72	713.59	1,594.87	1,472.91	1,835.03	1,480.32	539.58	1,205.95	1,693.85	2,110.28	1,702.37	620.52	1,386.84
75	1,782.51	2,220.31	1,791.46	653.09	1,450.42	2,049.88	2,553.36	2,060.18	751.05	1,667.98	1,550.01	1,930.70	1,557.79	567.90	1,261.24	1,782.51	2,220.31	1,791.46	653.09	1,450.42
76	1,858.88	2,315.63	1,868.23	682.03	1,503.26	2,137.71	2,662.98	2,148.45	784.33	1,728.75	1,616.42	2,013.59	1,624.54	593.07	1,307.19	1,858.88	2,315.63	1,868.23	682.03	1,503.26
77	1,937.79	2,414.23	1,947.53	711.96	1,557.03	2,228.46	2,776.37	2,239.66	818.76	1,790.58	1,685.04	2,099.33	1,693.50	619.09	1,353.94	1,937.79	2,414.23	1,947.53	711.96	1,557.03
78	2,019.32	2,516.23	2,029.47	742.89	1,611.71	2,322.22	2,893.66	2,333.89	854.33	1,853.47	1,755.93	2,188.02	1,764.75	646.00	1,401.48	2,019.32	2,516.23	2,029.47	742.89	1,611.71
79	2,103.54	2,621.69	2,114.11	774.89	1,667.33	2,419.07	3,014.95	2,431.23	891.12	1,917.43	1,829.17	2,279.74	1,838.37	673.82	1,449.85	2,103.54	2,621.69	2,114.11	774.89	1,667.33
80	2,190.56	2,730.76	2,201.57	791.44	1,723.90	2,519.15	3,140.38	2,531.80	910.16	1,982.48	1,904.83	2,374.58	1,914.41	688.21	1,499.04	2,190.56	2,730.76	2,201.57	791.44	1,723.90
81	2,279.53	2,842.43	2,290.98	824.96	1,780.61	2,621.46	3,268.79	2,634.63	948.70	2,047.70	1,982.20	2,471.68	1,992.16	717.35	1,548.36	2,279.53	2,842.43	2,290.98	824.96	1,780.61
82	2,371.40	2,957.86	2,383.31	859.59	1,838.28	2,727.10	3,401.54	2,740.81	988.52	2,114.02	2,062.09	2,572.06	2,072.45	747.47	1,598.50	2,371.40	2,957.86	2,383.31	859.59	1,838.28
83	2,466.27	3,077.20	2,478.66	895.39	1,896.92	2,836.21	3,538.78	2,850.46	1,029.70	2,181.45	2,144.58	2,675.83	2,155.36	778.60	1,649.49	2,466.27	3,077.20	2,478.66	895.39	1,896.92
84	2,536.33	3,200.53	2,577.11	932.37	1,956.55	2,916.78	3,680.60	2,963.68	1,072.23	2,250.04	2,205.50	2,783.07	2,240.97	810.75	1,701.35	2,536.33	3,200.53	2,577.11	932.37	1,956.55
85	2,608.22	3,327.99	2,678.76	950.32	2,017.18	2,999.44	3,827.20	3,080.57	1,092.87	2,319.75	2,268.01	2,893.92	2,329.35	826.37	1,754.07	2,608.22	3,327.99	2,678.76	950.32	2,017.18
86	2,671.27	3,445.31	2,772.04	985.44	2,067.30	3,071.96	3,962.11	3,187.85	1,133.26	2,377.40	2,322.85	2,995.93	2,410.48	856.91	1,797.66	2,671.27	3,445.31	2,772.04	985.44	2,067.30
87	2,735.82	3,566.35	2,868.21	1,021.68	2,118.23	3,146.19	4,101.29	3,298.45	1,174.92	2,435.97	2,378.98	3,101.17	2,494.10	888.42	1,841.94	2,735.82	3,566.35	2,868.21	1,021.68	2,118.23
88	2,801.86	3,691.19	2,967.32	1,059.06	2,169.96	3,222.15	4,244.86	3,412.41	1,217.93	2,495.45	2,436.40	3,209.72	2,580.28	920.93	1,886.92	2,801.86	3,691.19	2,967.32	1,059.06	2,169.96
89	2,869.46	3,819.95	3,069.48	1,097.65	2,222.53	3,299.88	4,392.94	3,529.90	1,262.30	2,555.90	2,495.18	3,321.69	2,669.11	954.48	1,932.63	2,869.46	3,819.95	3,069.48	1,097.65	2,222.53
90	2,938.65	3,952.77	3,174.76	1,137.46	2,275.92	3,379.45	4,545.68	3,650.98	1,308.08	2,617.30	2,555.35	3,437.19	2,760.66	989.09	1,979.06	2,938.65	3,952.77	3,174.76	1,137.46	2,275.92
91	3,000.16	4,080.72	3,276.01	1,176.35	2,323.51	3,450.19	4,692.83	3,767.41	1,352.80	2,672.03	2,608.84	3,548.46	2,848.70	1,022.91	2,020.44	3,000.16	4,080.72	3,276.01	1,176.35	2,323.51
92	3,062.98	4,212.52	3,380.25	1,216.43	2,371.82	3,522.42	4,844.40	3,887.28	1,398.89	2,727.60	2,663.46	3,663.06	2,939.34	1,057.77	2,062.45	3,062.98	4,212.52	3,380.25	1,216.43	2,371.82
93	3,127.10	4,348.30	3,487.54	1,257.76	2,420.86	3,596.17	5,000.55	4,010.67	1,446.42	2,783.99	2,719.22	3,781.13	3,032.64	1,093.70	2,105.10	3,127.10	4,348.30	3,487.54	1,257.76	2,420.86
94	3,192.55	4,488.15	3,598.00	1,300.33	2,470.65	3,671.44	5,161.38	4,137.70	1,495.38	2,841.24	2,776.14	3,902.74	3,128.70	1,130.73	2,148.39	3,192.55	4,488.15	3,598.00	1,300.33	2,470.65
95	3,259.39	4,632.22	3,711.69	1,344.23	2,521.19	3,748.30	5,327.05	4,268.45	1,545.86	2,899.37	2,834.25	4,028.02	3,227.56	1,168.89	2,192.35	3,259.39	4,632.22	3,711.69	1,344.23	2,521.19
96	3,262.37	4,780.91	3,828.98	1,389.58	2,572.78	3,751.72	5,498.05	4,403.33	1,598.02	2,958.69	2,836.84	4,157.31	3,329.55	1,208.34	2,237.19	3,262.37	4,780.91	3,828.98	1,389.58	2,572.78
97	3,265.35	4,934.36	3,949.98	1,436.50	2,625.40	3,755.15	5,674.52	4,542.48	1,651.96	3,019.21	2,839.44	4,290.75	3,434.77	1,249.12	2,282.96	3,265.35	4,934.36	3,949.98	1,436.50	2,625.40
98	3,268.34	5,092.74	4,074.79	1,484.97	2,679.11	3,758.59	5,856.65	4,686.01	1,707.72	3,080.98	2,842.03	4,428.47	3,543.29	1,291.28	2,329.66	3,268.34	5,092.74	4,074.79	1,484.97	2,679.11
99+	3,271.33	5,256.22	4,203.55	1,535.09	2,733.92	3,762.03	6,044.66	4,834.08	1,765.35	3,144.01	2,844.64	4,570.63	3,655.27	1,334.86	2,377.31	3,271.33	5,256.22	4,203.55	1,535.09	2,733.92

Modal Factors: Semi Annual: 0.5200 Quarterly: 0.2650 Monthly: 0.0833

Household Discount Factor: .93

MONITOR LIFE INSURANCE COMPANY OF NEW YORK

OHIO Standard Plans - ANNUAL

FOR USE IN ZIP CODES: 450-454, 459

Attained Age	MALE										FEMALE									
	Preferred					Standard					Preferred					Standard				
	Plan A	Plan F	Plan G	Plan HDG	Plan N	Plan A	Plan F	Plan G	Plan HDG	Plan N	Plan A	Plan F	Plan G	Plan HDG	Plan N	Plan A	Plan F	Plan G	Plan HDG	Plan N
65	1,586.52	1,983.54	1,594.49	581.62	1,232.09	1,824.49	2,281.07	1,833.67	668.87	1,416.90	1,379.58	1,724.82	1,386.52	505.76	1,071.37	1,586.52	1,983.54	1,594.49	581.62	1,232.09
66	1,586.52	1,983.54	1,594.49	581.62	1,232.09	1,824.49	2,281.07	1,833.67	668.87	1,416.90	1,379.58	1,724.82	1,386.52	505.76	1,071.37	1,586.52	1,983.54	1,594.49	581.62	1,232.09
67	1,586.52	1,983.54	1,594.49	581.62	1,232.09	1,824.49	2,281.07	1,833.67	668.87	1,416.90	1,379.58	1,724.82	1,386.52	505.76	1,071.37	1,586.52	1,983.54	1,594.49	581.62	1,232.09
68	1,586.52	1,983.54	1,594.49	581.62	1,232.09	1,824.49	2,281.07	1,833.67	668.87	1,416.90	1,379.58	1,724.82	1,386.52	505.76	1,071.37	1,586.52	1,983.54	1,594.49	581.62	1,232.09
69	1,586.52	1,983.54	1,594.49	581.62	1,232.09	1,824.49	2,281.07	1,833.67	668.87	1,416.90	1,379.58	1,724.82	1,386.52	505.76	1,071.37	1,586.52	1,983.54	1,594.49	581.62	1,232.09
70	1,586.52	1,983.54	1,594.49	581.62	1,232.09	1,824.49	2,281.07	1,833.67	668.87	1,416.90	1,379.58	1,724.82	1,386.52	505.76	1,071.37	1,586.52	1,983.54	1,594.49	581.62	1,232.09
71	1,637.39	2,044.90	1,645.61	600.14	1,283.04	1,882.99	2,351.65	1,892.46	690.16	1,475.50	1,423.81	1,778.18	1,430.97	521.86	1,115.69	1,637.39	2,044.90	1,645.61	600.14	1,283.04
72	1,688.09	2,106.26	1,696.57	618.60	1,333.99	1,941.31	2,422.19	1,951.05	711.39	1,534.09	1,467.90	1,831.52	1,475.28	537.92	1,159.99	1,688.09	2,106.26	1,696.57	618.60	1,333.99
73	1,738.63	2,167.56	1,747.37	637.01	1,398.80	1,999.43	2,492.69	2,009.48	732.56	1,608.61	1,511.85	1,884.83	1,519.45	553.92	1,216.34	1,738.63	2,167.56	1,747.37	637.01	1,398.80
74	1,789.01	2,228.83	1,798.00	655.38	1,464.76	2,057.36	2,563.16	2,067.70	753.68	1,684.47	1,555.66	1,938.12	1,563.48	569.89	1,273.70	1,789.01	2,228.83	1,798.00	655.38	1,464.76
75	1,882.65	2,345.05	1,892.11	689.78	1,531.91	2,165.05	2,696.80	2,175.92	793.25	1,761.69	1,637.09	2,039.17	1,645.31	599.80	1,332.09	1,882.65	2,345.05	1,892.11	689.78	1,531.91
76	1,963.31	2,445.72	1,973.18	720.35	1,587.72	2,257.80	2,812.58	2,269.15	828.39	1,825.87	1,707.23	2,126.71	1,715.81	626.39	1,380.63	1,963.31	2,445.72	1,973.18	720.35	1,587.72
77	2,046.65	2,549.86	2,056.95	751.96	1,644.50	2,353.66	2,932.35	2,365.48	864.75	1,891.18	1,779.70	2,217.27	1,788.64	653.87	1,430.00	2,046.65	2,549.86	2,056.95	751.96	1,644.50
78	2,132.77	2,657.59	2,143.48	784.63	1,702.26	2,452.69	3,056.22	2,465.01	902.32	1,957.60	1,854.58	2,310.94	1,863.90	682.29	1,480.22	2,132.77	2,657.59	2,143.48	784.63	1,702.26
79	2,221.72	2,768.98	2,232.89	818.42	1,761.01	2,554.98	3,184.33	2,567.82	941.18	2,025.15	1,931.94	2,407.81	1,941.65	711.67	1,531.31	2,221.72	2,768.98	2,232.89	818.42	1,761.01
80	2,313.62	2,884.17	2,325.25	835.90	1,820.75	2,660.67	3,316.81	2,674.04	961.29	2,093.86	2,011.84	2,507.99	2,021.96	726.87	1,583.26	2,313.62	2,884.17	2,325.25	835.90	1,820.75
81	2,407.59	3,002.12	2,419.69	871.30	1,880.65	2,768.73	3,452.43	2,782.64	1,001.99	2,162.74	2,093.56	2,610.54	2,104.08	757.65	1,635.35	2,407.59	3,002.12	2,419.69	871.30	1,880.65
82	2,504.62	3,124.03	2,517.21	907.88	1,941.55	2,880.31	3,592.64	2,894.79	1,044.06	2,232.78	2,177.93	2,716.55	2,188.87	789.46	1,688.31	2,504.62	3,124.03	2,517.21	907.88	1,941.55
83	2,604.82	3,250.08	2,617.91	945.70	2,003.49	2,995.55	3,737.59	3,010.59	1,087.55	2,304.01	2,265.06	2,826.16	2,276.45	822.34	1,742.16	2,604.82	3,250.08	2,617.91	945.70	2,003.49
84	2,678.82	3,380.33	2,721.89	984.75	2,066.47	3,080.64	3,887.38	3,130.18	1,132.47	2,376.44	2,329.40	2,939.42	2,366.86	856.30	1,796.93	2,678.82	3,380.33	2,721.89	984.75	2,066.47
85	2,754.75	3,514.96	2,829.25	1,003.70	2,130.50	3,167.95	4,042.21	3,253.63	1,154.26	2,450.07	2,395.43	3,056.49	2,460.22	872.79	1,852.61	2,754.75	3,514.96	2,829.25	1,003.70	2,130.50
86	2,821.34	3,638.87	2,927.77	1,040.81	2,183.44	3,244.54	4,184.70	3,366.94	1,196.93	2,510.97	2,453.34	3,164.24	2,545.90	905.05	1,898.65	2,821.34	3,638.87	2,927.77	1,040.81	2,183.44
87	2,889.52	3,766.70	3,029.35	1,079.07	2,237.23	3,322.95	4,331.70	3,483.75	1,240.93	2,572.82	2,512.63	3,275.39	2,634.22	938.33	1,945.41	2,889.52	3,766.70	3,029.35	1,079.07	2,237.23
88	2,959.27	3,898.56	3,134.03	1,118.56	2,291.87	3,403.17	4,483.34	3,604.12	1,286.35	2,635.65	2,573.28	3,390.04	2,725.24	972.67	1,992.93	2,959.27	3,898.56	3,134.03	1,118.56	2,291.87
89	3,030.66	4,034.56	3,241.92	1,159.32	2,347.39	3,485.27	4,639.74	3,728.21	1,333.21	2,699.49	2,635.36	3,508.31	2,819.06	1,008.10	2,041.20	3,030.66	4,034.56	3,241.92	1,159.32	2,347.39
90	3,103.74	4,174.83	3,353.12	1,201.36	2,403.78	3,569.30	4,801.06	3,856.09	1,381.57	2,764.34	2,698.91	3,630.29	2,915.76	1,044.66	2,090.24	3,103.74	4,174.83	3,353.12	1,201.36	2,403.78
91	3,168.71	4,309.98	3,460.06	1,242.44	2,454.04	3,644.02	4,956.47	3,979.07	1,428.80	2,822.14	2,755.40	3,747.81	3,008.74	1,080.38	2,133.95	3,168.71	4,309.98	3,460.06	1,242.44	2,454.04
92	3,235.06	4,449.18	3,570.15	1,284.77	2,505.07	3,720.31	5,116.56	4,105.67	1,477.48	2,880.84	2,813.09	3,868.85	3,104.47	1,117.19	2,178.32	3,235.06	4,449.18	3,570.15	1,284.77	2,505.07
93	3,302.78	4,592.59	3,683.47	1,328.42	2,556.87	3,798.20	5,281.47	4,235.99	1,527.68	2,940.40	2,871.98	3,993.55	3,203.01	1,155.15	2,223.36	3,302.78	4,592.59	3,683.47	1,328.42	2,556.87
94	3,371.91	4,740.30	3,800.14	1,373.39	2,609.45	3,877.70	5,451.34	4,370.15	1,579.39	3,000.87	2,932.10	4,121.99	3,304.47	1,194.25	2,269.08	3,371.91	4,740.30	3,800.14	1,373.39	2,609.45
95	3,442.51	4,892.46	3,920.21	1,419.75	2,662.83	3,958.88	5,626.32	4,508.25	1,632.70	3,062.26	2,993.48	4,254.31	3,408.88	1,234.56	2,315.51	3,442.51	4,892.46	3,920.21	1,419.75	2,662.83
96	3,445.65	5,049.50	4,044.10	1,467.65	2,717.31	3,962.49	5,806.93	4,650.71	1,687.80	3,124.91	2,996.21	4,390.87	3,516.61	1,276.22	2,362.88	3,445.65	5,049.50	4,044.10	1,467.65	2,717.31
97	3,448.79	5,211.58	4,171.89	1,517.20	2,772.90	3,966.11	5,993.32	4,797.68	1,744.77	3,188.83	2,998.96	4,531.81	3,627.73	1,319.30	2,411.21	3,448.79	5,211.58	4,171.89	1,517.20	2,772.90
98	3,451.95	5,378.85	4,303.71	1,568.40	2,829.63	3,969.74	6,185.68	4,949.27	1,803.66	3,254.07	3,001.69	4,677.26	3,742.36	1,363.83	2,460.54	3,451.95	5,378.85	4,303.71	1,568.40	2,829.63
99+	3,455.11	5,551.52	4,439.70	1,621.33	2,887.51	3,973.38	6,384.25	5,105.66	1,864.53	3,320.63	3,004.45	4,827.41	3,860.62	1,409.85	2,510.87	3,455.11	5,551.52	4,439.70	1,621.33	2,887.51

Modal Factors: Semi Annual: 0.5200 Quarterly: 0.2650 Monthly: 0.0833

Household Discount Factor: .93

MONITOR LIFE INSURANCE COMPANY OF NEW YORK

OHIO Standard Plans - ANNUAL

FOR USE IN ZIP CODES: 436, 440-445

Attained Age	MALE										FEMALE									
	Preferred					Standard					Preferred					Standard				
	Plan A	Plan F	Plan G	Plan HDG	Plan N	Plan A	Plan F	Plan G	Plan HDG	Plan N	Plan A	Plan F	Plan G	Plan HDG	Plan N	Plan A	Plan F	Plan G	Plan HDG	Plan N
65	1,687.79	2,110.15	1,696.27	618.74	1,310.73	1,940.95	2,426.67	1,950.71	711.56	1,507.34	1,467.64	1,834.91	1,475.02	538.04	1,139.76	1,687.79	2,110.15	1,696.27	618.74	1,310.73
66	1,687.79	2,110.15	1,696.27	618.74	1,310.73	1,940.95	2,426.67	1,950.71	711.56	1,507.34	1,467.64	1,834.91	1,475.02	538.04	1,139.76	1,687.79	2,110.15	1,696.27	618.74	1,310.73
67	1,687.79	2,110.15	1,696.27	618.74	1,310.73	1,940.95	2,426.67	1,950.71	711.56	1,507.34	1,467.64	1,834.91	1,475.02	538.04	1,139.76	1,687.79	2,110.15	1,696.27	618.74	1,310.73
68	1,687.79	2,110.15	1,696.27	618.74	1,310.73	1,940.95	2,426.67	1,950.71	711.56	1,507.34	1,467.64	1,834.91	1,475.02	538.04	1,139.76	1,687.79	2,110.15	1,696.27	618.74	1,310.73
69	1,687.79	2,110.15	1,696.27	618.74	1,310.73	1,940.95	2,426.67	1,950.71	711.56	1,507.34	1,467.64	1,834.91	1,475.02	538.04	1,139.76	1,687.79	2,110.15	1,696.27	618.74	1,310.73
70	1,687.79	2,110.15	1,696.27	618.74	1,310.73	1,940.95	2,426.67	1,950.71	711.56	1,507.34	1,467.64	1,834.91	1,475.02	538.04	1,139.76	1,687.79	2,110.15	1,696.27	618.74	1,310.73
71	1,741.90	2,175.43	1,750.65	638.45	1,364.94	2,003.18	2,501.75	2,013.25	734.21	1,569.68	1,514.69	1,891.68	1,522.31	555.17	1,186.90	1,741.90	2,175.43	1,750.65	638.45	1,364.94
72	1,795.84	2,240.70	1,804.86	658.09	1,419.14	2,065.22	2,576.80	2,075.59	756.80	1,632.01	1,561.60	1,948.43	1,569.45	572.25	1,234.03	1,795.84	2,240.70	1,804.86	658.09	1,419.14
73	1,849.61	2,305.91	1,858.90	677.67	1,488.08	2,127.05	2,651.80	2,137.74	779.32	1,711.29	1,608.35	2,005.14	1,616.44	589.28	1,293.98	1,849.61	2,305.91	1,858.90	677.67	1,488.08
74	1,903.20	2,371.10	1,912.77	697.21	1,558.25	2,188.68	2,726.77	2,199.68	801.79	1,791.99	1,654.96	2,061.83	1,663.28	606.27	1,355.00	1,903.20	2,371.10	1,912.77	697.21	1,558.25
75	2,002.82	2,494.73	2,012.88	733.81	1,629.69	2,303.24	2,868.94	2,314.81	843.88	1,874.14	1,741.58	2,169.33	1,750.33	638.09	1,417.12	2,002.82	2,494.73	2,012.88	733.81	1,629.69
76	2,088.63	2,601.83	2,099.13	766.33	1,689.06	2,401.92	2,992.11	2,413.99	881.27	1,942.42	1,816.20	2,262.46	1,825.33	666.37	1,468.75	2,088.63	2,601.83	2,099.13	766.33	1,689.06
77	2,177.29	2,712.62	2,188.24	799.96	1,749.47	2,503.89	3,119.52	2,516.47	919.95	2,011.89	1,893.30	2,358.80	1,902.81	695.61	1,521.28	2,177.29	2,712.62	2,188.24	799.96	1,749.47
78	2,268.90	2,827.22	2,280.30	834.71	1,810.91	2,609.24	3,251.30	2,622.35	959.92	2,082.55	1,972.96	2,458.45	1,982.87	725.84	1,574.70	2,268.90	2,827.22	2,280.30	834.71	1,810.91
79	2,363.53	2,945.72	2,375.41	870.66	1,873.41	2,718.06	3,387.58	2,731.72	1,001.26	2,154.42	2,055.25	2,561.50	2,065.58	757.10	1,629.05	2,363.53	2,945.72	2,375.41	870.66	1,873.41
80	2,461.30	3,068.27	2,473.67	889.26	1,936.97	2,830.50	3,528.52	2,844.72	1,022.65	2,227.51	2,140.26	2,668.07	2,151.02	773.27	1,684.32	2,461.30	3,068.27	2,473.67	889.26	1,936.97
81	2,561.27	3,193.74	2,574.14	926.92	2,000.69	2,945.46	3,672.80	2,960.26	1,065.95	2,300.79	2,227.19	2,777.17	2,238.38	806.01	1,739.73	2,561.27	3,193.74	2,574.14	926.92	2,000.69
82	2,664.49	3,323.44	2,677.88	965.83	2,065.48	3,064.16	3,821.96	3,079.56	1,110.70	2,375.30	2,316.95	2,889.95	2,328.59	839.85	1,796.07	2,664.49	3,323.44	2,677.88	965.83	2,065.48
83	2,771.09	3,457.53	2,785.01	1,006.06	2,131.37	3,186.75	3,976.16	3,202.76	1,156.97	2,451.07	2,409.64	3,006.55	2,421.75	874.83	1,853.36	2,771.09	3,457.53	2,785.01	1,006.06	2,131.37
84	2,849.81	3,596.10	2,895.63	1,047.61	2,198.37	3,277.28	4,135.51	3,329.98	1,204.75	2,528.13	2,478.09	3,127.04	2,517.94	910.96	1,911.63	2,849.81	3,596.10	2,895.63	1,047.61	2,198.37
85	2,930.58	3,739.32	3,009.84	1,067.77	2,266.49	3,370.16	4,300.22	3,461.31	1,227.94	2,606.46	2,548.33	3,251.59	2,617.25	928.50	1,970.86	2,930.58	3,739.32	3,009.84	1,067.77	2,266.49
86	3,001.43	3,871.14	3,114.65	1,107.24	2,322.81	3,451.64	4,451.81	3,581.85	1,273.33	2,671.24	2,609.94	3,366.21	2,708.40	962.82	2,019.84	3,001.43	3,871.14	3,114.65	1,107.24	2,322.81
87	3,073.96	4,007.13	3,222.71	1,147.95	2,380.03	3,535.05	4,608.19	3,706.12	1,320.14	2,737.04	2,673.01	3,484.46	2,802.36	998.22	2,069.59	3,073.96	4,007.13	3,222.71	1,147.95	2,380.03
88	3,148.16	4,147.40	3,334.07	1,189.96	2,438.16	3,620.39	4,769.51	3,834.17	1,368.46	2,803.88	2,737.53	3,606.43	2,899.19	1,034.75	2,120.14	3,148.16	4,147.40	3,334.07	1,189.96	2,438.16
89	3,224.11	4,292.08	3,448.85	1,233.32	2,497.22	3,707.73	4,935.89	3,966.18	1,418.31	2,871.80	2,803.57	3,732.24	2,999.00	1,072.45	2,171.49	3,224.11	4,292.08	3,448.85	1,233.32	2,497.22
90	3,301.85	4,441.31	3,567.15	1,278.04	2,557.21	3,797.13	5,107.51	4,102.22	1,469.75	2,940.79	2,871.18	3,862.01	3,101.87	1,111.34	2,223.66	3,301.85	4,441.31	3,567.15	1,278.04	2,557.21
91	3,370.97	4,585.08	3,680.91	1,321.74	2,610.68	3,876.62	5,272.84	4,233.05	1,520.00	3,002.28	2,931.28	3,987.03	3,200.79	1,149.34	2,270.16	3,370.97	4,585.08	3,680.91	1,321.74	2,610.68
92	3,441.55	4,733.17	3,798.03	1,366.78	2,664.97	3,957.78	5,443.15	4,367.73	1,571.79	3,064.72	2,992.65	4,115.80	3,302.63	1,188.50	2,317.36	3,441.55	4,733.17	3,798.03	1,366.78	2,664.97
93	3,513.60	4,885.73	3,918.58	1,413.21	2,720.07	4,040.64	5,618.59	4,506.37	1,625.19	3,128.08	3,055.30	4,248.46	3,407.46	1,228.88	2,365.28	3,513.60	4,885.73	3,918.58	1,413.21	2,720.07
94	3,587.14	5,042.87	4,042.70	1,461.05	2,776.01	4,125.21	5,799.30	4,649.10	1,680.20	3,192.41	3,119.26	4,385.10	3,515.39	1,270.48	2,413.92	3,587.14	5,042.87	4,042.70	1,461.05	2,776.01
95	3,662.24	5,204.74	4,170.44	1,510.37	2,832.80	4,211.57	5,985.45	4,796.01	1,736.92	3,257.72	3,184.55	4,525.86	3,626.47	1,313.36	2,463.31	3,662.24	5,204.74	4,170.44	1,510.37	2,832.80
96	3,665.58	5,371.81	4,302.23	1,561.33	2,890.76	4,215.42	6,177.58	4,947.56	1,795.53	3,324.37	3,187.46	4,671.14	3,741.07	1,357.68	2,513.70	3,665.58	5,371.81	4,302.23	1,561.33	2,890.76
97	3,668.93	5,544.23	4,438.18	1,614.04	2,949.89	4,219.27	6,375.87	5,103.91	1,856.14	3,392.37	3,190.38	4,821.07	3,859.29	1,403.51	2,565.12	3,668.93	5,544.23	4,438.18	1,614.04	2,949.89
98	3,672.29	5,722.18	4,578.42	1,668.51	3,010.24	4,223.13	6,580.51	5,265.18	1,918.79	3,461.78	3,193.29	4,975.81	3,981.23	1,450.88	2,617.60	3,672.29	5,722.18	4,578.42	1,668.51	3,010.24
99+	3,675.65	5,905.87	4,723.09	1,724.82	3,071.82	4,227.00	6,791.75	5,431.55	1,983.54	3,532.59	3,196.22	5,135.54	4,107.04	1,499.84	2,671.14	3,675.65	5,905.87	4,723.09	1,724.82	3,071.82

Modal Factors: Semi Annual: 0.5200 Quarterly: 0.2650 Monthly: 0.0833

Household Discount Factor: .93

PREMIUM INFORMATION

We, Monitor Life Insurance Company of New York can only raise your premium on any premium due date if we raise the premium for all policies like yours in this State. Premiums are based on your attained age and will change on your policy anniversary date.

PREFERRED AND STANDARD PREMIUMS

Preferred and Standard premiums are shown on the premium charts. You are eligible for Preferred premiums if:

1. You apply for your Medicare Supplement insurance policy during the 6-month open enrollment period that begins on your Part B date
2. You apply for your Medicare Supplement insurance policy during your eligible guaranteed issue period, or
3. Your answer is "no" to the question on the application that asks, "Have you used tobacco products in the last 12 months such as cigarettes, cigars, pipe, vaping devices, or chewing tobacco?".

HOUSEHOLD PREMIUM DISCOUNT

You are eligible for a household premium discount if, for the past year, You have resided with one other Medicare-eligible adult who owns or who will be issued a Medicare Supplement policy from Us. If You live with another adult who is your legal spouse, We will waive the one (1) year requirement. For the purposes of this discount, a civil union partner or domestic partner will be considered a legal spouse when such partnerships are valid under applicable state law. We may request additional documentation to determine eligibility.

Your policy's household premium discount will be terminated if the other Medicare Supplement policyholder chooses to terminate his or her Medicare Supplement policy or he or she no longer resides with You.

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 Monitor Life Insurance Company of New York.

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to: Monitor Life Insurance Company of New York, Medicare Supplement Administration, P.O. Box 10841, Clearwater, Florida 33757-8841. 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 of your medical costs. Neither Monitor 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

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. Monitor Life Insurance Company of New York may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information.

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

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 $1600	$0	$1600 (Part A deductible)
61st thru 90th day	All but $400 a day	$400 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $800 a day	$800 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 $200 a day	$0	Up to $200 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 co-payment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN A

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

*Once you have been billed $226 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 $226 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 $0 Generally 80%	 $0 Generally 20%	 $226 (Part B deductible) $0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD First 3 pints Next $226 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 $0 $0 80%	 All costs $0 20%	 $0 $226 (Part B deductible) $0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES — Medically necessary skilled care services and medical supplies — Durable medical equipment First $226 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 100% $0 80%	 $0 $0 20%	 $0 $226 (Part B deductible) $0

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.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1600	$1600 (Part A deductible)	$0
61st thru 90th day	All but $400 a day	$400 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $800 a day	$800 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 $200 a day	Up to $200 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

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN F

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

*Once you have been billed $226 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 $226 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 $0 Generally 80%	 $226 (Part B deductible) Generally 20%	 $0 $0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD First 3 pints Next $226 of Medicare Approved amounts* Remainder of Medicare Approved amounts	 $0 $0 80%	 All costs $226 (Part B deductible) 20%	 $0 $0 $0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

PLAN F

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE			
MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
- First $226 of Medicare Approved Amounts*	$0	$226 (Part B deductible)	$0
- Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN G

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 $1600	$1600 (Part A deductible)	$0
61st thru 90th day	All but $400 a day	$400 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $800 a day	$800 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 $200 a day	Up to $200 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

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

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

*Once you have been billed $226 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 $226 of Medicare Approved Amounts*	$0	$0	$226 (Unless Part B deductible has been met)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $226 of Medicare Approved Amounts*	$0	$0	$226 (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

(continued)

PLAN G

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment - First $226 of Medicare Approved Amounts*	$0	$0	$226 (Unless Part B deductible has been met)
- Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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

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 you have paid a calendar year $2700 deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are $2700. 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 $2700 DEDUCTIBLE ** PLAN PAYS	IN ADDITION TO $2700 DEDUCTIBLE ** YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1600	$1600 (Part A deductible)	$0
61st thru 90th day	All but $400 a day	$400 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $800 a day	$800 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 $200 a day	Up to $200 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

*****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

HIGH DEDUCTIBLE PLAN G

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

*Once you have been billed $226 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 you have paid a calendar year $2700 deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are $2700. 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 $2700 DEDUCTIBLE ** PLAN PAYS	IN ADDITION TO $2700 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 $226 of Medicare Approved Amounts*	$0	$0	$226 (Unless Part B deductible has been met)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $226 of Medicare Approved amounts*	$0	$0	$226 (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

(continued)

HIGH DEDUCTIBLE PLAN G

PARTS A & B

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2700 DEDUCTIBLE ** PLAN PAYS	IN ADDITION TO $2700 DEDUCTIBLE ** YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment - First $226 of Medicare Approved Amounts*	$0	$0	$226 (Unless Part B deductible has been met)
- Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2700 DEDUCTIBLE ** PLAN PAYS	IN ADDITION TO $2700 DEDUCTIBLE ** YOU PAY
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 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 $1600	$1600 (Part A deductible)	$0
61st thru 90th day	All but $400 a day	$400 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $800 a day	$800 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 $200 a day	Up to $200 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

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN N

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

*Once you have been billed $226 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 $226 of Medicare Approved Amounts*	$0	$0	$226 (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Balance, other than up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $226 of Medicare Approved Amounts*	$0	$0	$226 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

PLAN N

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment - First $226 of Medicare Approved Amounts*	$0	$0	$226 (Part B deductible)
- Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
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.