BANKERS FIDELITY LIFE INSURANCE COMPANY®

4370 Peachtree Road NE, Atlanta, GA 30319

Benefit Chart of Medicare Supplement Plans Sold for Effective Dates On or After 01-01-2020

This chart shows the benefits included in each of the standard Medicare Supplement Plans. Every company must make available Plan "A". Some plans may not be available in your state. Only applicants **first** eligible for Medicare before 2020 may purchase Plan C, Plan F, or High Deductible F.

†Bankers Fidelity Life Insurance Company does not currently offer the plans marked below.

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%	✓	✓	✓	✓
Part A deductible		✓	✓	✓	50%	75%	50%	✓	✓	✓
Part B deductible									✓	✓
Part B excess charges				✓						✓
Foreign travel emergency (up to plan limits)			80%	80%			80%	80%	80%	80%
Out-of-pocket limit in [2025][2]					$[7,220][2]	$[3,610][2]				

[1]Plans F and G also have a high deductible option which require 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.

[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 co-payment of up to $20 for some office visits and up to a $50 co-payment for emergency room visits that do not result in an inpatient admission.

BANKERS FIDELITY LIFE INSURANCE COMPANY®

4370 Peachtree Road NE, Atlanta, GA 30319

WYOMING – MONTHLY BANK DRAFT RATES

PREFERRED - NON-TOBACCO

All Zip Codes

Rates Effective 07-03-2024

AGE AT ISSUE	ISSUE AGE RATES	AGE AT ISSUE	ATTAINED AGE RATES									
			FEMALE					MALE				
	FEMALE OR MALE											
	A		F	High Ded F2	G	K	N	F	High Ded F2	G	K	N
65	314.57	65	293.97	33.50	224.09	78.58	177.91	329.25	37.52	250.98	78.58	199.26
66	314.57	66	293.97	33.50	224.09	78.58	177.91	329.25	37.52	250.98	78.58	199.26
67	324.57	67	293.97	33.50	224.09	84.25	177.91	329.25	37.52	250.98	84.25	199.26
68	332.07	68	305.65	35.33	234.02	86.50	185.65	342.33	39.57	262.11	86.50	207.93
69	339.82	69	317.62	37.23	244.20	91.00	193.41	355.74	41.70	273.51	91.00	216.61
70	349.65	70	328.76	39.07	253.67	93.25	200.72	368.21	43.76	284.11	93.25	224.80
71	359.82	71	339.52	40.47	262.82	97.75	208.06	380.26	45.33	294.37	97.75	233.03
72	367.32	72	350.28	41.88	271.98	102.25	215.40	392.31	46.90	304.61	102.25	241.25
73	377.48	73	361.04	43.28	281.13	104.50	222.75	404.36	48.47	314.86	104.50	249.47
74	387.57	74	371.80	44.68	290.28	109.00	230.09	416.42	50.04	325.11	109.00	257.70
75	395.15	75	382.88	46.12	299.68	111.25	237.63	428.82	51.66	335.64	111.25	266.14
76	400.07	76	393.78	47.57	308.73	116.83	245.22	441.03	53.28	345.78	116.83	274.65
77	407.57	77	404.83	49.05	317.91	119.08	252.93	453.41	54.93	356.07	119.08	283.28
78	412.65	78	416.39	50.58	327.50	121.33	260.96	466.35	56.65	366.80	121.33	292.27
79	417.73	79	428.12	52.14	337.24	124.75	269.11	479.49	58.40	377.70	124.75	301.41
80	427.65	80	440.39	53.77	347.41	126.91	277.62	493.24	60.22	389.10	126.91	310.94
81	432.90	81	452.74	55.43	357.64	128.08	286.57	507.07	62.09	400.55	128.08	320.96
82	435.40	82	465.68	57.18	368.35	131.41	295.91	521.56	64.04	412.54	131.41	331.42
83	440.40	83	478.84	58.95	379.24	133.74	305.42	536.30	66.02	424.75	133.74	342.07
84	442.98	84	492.23	60.75	390.33	135.91	315.10	551.30	68.04	437.17	135.91	352.91
85	445.48	85	505.86	62.59	401.61	137.08	324.95	566.56	70.10	449.80	137.08	363.95
86	450.40	86	519.53	64.45	412.80	138.24	334.67	581.87	72.19	462.34	138.24	374.84
87	455.23	87	533.49	66.36	424.25	141.58	344.61	597.51	74.33	475.16	141.58	385.96
88	462.90	88	547.76	68.32	435.94	142.66	354.77	613.49	76.52	488.25	142.66	397.34
89	467.98	89	561.87	70.26	447.52	144.91	364.86	629.30	78.69	501.22	144.91	408.64
90+	470.48	90+	575.80	72.18	458.96	146.08	374.86	644.90	80.84	514.03	146.08	419.84

Other Premium Modes: Multiply the Monthly Bank Draft premiums by the following: Annual = 12; Semi-Annual = 6; Quarterly = 3

Monthly Direct Bill: Add $2.00 monthly service fee to Monthly Bank Draft Premium.

Monthly Credit Card Premiums: Add 3% to Monthly Bank Draft Rates (refer to Monthly Credit Card rate sheet)

7% Household Discount may be available; refer to application for qualifications.

A one-time Policy Fee of $25.00 is required with the initial premium.

BANKERS FIDELITY LIFE INSURANCE COMPANY®

4370 Peachtree Road NE, Atlanta, GA 30319

WYOMING – MONTHLY BANK DRAFT RATES

STANDARD

All Zip Codes

Rates Effective 07-03-2024

AGE AT ISSUE	ISSUE AGE RATES FEMALE OR MALE A
65	393.90
66	393.90
67	409.57
68	417.40
69	425.40
70	435.90
71	451.65
72	462.23
73	470.15
74	488.40
75	493.48
76	501.65
77	509.48
78	525.23
79	527.81
80	532.90
81	540.73
82	543.48
83	551.31
84	554.14
85	564.56
86	569.64
87	572.48
88	575.23
89	582.81
90+	588.06

AGE AT ISSUE	ATTAINED AGE RATES FEMALE F	High Ded F2	G	K	N	MALE F	High Ded F2	G	K	N
65	368.10	41.95	280.60	99.66	222.78	412.27	46.98	314.27	99.66	249.51
66	368.10	41.95	280.60	99.66	222.78	412.27	46.98	314.27	99.66	249.51
67	368.10	41.95	280.60	105.58	222.78	412.27	46.98	314.27	105.58	249.51
68	382.73	44.24	293.04	109.08	232.47	428.66	49.54	328.20	109.08	260.36
69	397.72	46.62	305.79	113.75	242.18	445.44	52.21	342.48	113.75	271.24
70	411.66	48.92	317.64	117.25	251.33	461.06	54.79	355.76	117.25	281.49
71	425.14	50.68	329.10	123.16	260.53	476.15	56.76	368.60	123.16	291.79
72	438.61	52.44	340.56	128.91	269.72	491.24	58.73	381.43	128.91	302.09
73	452.08	54.19	352.02	131.41	278.91	506.33	60.70	394.26	131.41	312.38
74	465.56	55.95	363.48	137.16	288.11	521.42	62.66	407.10	137.16	322.68
75	479.43	57.75	375.25	140.66	297.55	536.96	64.68	420.28	140.66	333.26
76	493.08	59.57	386.59	146.49	307.06	552.25	66.72	432.98	146.49	343.91
77	506.92	61.42	398.09	148.83	316.71	567.75	68.78	445.86	148.83	354.71
78	521.39	63.34	410.09	153.58	326.76	583.95	70.94	459.30	153.58	365.97
79	536.08	65.29	422.28	155.99	336.98	600.41	73.12	472.95	155.99	377.41
80	551.45	67.33	435.02	159.49	347.63	617.62	75.41	487.22	159.49	389.35
81	566.91	69.41	447.83	162.91	358.84	634.94	77.74	501.57	162.91	401.90
82	583.11	71.59	461.23	165.41	370.53	653.08	80.18	516.58	165.41	415.00
83	599.59	73.81	474.87	167.66	382.44	671.54	82.67	531.86	167.66	428.33
84	616.36	76.07	488.75	171.16	394.56	690.33	85.20	547.41	171.16	441.90
85	633.42	78.37	502.88	172.33	406.90	709.44	87.77	563.23	172.33	455.73
86	650.54	80.71	516.90	173.58	419.07	728.60	90.39	578.93	173.58	469.36
87	668.02	83.10	531.23	177.08	431.51	748.19	93.07	594.98	177.08	483.29
88	685.89	85.54	545.87	180.58	444.24	768.20	95.81	611.37	180.58	497.54
89	703.56	87.97	560.37	182.83	456.87	787.99	98.53	627.61	182.83	511.70
90+	721.00	90.38	574.70	184.08	469.38	807.52	101.22	643.66	184.08	525.71

Other Premium Modes: Multiply the Monthly Bank Draft premiums by the following: Annual = 12; Semi-Annual = 6; Quarterly = 3

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Monthly Credit Card Premiums: Add 3% to Monthly Bank Draft Rates (refer to Monthly Credit Card rate sheet)

7% Household Discount may be available; refer to application for qualifications.

A one-time Policy Fee of $25.00 is required with the initial premium.

BANKERS FIDELITY LIFE INSURANCE COMPANY®

4370 Peachtree Road NE, Atlanta, GA 30319

WYOMING – MONTHLY CREDIT CARD RATES

PREFERRED - NON-TOBACCO

All Zip Codes

Rates Effective 07-03-2024

AGE AT ISSUE	ISSUE AGE RATES	AGE AT ISSUE	ATTAINED AGE RATES									
	FEMALE OR MALE		FEMALE					MALE				
	A		F	High Ded F2	G	K	N	F	High Ded F2	G	K	N
65	324.01	65	302.79	34.50	230.81	80.94	183.25	339.12	38.64	258.51	80.94	205.24
66	324.01	66	302.79	34.50	230.81	80.94	183.25	339.12	38.64	258.51	80.94	205.24
67	334.31	67	302.79	34.50	230.81	86.77	183.25	339.12	38.64	258.51	86.77	205.24
68	342.03	68	314.82	36.39	241.05	89.09	191.22	352.60	40.75	269.97	89.09	214.17
69	350.01	69	327.15	38.35	251.53	93.73	199.21	366.41	42.95	281.71	93.73	223.11
70	360.14	70	338.62	40.24	261.28	96.04	206.74	379.26	45.07	292.64	96.04	231.55
71	370.61	71	349.70	41.69	270.71	100.68	214.30	391.67	46.69	303.20	100.68	240.02
72	378.34	72	360.79	43.13	280.14	105.31	221.86	404.08	48.31	313.75	105.31	248.49
73	388.81	73	371.87	44.58	289.56	107.63	229.43	416.49	49.93	324.31	107.63	256.96
74	399.20	74	382.95	46.02	298.99	112.27	236.99	428.91	51.55	334.87	112.27	265.43
75	407.01	75	394.36	47.51	308.67	114.58	244.76	441.69	53.21	345.71	114.58	274.13
76	412.07	76	405.59	49.00	318.00	120.33	252.58	454.26	54.88	356.16	120.33	282.89
77	419.79	77	416.97	50.52	327.45	122.65	260.51	467.01	56.58	366.75	122.65	291.77
78	425.03	78	428.88	52.10	337.33	124.97	268.79	480.34	58.35	377.81	124.97	301.04
79	430.27	79	440.96	53.71	347.35	128.49	277.18	493.88	60.15	389.04	128.49	310.45
80	440.48	80	453.61	55.38	357.83	130.72	285.95	508.04	62.03	400.77	130.72	320.27
81	445.89	81	466.32	57.10	368.37	131.92	295.17	522.28	63.95	412.57	131.92	330.59
82	448.46	82	479.65	58.89	379.40	135.35	304.79	537.21	65.96	424.92	135.35	341.36
83	453.61	83	493.20	60.72	390.62	137.76	314.58	552.39	68.00	437.49	137.76	352.33
84	456.27	84	507.00	62.57	402.04	139.99	324.55	567.84	70.08	450.28	139.99	363.50
85	458.85	85	521.04	64.46	413.66	141.19	334.70	583.56	72.20	463.30	141.19	374.87
86	463.91	86	535.11	66.39	425.19	142.39	344.71	599.33	74.35	476.21	142.39	386.08
87	468.89	87	549.50	68.36	436.97	145.83	354.95	615.44	76.56	489.41	145.83	397.54
88	476.79	88	564.19	70.37	449.02	146.94	365.42	631.89	78.81	502.90	146.94	409.26
89	482.02	89	578.73	72.36	460.94	149.26	375.81	648.18	81.05	516.25	149.26	420.90
90+	484.60	90+	593.08	74.34	472.73	150.46	386.10	664.24	83.26	529.45	150.46	432.43

Premium Modes other than Monthly Credit Card: Refer to Monthly Bank Draft rate sheet.

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WYOMING – MONTHLY CREDIT CARD RATES

STANDARD

All Zip Codes

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AGE AT ISSUE	ISSUE AGE RATES FEMALE OR MALE A
65	405.72
66	405.72
67	421.85
68	429.92
69	438.16
70	448.98
71	465.20
72	476.10
73	484.25
74	503.05
75	508.29
76	516.70
77	524.76
78	540.99
79	543.65
80	548.88
81	556.95
82	559.78
83	567.85
84	570.77
85	581.50
86	586.73
87	589.65
88	592.48
89	600.30
90+	605.70

AGE AT ISSUE	ATTAINED AGE RATES FEMALE F	High Ded F2	G	K	N
65	379.14	43.21	289.01	102.65	229.46
66	379.14	43.21	289.01	102.65	229.46
67	379.14	43.21	289.01	108.75	229.46
68	394.22	45.56	301.83	112.35	239.44
69	409.66	48.02	314.96	117.16	249.44
70	424.01	50.39	327.17	120.76	258.87
71	437.89	52.20	338.98	126.86	268.34
72	451.77	54.01	350.78	132.78	277.81
73	465.65	55.82	362.58	135.35	287.28
74	479.52	57.63	374.39	141.28	296.75
75	493.81	59.49	386.51	144.88	306.48
76	507.87	61.36	398.19	150.89	316.27
77	522.13	63.26	410.03	153.29	326.21
78	537.03	65.24	422.39	158.18	336.57
79	552.16	67.25	434.95	160.67	347.09
80	567.99	69.35	448.07	164.28	358.06
81	583.92	71.50	461.26	167.80	369.60
82	600.60	73.74	475.07	170.37	381.65
83	617.58	76.03	489.12	172.69	393.91
84	634.85	78.35	503.42	176.29	406.40
85	652.43	80.72	517.97	177.50	419.11
86	670.06	83.13	532.41	178.78	431.64
87	688.06	85.59	547.17	182.39	444.46
88	706.47	88.11	562.24	185.99	457.56
89	724.67	90.61	577.18	188.31	470.58
90+	742.63	93.09	591.94	189.60	483.46

AGE AT ISSUE	ATTAINED AGE RATES MALE F	High Ded F2	G	K	N
65	424.64	48.39	323.70	102.65	257.00
66	424.64	48.39	323.70	102.65	257.00
67	424.64	48.39	323.70	108.75	257.00
68	441.52	51.03	338.05	112.35	268.17
69	458.81	53.78	352.76	117.16	279.38
70	474.89	56.44	366.44	120.76	289.94
71	490.44	58.46	379.65	126.86	300.54
72	505.98	60.49	392.87	132.78	311.15
73	521.52	62.52	406.09	135.35	321.75
74	537.07	64.54	419.31	141.28	332.36
75	553.07	66.63	432.89	144.88	343.26
76	568.81	68.72	445.97	150.89	354.22
77	584.78	70.85	459.23	153.29	365.35
78	601.47	73.07	473.08	158.18	376.95
79	618.42	75.32	487.14	160.67	388.74
80	636.15	77.67	501.83	164.28	401.03
81	653.99	80.08	516.61	167.80	413.95
82	672.67	82.59	532.07	170.37	427.45
83	691.69	85.15	547.82	172.69	441.18
84	711.04	87.75	563.83	176.29	455.16
85	730.72	90.41	580.13	177.50	469.40
86	750.46	93.10	596.30	178.78	483.44
87	770.63	95.86	612.83	182.39	497.79
88	791.24	98.68	629.71	185.99	512.47
89	811.63	101.49	646.44	188.31	527.05
90+	831.75	104.26	662.97	189.60	541.48

Premium Modes other than Monthly Credit Card: Refer to Monthly Bank Draft rate sheet.

7% Household Discount may be available; refer to application for qualifications.

A one-time Policy Fee of $25.00 is required with the initial premium.

BANKERS FIDELITY LIFE INSURANCE COMPANY®
4370 Peachtree Road, NE, Atlanta, GA 30319

PREMIUM INFORMATION

We, Bankers Fidelity Life Insurance Company, can only raise your premium if we raise the premium for all policies like yours in this State.

Premiums for Plan A are Issue Age Premiums; they do not increase solely when your age increases. They can, however, increase periodically as stated above.

Premiums for Plans F, High Deductible F, G, K and N are Attained Age Premiums; which means that they will increase each year as your age increases. The increase will be effective on the first premium due date on or after each Anniversary Date of your Policy. Premium rates are based on where you live, and therefore may change if you your place of residence changes. Rates can also increase periodically as stated above.

Household Premium Discount: You will be eligible for the Household Premium Discount if you are married and residing with Your spouse or residing with at least one other (1) person, but not more than three other (3) persons, who are all aged 50 or older for at least the last 12 months. The discounted premium will be 7% lower than the rates illustrated. Your Household Premium Discount will be removed if, other than in the event of the other person(s) death, You no longer reside with Your spouse, or you are no longer residing with at least one other (1) person who is aged 50 or older; or You are living with more than three other (3) persons regardless of their age.

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 4370 Peachtree Road, NE, Atlanta, GA 30319. 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 Bankers Fidelity Life Insurance Company 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. The company 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*			
Semi-private room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[1,676]	$0	$[1,676] (Part A deductible)
61st through 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
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 through 100th day	All but $[209.50] a day	$0	Up to $[209.50] a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional Amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

**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 $[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
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient 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
PART B EXCESS CHARGES (above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
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
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
- Medically necessary skilled care services and medical supplies	100%	$0	$0
- Durable medical equipment			
First $[257] of Medicare approved amounts*	$0	$0	$[257] (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	$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*			
Semi-private room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[1,676]	$[1,676] (Part A deductible)	$0
61st through 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
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 through 100th day	All but $[209.50] a day	Up to $[209.50] 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 $[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
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient 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
PART B EXCESS CHARGES (above Medicare Approved Amounts)	$0	100%	$0
BLOOD			
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
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
- Medically necessary skilled care services and medical supplies	100%	$0	$0
- Durable medical equipment			
First $[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

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 of $50,000	20% and amounts over the $50,000 lifetime maximum

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 you have paid a calendar year [$2,870] deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are [$2,870]. 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 $[2,870] DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO $[2,870] DEDUCTIBLE,** YOU PAY
HOSPITALIZATION*			
Semi-private room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[1,676]	$[1,676] (Part A deductible)	$0
61st through 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
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 through 100th day	All but $[209.50] a day	Up to $[209.50] 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 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 you have paid a calendar year [$2,870] deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are [$2,870]. 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 $[2,870] DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO $[2,870] DEDUCTIBLE,** YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient 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
PART B EXCESS CHARGES (above Medicare Approved Amounts)	$0	100%	$0
BLOOD			
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
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
- Medically necessary skilled care services and medical supplies	100%	$0	$0
- Durable medical equipment			
First $[257] of Medicare approved amounts*	$0	$[257] Part B deductible	$0
Remainder of Medicare approved amounts	80%	20%	$0

HIGH DEDUCTIBLE PLAN F

OTHER BENEFITS NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY $[2,870] DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO $[2,870] 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 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*			
Semi-private room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[1,676]	$[1,676] (Part A deductible)	$0
61st through 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
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 through 100th day	All but $[209.50] a day	Up to $[209.50] 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 $[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
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient 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
PART B EXCESS CHARGES (above Medicare Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $[257] of Medicare Approved Amounts*	$0	$0	$[257] (Unless Part B deductible has been met)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
- Medically necessary skilled care services and medical supplies	100%	$0	$0
- Durable medical equipment			
First $[257] of Medicare approved amounts*	$0	$0	$[257] (Unless Part B deductible has been met)
Remainder of Medicare approved amounts	80%	20%	$0

OTHER BENEFITS NOT COVERED BY MEDICARE

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

PLAN K

*You will pay half the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $[7,220] 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 co-payment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

**A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION**			
Semi-private room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[1,676]	$[838] (50% of Part A deductible)	$[838] (50% of Part A deductible)♦
61st through 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
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 through 100th day	All but $[209.50] a day	Up to $[104.75] a day (50% of Part A deductible)	Up to $[104.75] a day (50% of Part A deductible)♦
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	50%	50%♦
Additional Amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	50% of Medicare copayment/coinsurance	50% of Medicare copayment/coinsurance♦

***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 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*
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $[257] of Medicare Approved Amounts****	$0	$0	$[257] (Part B deductible)****♦
Preventive Benefits for Medicare covered services	Generally 80% or more of Medicare Approved Amounts	Remainder of Medicare Approved Amounts	All costs above Medicare Approved Amounts
Remainder of Medicare Approved Amounts	Generally 80%	Generally 10%	Generally 10%♦
PART B EXCESS CHARGES (above Medicare Approved Amounts)	$0	$0	All costs (and they do not count toward annual out-of-pocket limit of $[7,220])*
BLOOD			
First 3 pints	$0	50%	50%♦
Next $[257] of Medicare Approved Amounts****	$0	$0	$[257] (Part B deductible)****♦
Remainder of Medicare Approved Amounts	Generally 80%	Generally 10%	Generally 10%♦
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
- Medically necessary skilled care services and medical supplies	100%	$0	$0
- Durable medical equipment			
First $[257] of Medicare approved amounts****	$0	$0	$[257] (Part B deductible)♦
Remainder of Medicare approved amounts	80%	10%	10%♦

*This plan limits your annual out-of-pocket payments for Medicare-approved amounts to $[7,220] per year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

****Medicare benefits are subject to change. Please consult the latest Guide to Health Insurance for People with Medicare.

PLAN N

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semi-private room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[1,676]	$[1,676] (Part A deductible)	$0
61st through 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
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 through 100th day	All but $[209.50] a day	Up to $[209.50] 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 $[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
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient 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%	Balance, other than up to $[20] per office visit and up to $[50] per emergency room visit. The co-payment 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 co-payment 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 $[257] of Medicare Approved Amounts*	$0	$0	$[257] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
- Medically necessary skilled care services and medical supplies	100%	$0	$0
- Durable medical equipment			
First $[257] of Medicare approved amounts*	$0	$0	$[257] (Part B deductible)
Remainder of Medicare approved amounts	80%	20%	$0

PLAN N

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 Remainder of Charges	 $0 $0	 $0 80% to a lifetime maximum of $50,000	 $250 20% and amounts over the $50,000 lifetime maximum