BANKERS FIDELITY ASSURANCE 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 Assurance 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 ASSURANCE COMPANY®

4370 Peachtree Road, NE; Atlanta, GA 30319

SOUTH CAROLINA – MONTHLY BANK DRAFT RATES - Effective 02-01-2024

PREFERRED NON-TOBACCO - All Other Zip Codes

ATTAINED AGE RATES

Age at	A		F		High Deductible F		G		High Deductible G		N	
Issue	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male
65	195.02	218.42	211.06	236.36	34.96	39.16	102.00	114.61	31.10	34.95	76.57	86.04
66	195.02	218.42	211.06	236.36	34.96	39.16	102.00	114.61	31.10	34.95	76.57	86.04
67	195.02	218.42	211.06	236.36	34.96	39.16	102.00	114.61	31.10	34.95	76.57	86.04
68	203.32	227.72	219.43	245.77	36.87	41.29	102.37	115.02	31.21	35.07	79.43	89.24
69	211.46	236.84	228.03	255.39	38.86	43.52	105.60	118.65	32.20	36.18	83.66	94.00
70	219.37	245.70	236.02	264.33	40.77	45.67	108.43	121.83	33.06	37.15	83.66	94.00
71	225.95	253.06	243.74	273.01	42.23	47.30	111.53	125.32	34.01	38.21	87.34	98.13
72	232.48	260.37	251.48	281.65	43.69	48.94	117.92	132.50	35.24	39.59	90.50	101.68
73	239.06	267.75	259.20	290.30	45.17	50.59	122.04	137.12	36.47	40.97	93.65	105.23
74	245.62	275.09	266.90	298.94	46.63	52.22	126.15	141.75	37.70	42.36	96.81	108.78
75	252.40	282.69	274.87	307.85	48.13	53.91	128.93	144.86	39.31	44.17	100.96	113.44
76	257.84	288.77	282.71	316.62	49.64	55.61	134.33	150.93	40.96	46.02	105.19	118.19
77	263.37	294.98	290.63	325.52	51.18	57.33	141.16	158.60	41.97	47.16	108.87	122.33
78	269.19	301.50	298.93	334.80	52.78	59.12	145.43	163.41	43.24	48.59	112.17	126.03
79	275.11	308.14	307.36	344.24	54.41	60.95	150.21	168.78	44.13	49.59	114.48	128.63
80	281.36	315.10	316.15	354.11	56.11	62.84	155.58	174.81	45.47	51.09	118.54	133.19
81	286.60	321.00	325.03	364.03	57.85	64.79	160.14	179.93	46.81	52.60	122.04	137.13
82	292.17	327.25	334.32	374.42	59.67	66.82	163.80	184.05	48.22	54.18	125.71	141.25
83	297.82	333.56	343.77	385.02	61.51	68.89	169.84	190.83	49.65	55.79	129.44	145.44
84	303.59	339.99	353.37	395.77	63.40	71.00	174.84	196.45	51.11	57.43	133.24	149.71
85	309.41	346.53	363.16	406.75	65.31	73.15	179.91	202.15	52.59	59.10	137.11	154.06
86	315.37	353.19	372.98	417.73	67.27	75.34	184.99	207.85	54.07	60.75	140.95	158.37
87	321.41	359.99	383.01	428.95	69.25	77.57	190.13	213.63	55.57	62.44	144.87	162.77
88	327.58	366.89	393.25	440.42	71.29	79.85	195.36	219.50	57.11	64.16	148.87	167.27
89	333.60	373.64	403.38	451.79	73.32	82.12	200.58	225.37	58.63	65.87	152.84	171.74
90	339.44	380.17	413.37	462.97	75.33	84.36	205.73	231.16	60.13	67.57	156.77	176.14
91	343.47	384.65	421.54	472.14	77.02	86.26	209.91	235.85	61.36	68.95	159.98	179.75
92	347.51	389.21	429.84	481.44	78.75	88.19	214.24	240.72	62.61	70.35	163.24	183.41
93	351.05	393.16	437.56	490.07	80.37	90.01	218.19	245.16	63.78	71.66	166.27	186.82
94	354.60	397.15	445.37	498.80	82.01	91.84	222.22	249.69	64.96	72.99	169.35	190.28
95	358.22	401.17	453.31	507.70	83.68	93.70	226.33	254.30	66.16	74.33	172.47	193.79
96	364.18	407.87	460.83	516.17	85.06	95.27	230.13	258.57	67.26	75.57	175.35	197.02
97	370.24	414.68	468.54	524.76	86.48	96.86	233.94	262.85	68.38	76.83	178.27	200.30
98	376.41	421.58	476.35	533.51	87.93	98.47	237.82	267.21	69.52	78.11	181.24	203.64
99+	382.70	428.59	484.29	542.39	89.39	100.12	241.77	271.65	70.68	79.42	184.26	207.04

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 2.76% to Monthly Bank Draft Rates (refer to Monthly Credit Card rate sheet)

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

BANKERS FIDELITY ASSURANCE COMPANY®

4370 Peachtree Road, NE; Atlanta, GA 30319

SOUTH CAROLINA – MONTHLY BANK DRAFT RATES - Effective 02-01-2024

PREFERRED NON-TOBACCO - Zip Codes 294-295, 298-299

ATTAINED AGE RATES

Age at	A		F		High Deductible F		G		High Deductible G		N	
Issue	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male
65	212.96	238.51	230.47	258.11	38.17	42.76	111.18	124.92	33.90	38.09	83.47	93.78
66	212.96	238.51	230.47	258.11	38.17	42.76	111.18	124.92	33.90	38.09	83.47	93.78
67	212.96	238.51	230.47	258.11	38.17	42.76	111.18	124.92	33.90	38.09	83.47	93.78
68	222.02	248.66	239.60	268.37	40.26	45.09	111.58	125.37	34.02	38.23	86.58	97.28
69	230.92	258.63	248.99	278.86	42.42	47.53	115.11	129.33	35.10	39.44	91.19	102.46
70	239.53	268.29	257.73	288.65	44.52	49.87	118.19	132.80	36.04	40.49	91.19	102.46
71	246.71	276.30	266.16	298.09	46.12	51.66	121.57	136.60	37.07	41.65	95.20	106.97
72	253.86	284.34	274.59	307.55	47.72	53.45	128.54	144.43	38.41	43.16	98.64	110.83
73	261.03	292.35	283.03	317.00	49.33	55.24	133.02	149.46	39.75	44.66	102.08	114.70
74	268.20	300.39	291.44	326.44	50.92	57.03	137.51	154.50	41.09	46.17	105.53	118.57
75	275.60	308.67	300.14	336.15	52.56	58.87	140.53	157.90	42.85	48.15	110.05	123.65
76	281.56	315.35	308.70	345.72	54.21	60.73	146.41	164.51	44.64	50.16	114.66	128.83
77	287.58	322.11	317.36	355.44	55.89	62.60	153.86	172.88	45.75	51.40	118.67	133.34
78	293.95	329.22	326.42	365.59	57.64	64.55	158.52	178.11	47.13	52.96	122.26	137.37
79	300.41	336.48	335.61	375.88	59.42	66.54	163.73	183.97	48.10	54.05	124.78	140.21
80	307.21	344.08	345.24	386.67	61.27	68.63	169.59	190.55	49.56	55.69	129.20	145.17
81	312.97	350.51	354.91	397.51	63.17	70.75	174.55	196.12	51.03	57.33	133.03	149.47
82	319.05	357.32	365.05	408.87	65.16	72.98	178.54	200.61	52.56	59.06	137.02	153.96
83	325.19	364.24	375.36	420.41	67.17	75.24	185.12	208.00	54.12	60.81	141.10	158.53
84	331.50	371.25	385.87	432.18	69.23	77.53	190.57	214.13	55.71	62.60	145.24	163.19
85	337.85	378.40	396.56	444.14	71.32	79.88	196.10	220.34	57.33	64.41	149.45	167.92
86	344.37	385.68	407.27	456.14	73.46	82.26	201.63	226.56	58.93	66.22	153.63	172.62
87	350.97	393.10	418.24	468.41	75.62	84.70	207.25	232.86	60.57	68.06	157.91	177.42
88	357.71	400.64	429.40	480.93	77.85	87.19	212.94	239.26	62.25	69.94	162.27	182.33
89	364.28	407.98	440.46	493.31	80.07	89.67	218.63	245.66	63.90	71.80	166.60	187.19
90	370.66	415.11	451.37	505.54	82.25	92.12	224.25	251.96	65.55	73.65	170.87	191.99
91	375.01	420.02	460.31	515.55	84.10	94.19	228.80	257.08	66.89	75.15	174.37	195.92
92	379.47	424.99	469.37	525.72	85.99	96.30	233.52	262.38	68.25	76.69	177.93	199.92
93	383.31	429.31	477.80	535.12	87.76	98.29	237.83	267.22	69.52	78.11	181.24	203.64
94	387.20	433.67	486.33	544.69	89.55	100.29	242.22	272.16	70.81	79.56	184.59	207.41
95	391.15	438.06	494.98	554.39	91.36	102.33	246.69	277.19	72.11	81.03	188.00	211.23
96	397.64	445.38	503.23	563.62	92.89	104.05	250.84	281.85	73.31	82.38	191.13	214.75
97	404.28	452.80	511.62	573.02	94.43	105.77	254.99	286.51	74.54	83.75	194.31	218.33
98	411.02	460.34	520.14	582.56	96.01	107.53	259.22	291.26	75.78	85.14	197.55	221.97
99+	417.86	468.01	528.82	592.27	97.60	109.33	263.53	296.10	77.04	86.56	200.85	225.67

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SOUTH CAROLINA – MONTHLY BANK DRAFT RATES - Effective 02-01-2024

STANDARD - All Other Zip Codes

Age at Issue	A		F		High Deductible F		G		High Deductible G		N	
	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male
65	234.01	262.11	253.26	283.65	41.95	46.99	122.40	137.53	37.32	41.93	91.89	103.25
66	234.01	262.11	253.26	283.65	41.95	46.99	122.40	137.53	37.32	41.93	91.89	103.25
67	234.01	262.11	253.26	283.65	41.95	46.99	122.40	137.53	37.32	41.93	91.89	103.25
68	243.99	273.26	263.32	294.90	44.24	49.56	122.84	138.02	37.46	42.08	95.31	107.09
69	253.79	284.22	273.62	306.46	46.62	52.21	126.72	142.39	38.64	43.41	100.40	112.80
70	263.24	294.83	283.23	317.20	48.93	54.80	130.12	146.20	39.67	44.58	100.40	112.80
71	271.11	303.65	292.50	327.58	50.68	56.77	133.84	150.38	40.81	45.85	104.81	117.76
72	278.99	312.48	301.77	337.98	52.45	58.73	141.51	159.00	42.28	47.51	108.60	122.02
73	286.88	321.28	311.04	348.37	54.20	60.71	146.45	164.55	43.76	49.17	112.39	126.28
74	294.73	330.09	320.30	358.75	55.96	62.66	151.38	170.10	45.24	50.83	116.18	130.53
75	302.88	339.20	329.83	369.42	57.75	64.69	154.71	173.83	47.17	53.00	121.15	136.13
76	309.42	346.56	339.23	379.93	59.58	66.73	161.19	181.11	49.15	55.22	126.22	141.83
77	316.06	353.98	348.76	390.60	61.43	68.80	169.39	190.33	50.36	56.59	130.65	146.79
78	323.03	361.81	358.71	401.76	63.34	70.95	174.52	196.09	51.89	58.30	134.60	151.24
79	330.13	369.76	368.81	413.09	65.29	73.14	180.25	202.53	52.96	59.51	137.38	154.36
80	337.62	378.13	379.40	424.93	67.33	75.42	186.70	209.78	54.56	61.31	142.24	159.82
81	343.92	385.18	390.03	436.84	69.43	77.76	192.16	215.91	56.18	63.12	146.45	164.55
82	350.61	392.67	401.17	449.30	71.61	80.20	196.56	220.86	57.86	65.02	150.85	169.50
83	357.39	400.28	412.50	462.03	73.82	82.68	203.81	229.00	59.58	66.95	155.33	174.53
84	364.28	408.00	424.06	474.93	76.09	85.20	209.80	235.74	61.33	68.91	159.89	179.66
85	371.31	415.83	435.80	488.07	78.39	87.79	215.89	242.58	63.11	70.91	164.54	184.87
86	378.43	423.85	447.56	501.28	80.72	90.41	221.98	249.42	64.88	72.90	169.14	190.04
87	385.72	431.98	459.59	514.76	83.11	93.08	228.16	256.36	66.68	74.93	173.84	195.33
88	393.10	440.28	471.90	528.51	85.56	95.82	234.43	263.40	68.53	77.00	178.65	200.73
89	400.30	448.36	484.04	542.13	87.98	98.54	240.70	270.45	70.35	79.05	183.41	206.08
90	407.31	456.21	496.06	555.57	90.39	101.23	246.88	277.39	72.16	81.08	188.12	211.37
91	412.14	461.59	505.85	566.56	92.43	103.52	251.89	283.02	73.64	82.74	191.97	215.70
92	417.01	467.04	515.84	577.72	94.49	105.84	257.08	288.86	75.14	84.42	195.88	220.09
93	421.23	471.80	525.07	588.08	96.44	108.01	261.83	294.19	76.54	85.99	199.53	224.19
94	425.52	476.58	534.45	598.58	98.41	110.21	266.67	299.62	77.95	87.59	203.22	228.34
95	429.83	481.43	543.96	609.23	100.41	112.46	271.59	305.16	79.39	89.20	206.97	232.55
96	437.02	489.43	553.04	619.37	102.08	114.32	276.16	310.29	80.71	90.69	210.42	236.42
97	444.26	497.60	562.23	629.71	103.78	116.23	280.72	315.42	82.06	92.20	213.92	240.36
98	451.69	505.90	571.63	640.19	105.51	118.18	285.38	320.65	83.43	93.74	217.49	244.37
99+	459.23	514.33	581.14	650.87	107.26	120.14	290.13	325.99	84.82	95.30	221.12	248.45

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SOUTH CAROLINA – MONTHLY BANK DRAFT RATES - Effective 02-01-2024

STANDARD - Zip Codes 294-295, 298-299

Age at Issue	A		F		High Deductible F		G		High Deductible G		N	
	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male
65	255.52	286.19	276.56	309.71	45.80	51.31	133.42	149.91	40.68	45.71	100.16	112.54
66	255.52	286.19	276.56	309.71	45.80	51.31	133.42	149.91	40.68	45.71	100.16	112.54
67	255.52	286.19	276.56	309.71	45.80	51.31	133.42	149.91	40.68	45.71	100.16	112.54
68	266.44	298.37	287.53	322.04	48.31	54.11	133.89	150.44	40.83	45.87	103.89	116.73
69	277.12	310.36	298.80	334.66	50.92	57.01	138.13	155.20	42.12	47.32	109.43	122.96
70	287.46	321.94	309.28	346.38	53.42	59.84	141.83	159.36	43.24	48.59	109.43	122.96
71	296.03	331.57	319.37	357.71	55.34	61.99	145.88	163.92	44.48	49.98	114.24	128.36
72	304.66	341.20	329.51	369.06	57.27	64.13	154.25	173.31	46.09	51.79	118.37	133.00
73	313.26	350.83	339.61	380.39	59.18	66.29	159.63	179.36	47.70	53.59	122.50	137.64
74	321.83	360.46	349.75	391.72	61.11	68.43	165.01	185.40	49.31	55.40	126.63	142.28
75	330.71	370.41	360.17	403.40	63.07	70.64	168.64	189.48	51.42	57.78	132.06	148.38
76	337.87	378.41	370.44	414.88	65.06	72.87	175.70	197.41	53.57	60.19	137.59	154.59
77	345.12	386.53	380.84	426.53	67.07	75.12	184.63	207.46	54.90	61.68	142.40	160.01
78	352.76	395.07	391.68	438.69	69.16	77.48	190.22	213.73	56.56	63.55	146.71	164.85
79	360.50	403.76	402.74	451.06	71.30	79.86	196.48	220.76	57.73	64.86	149.74	168.25
80	368.67	412.91	414.28	463.98	73.53	82.36	203.51	228.66	59.47	66.82	155.04	174.21
81	375.55	420.61	425.91	477.01	75.80	84.91	209.46	235.35	61.23	68.80	159.63	179.36
82	382.85	428.78	438.07	490.63	78.19	87.57	214.25	240.73	63.07	70.87	164.43	184.75
83	390.25	437.08	450.44	504.51	80.61	90.28	222.15	249.60	64.95	72.97	169.31	190.24
84	397.77	445.51	463.05	518.60	83.07	93.05	228.69	256.95	66.85	75.12	174.28	195.83
85	405.45	454.07	475.88	532.97	85.59	95.85	235.32	264.41	68.79	77.30	179.34	201.51
86	413.23	462.81	488.72	547.36	88.14	98.73	241.96	271.87	70.72	79.46	184.36	207.15
87	421.17	471.70	501.86	562.10	90.75	101.65	248.70	279.43	72.69	81.67	189.49	212.91
88	429.23	480.74	515.29	577.11	93.42	104.63	255.53	287.11	74.69	83.93	194.73	218.80
89	437.13	489.58	528.55	591.98	96.07	107.60	262.36	294.79	76.69	86.16	199.92	224.63
90	444.76	498.14	541.67	606.66	98.71	110.54	269.10	302.35	78.65	88.38	205.05	230.39
91	450.03	504.03	552.38	618.67	100.92	113.04	274.56	308.50	80.26	90.18	209.25	235.11
92	455.35	510.00	563.25	630.84	103.18	115.56	280.22	314.86	81.90	92.02	213.51	239.90
93	459.98	515.19	573.33	642.16	105.30	117.94	285.40	320.67	83.42	93.73	217.48	244.36
94	464.64	520.40	583.60	653.63	107.46	120.34	290.67	326.59	84.97	95.47	221.51	248.89
95	469.36	525.69	593.99	665.27	109.64	122.80	296.03	332.62	86.53	97.23	225.59	253.48
96	477.18	534.44	603.88	676.33	111.47	124.84	301.01	338.22	87.98	98.85	229.36	257.70
97	485.12	543.37	613.92	687.62	113.32	126.92	305.99	343.81	89.44	100.50	233.18	262.00
98	493.23	552.42	624.19	699.06	115.21	129.04	311.07	349.51	90.93	102.17	237.07	266.37
99+	501.46	561.61	634.59	710.71	117.13	131.18	316.24	355.32	92.45	103.88	241.02	270.81

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 2.76% to Monthly Bank Draft Rates (refer to Monthly Credit Card rate sheet)

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

BANKERS FIDELITY ASSURANCE COMPANY®

4370 Peachtree Road, NE; Atlanta, GA 30319

SOUTH CAROLINA – MONTHLY CREDIT CARD RATES - Effective 02-01-2024

PREFERRED NON-TOBACCO - All Other Zip Codes

ATTAINED AGE RATES

Age at Issue	A		F		High Deductible F		G		High Deductible G		N	
	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male
65	200.40	224.45	216.89	242.88	35.93	40.24	104.82	117.77	31.96	35.91	78.69	88.41
66	200.40	224.45	216.89	242.88	35.93	40.24	104.82	117.77	31.96	35.91	78.69	88.41
67	200.40	224.45	216.89	242.88	35.93	40.24	104.82	117.77	31.96	35.91	78.69	88.41
68	208.93	234.00	225.49	252.55	37.89	42.43	105.19	118.19	32.07	36.04	81.62	91.71
69	217.29	243.38	234.32	262.44	39.93	44.72	108.52	121.93	33.09	37.18	85.97	96.60
70	225.43	252.48	242.53	271.62	41.89	46.93	111.42	125.19	33.97	38.17	85.97	96.60
71	232.18	260.04	250.47	280.54	43.40	48.61	114.61	128.78	34.95	39.27	89.75	100.84
72	238.90	267.56	258.42	289.43	44.90	50.29	121.18	136.16	36.21	40.69	93.00	104.49
73	245.66	275.14	266.35	298.31	46.42	51.98	125.41	140.91	37.47	42.11	96.24	108.13
74	252.39	282.68	274.27	307.20	47.91	53.67	129.64	145.66	38.74	43.52	99.48	111.78
75	259.37	290.49	282.46	316.34	49.46	55.40	132.49	148.86	40.40	45.39	103.75	116.57
76	264.96	296.74	290.51	325.36	51.01	57.14	138.03	155.09	42.09	47.29	108.09	121.45
77	270.64	303.12	298.65	334.50	52.59	58.91	145.05	162.98	43.13	48.46	111.88	125.70
78	276.62	309.82	307.18	344.04	54.24	60.75	149.44	167.92	44.43	49.93	115.26	129.51
79	282.70	316.64	315.84	353.74	55.91	62.63	154.36	173.44	45.35	50.96	117.64	132.18
80	289.12	323.80	324.87	363.89	57.66	64.58	159.88	179.64	46.72	52.50	121.81	136.86
81	294.51	329.86	334.00	374.08	59.45	66.58	164.56	184.89	48.11	54.05	125.41	140.91
82	300.23	336.28	343.55	384.75	61.31	68.67	168.32	189.13	49.55	55.68	129.18	145.15
83	306.04	342.76	353.26	395.64	63.21	70.79	174.53	196.10	51.02	57.33	133.02	149.46
84	311.97	349.38	363.12	406.69	65.15	72.96	179.66	201.87	52.52	59.01	136.92	153.85
85	317.95	356.09	373.18	417.98	67.11	75.17	184.88	207.73	54.05	60.73	140.90	158.31
86	324.07	362.94	383.28	429.26	69.13	77.42	190.09	213.59	55.56	62.43	144.84	162.74
87	330.28	369.92	393.58	440.79	71.16	79.71	195.38	219.53	57.10	64.16	148.87	167.27
88	336.62	377.02	404.10	452.58	73.25	82.05	200.75	225.56	58.68	65.94	152.98	171.89
89	342.81	383.95	414.51	464.26	75.34	84.39	206.12	231.59	60.25	67.69	157.06	176.48
90	348.80	390.66	424.77	475.75	77.41	86.69	211.41	237.54	61.79	69.43	161.09	181.00
91	352.95	395.27	433.17	485.17	79.14	88.64	215.70	242.36	63.06	70.85	164.39	184.71
92	357.11	399.95	441.70	494.73	80.92	90.62	220.15	247.36	64.34	72.30	167.74	188.47
93	360.74	404.01	449.64	503.59	82.58	92.49	224.21	251.93	65.54	73.64	170.86	191.98
94	364.39	408.11	457.66	512.57	84.27	94.38	228.36	256.58	66.75	75.00	174.03	195.53
95	368.11	412.25	465.82	521.72	85.99	96.29	232.57	261.32	67.98	76.39	177.23	199.14
96	374.23	419.13	473.55	530.41	87.41	97.90	236.48	265.71	69.12	77.66	180.19	202.46
97	380.46	426.12	481.47	539.24	88.86	99.54	240.39	270.11	70.27	78.95	183.19	205.83
98	386.80	433.22	489.50	548.24	90.35	101.19	244.38	274.59	71.44	80.27	186.25	209.26
99+	393.26	440.42	497.65	557.36	91.86	102.88	248.45	279.15	72.63	81.61	189.35	212.75

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 2.76% to Monthly Bank Draft Rates (refer to Monthly Credit Card rate sheet)

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

BANKERS FIDELITY ASSURANCE COMPANY®

4370 Peachtree Road, NE; Atlanta, GA 30319

SOUTH CAROLINA – MONTHLY CREDIT CARD RATES - Effective 02-01-2024

PREFERRED NON-TOBACCO - Zip Codes 294-295, 298-299

ATTAINED AGE RATES

Age at	A		F		High Deductible F		G		High Deductible G		N	
Issue	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male
65	218.84	245.09	236.83	265.23	39.22	43.94	114.25	128.37	34.84	39.14	85.77	96.37
66	218.84	245.09	236.83	265.23	39.22	43.94	114.25	128.37	34.84	39.14	85.77	96.37
67	218.84	245.09	236.83	265.23	39.22	43.94	114.25	128.37	34.84	39.14	85.77	96.37
68	228.15	255.52	246.22	275.78	41.37	46.33	114.66	128.83	34.96	39.28	88.97	99.96
69	237.30	265.76	255.87	286.56	43.60	48.84	118.28	132.90	36.07	40.52	93.71	105.29
70	246.14	275.69	264.84	296.62	45.75	51.24	121.45	136.46	37.03	41.61	93.71	105.29
71	253.52	283.93	273.50	306.32	47.40	53.08	124.93	140.37	38.09	42.80	97.83	109.92
72	260.86	292.19	282.16	316.04	49.03	54.92	132.09	148.41	39.47	44.35	101.37	113.89
73	268.24	300.42	290.84	325.75	50.69	56.76	136.69	153.59	40.85	45.89	104.90	117.87
74	275.61	308.68	299.49	335.45	52.33	58.61	141.30	158.77	42.22	47.44	108.44	121.84
75	283.21	317.19	308.43	345.43	54.01	60.49	144.41	162.26	44.03	49.47	113.08	127.06
76	289.33	324.05	317.22	355.27	55.71	62.41	150.46	169.05	45.88	51.55	117.82	132.38
77	295.52	331.00	326.12	365.25	57.43	64.33	158.11	177.65	47.01	52.82	121.94	137.02
78	302.07	338.31	335.43	375.68	59.23	66.34	162.89	183.03	48.43	54.42	125.64	141.17
79	308.70	345.76	344.87	386.26	61.06	68.38	168.25	189.05	49.43	55.54	128.23	144.08
80	315.69	353.58	354.76	397.34	62.96	70.53	174.27	195.81	50.93	57.22	132.77	149.18
81	321.60	360.19	364.71	408.48	64.91	72.70	179.37	201.54	52.43	58.92	136.70	153.59
82	327.86	367.18	375.12	420.16	66.96	74.99	183.47	206.15	54.01	60.69	140.81	158.21
83	334.17	374.30	385.72	432.02	69.03	77.31	190.23	213.74	55.62	62.49	144.99	162.91
84	340.65	381.50	396.52	444.11	71.14	79.67	195.83	220.04	57.25	64.32	149.25	167.69
85	347.18	388.85	407.51	456.40	73.29	82.09	201.52	226.42	58.91	66.19	153.58	172.56
86	353.87	396.32	418.51	468.73	75.48	84.53	207.20	232.81	60.56	68.04	157.88	177.39
87	360.65	403.95	429.78	481.34	77.71	87.04	212.97	239.29	62.24	69.94	162.27	182.32
88	367.58	411.70	441.26	494.21	80.00	89.59	218.82	245.86	63.96	71.87	166.75	187.36
89	374.34	419.24	452.62	506.93	82.28	92.15	224.67	252.44	65.67	73.79	171.20	192.36
90	380.89	426.57	463.83	519.50	84.52	94.66	230.44	258.92	67.35	75.68	175.59	197.29
91	385.36	431.61	473.01	529.78	86.42	96.79	235.12	264.18	68.73	77.23	179.19	201.33
92	389.94	436.72	482.33	540.23	88.37	98.95	239.96	269.62	70.13	78.80	182.84	205.44
93	393.89	441.16	490.99	549.89	90.18	101.00	244.39	274.60	71.44	80.27	186.24	209.26
94	397.88	445.64	499.76	559.73	92.02	103.06	248.91	279.67	72.76	81.75	189.69	213.13
95	401.94	450.15	508.64	569.69	93.89	105.15	253.50	284.84	74.10	83.26	193.18	217.06
96	408.61	457.67	517.12	579.17	95.45	106.92	257.77	289.63	75.34	84.65	196.41	220.68
97	415.44	465.30	525.74	588.84	97.04	108.69	262.03	294.42	76.59	86.06	199.68	224.36
98	422.36	473.05	534.49	598.64	98.66	110.50	266.38	299.30	77.87	87.50	203.01	228.10
99+	429.40	480.93	543.41	608.62	100.29	112.34	270.81	304.28	79.17	88.95	206.39	231.90

Other Premium Modes: Multiply the Monthly Bank Draft premiums by the following:
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Monthly Direct Bill: Add $2.00 monthly service fee to Monthly Bank Draft Premium.

Monthly Credit Card Premiums: Add 2.76% to Monthly Bank Draft Rates (refer to Monthly Credit Card rate sheet)

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

BANKERS FIDELITY ASSURANCE COMPANY®

4370 Peachtree Road, NE; Atlanta, GA 30319

SOUTH CAROLINA – MONTHLY CREDIT CARD RATES - Effective 02-01-2024

STANDARD - All Other Zip Codes

Age at Issue	A		F		High Deductible F		G		High Deductible G		N	
	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male
65	240.47	269.34	260.25	291.48	43.11	48.29	125.78	141.33	38.35	43.09	94.43	106.10
66	240.47	269.34	260.25	291.48	43.11	48.29	125.78	141.33	38.35	43.09	94.43	106.10
67	240.47	269.34	260.25	291.48	43.11	48.29	125.78	141.33	38.35	43.09	94.43	106.10
68	250.72	280.80	270.59	303.04	45.46	50.92	126.23	141.83	38.49	43.25	97.94	110.05
69	260.79	292.06	281.18	314.92	47.90	53.65	130.22	146.32	39.71	44.61	103.17	115.92
70	270.51	302.97	291.05	325.96	50.28	56.31	133.71	150.23	40.77	45.81	103.17	115.92
71	278.60	312.03	300.57	336.63	52.08	58.34	137.53	154.53	41.94	47.12	107.70	121.01
72	286.69	321.11	310.10	347.31	53.90	60.35	145.42	163.39	43.45	48.82	111.59	125.39
73	294.80	330.14	319.62	357.98	55.70	62.39	150.49	169.09	44.97	50.53	115.49	129.76
74	302.86	339.20	329.14	368.65	57.50	64.39	155.56	174.79	46.49	52.23	119.38	134.14
75	311.24	348.57	338.94	379.61	59.35	66.48	158.98	178.63	48.48	54.47	124.50	139.88
76	317.96	356.12	348.60	390.42	61.22	68.57	165.64	186.11	50.51	56.75	129.71	145.74
77	324.79	363.75	358.39	401.38	63.12	70.70	174.07	195.58	51.75	58.15	134.25	150.85
78	331.95	371.79	368.61	412.85	65.09	72.91	179.33	201.50	53.32	59.91	138.32	155.41
79	339.24	379.97	378.99	424.49	67.10	75.15	185.23	208.12	54.42	61.15	141.17	158.62
80	346.94	388.56	389.88	436.66	69.19	77.50	191.85	215.57	56.07	63.00	146.17	164.23
81	353.42	395.82	400.80	448.90	71.34	79.90	197.47	221.87	57.73	64.86	150.49	169.09
82	360.29	403.51	412.25	461.70	73.58	82.41	201.99	226.95	59.46	66.81	155.02	174.17
83	367.25	411.33	423.89	474.78	75.86	84.96	209.43	235.32	61.23	68.80	159.62	179.35
84	374.33	419.26	435.76	488.04	78.19	87.55	215.60	242.24	63.03	70.82	164.31	184.61
85	381.56	427.31	447.83	501.55	80.55	90.21	221.85	249.27	64.86	72.87	169.08	189.97
86	388.87	435.55	459.92	515.11	82.94	92.90	228.11	256.30	66.67	74.91	173.81	195.29
87	396.37	443.90	472.28	528.97	85.40	95.65	234.46	263.44	68.52	76.99	178.64	200.72
88	403.95	452.43	484.93	543.10	87.92	98.47	240.90	270.67	70.42	79.12	183.58	206.27
89	411.35	460.74	497.40	557.09	90.41	101.26	247.34	277.91	72.30	81.23	188.48	211.77
90	418.56	468.80	509.75	570.91	92.88	104.03	253.69	285.05	74.15	83.32	193.31	217.20
91	423.52	474.33	519.81	582.20	94.98	106.37	258.84	290.84	75.67	85.02	197.27	221.65
92	428.52	479.93	530.08	593.67	97.10	108.76	264.18	296.83	77.21	86.75	201.29	226.17
93	432.86	484.82	539.56	604.32	99.10	111.00	269.06	302.31	78.65	88.37	205.03	230.37
94	437.27	489.74	549.20	615.10	101.12	113.25	274.03	307.89	80.10	90.00	208.83	234.64
95	441.70	494.72	558.98	626.04	103.18	115.56	279.09	313.58	81.58	91.66	212.68	238.97
96	449.08	502.94	568.30	636.46	104.90	117.48	283.78	318.85	82.94	93.19	216.23	242.95
97	456.53	511.33	577.75	647.09	106.64	119.44	288.47	324.13	84.32	94.75	219.83	247.00
98	464.15	519.86	587.41	657.86	108.42	121.44	293.26	329.50	85.73	96.32	223.49	251.12
99+	471.91	528.52	597.18	668.84	110.22	123.45	298.13	334.98	87.16	97.93	227.22	255.30

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SOUTH CAROLINA – MONTHLY CREDIT CARD RATES - Effective 02-01-2024

STANDARD – Zip Codes 294-295, 298-299

Age at Issue	A		F		High Deductible F		G		High Deductible G		N	
	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male
65	262.58	294.09	284.19	318.26	47.06	52.73	137.10	154.04	41.80	46.97	102.92	115.65
66	262.58	294.09	284.19	318.26	47.06	52.73	137.10	154.04	41.80	46.97	102.92	115.65
67	262.58	294.09	284.19	318.26	47.06	52.73	137.10	154.04	41.80	46.97	102.92	115.65
68	273.79	306.61	295.46	330.93	49.64	55.60	137.59	154.60	41.95	47.14	106.76	119.95
69	284.77	318.93	307.04	343.89	52.32	58.59	141.94	159.48	43.28	48.63	112.45	126.35
70	295.39	330.83	317.81	355.94	54.89	61.49	145.74	163.76	44.44	49.93	112.45	126.35
71	304.20	340.72	328.19	367.58	56.87	63.70	149.91	168.44	45.71	51.36	117.39	131.90
72	313.06	350.62	338.61	379.24	58.85	65.90	158.50	178.09	47.36	53.22	121.64	136.67
73	321.90	360.51	348.99	390.89	60.82	68.12	164.03	184.31	49.02	55.07	125.88	141.44
74	330.72	370.41	359.40	402.53	62.79	70.32	169.56	190.52	50.67	56.93	130.13	146.21
75	339.84	380.63	370.11	414.54	64.81	72.59	173.29	194.71	52.84	59.37	135.70	152.47
76	347.20	388.85	380.66	426.33	66.86	74.89	180.55	202.86	55.05	61.85	141.38	158.86
77	354.65	397.20	391.35	438.31	68.92	77.19	189.73	213.18	56.41	63.39	146.33	164.42
78	362.49	405.97	402.49	450.80	71.07	79.61	195.47	219.63	58.12	65.30	150.76	169.40
79	370.45	414.90	413.86	463.51	73.27	82.06	201.90	226.85	59.32	66.65	153.87	172.89
80	378.84	424.31	425.71	476.79	75.56	84.63	209.12	234.97	61.11	68.67	159.32	179.02
81	385.92	432.22	437.66	490.18	77.90	87.26	215.24	241.84	62.92	70.70	164.04	184.31
82	393.41	440.62	450.16	504.17	80.35	89.99	220.17	247.38	64.81	72.82	168.97	189.85
83	401.02	449.14	462.87	518.44	82.84	92.78	228.28	256.49	66.74	74.99	173.99	195.49
84	408.75	457.81	475.84	532.91	85.37	95.62	235.00	264.04	68.70	77.19	179.10	201.23
85	416.64	466.60	489.01	547.68	87.95	98.50	241.82	271.71	70.69	79.43	184.29	207.07
86	424.64	475.59	502.21	562.47	90.58	101.45	248.64	279.37	72.67	81.65	189.45	212.87
87	432.79	484.71	515.71	577.61	93.26	104.45	255.56	287.15	74.69	83.92	194.72	218.79
88	441.08	494.01	529.51	593.04	96.00	107.52	262.58	295.03	76.76	86.24	200.10	224.84
89	449.19	503.09	543.13	608.32	98.72	110.57	269.60	302.92	78.80	88.54	205.44	230.83
90	457.03	511.89	556.62	623.40	101.43	113.59	276.52	310.70	80.83	90.81	210.71	236.75
91	462.46	517.95	567.62	635.74	103.71	116.16	282.14	317.01	82.48	92.67	215.02	241.60
92	467.92	524.07	578.80	648.26	106.03	118.75	287.96	323.55	84.16	94.56	219.41	246.52
93	472.68	529.41	589.16	659.88	108.21	121.20	293.27	329.52	85.73	96.32	223.49	251.11
94	477.46	534.76	599.71	671.68	110.43	123.67	298.69	335.60	87.31	98.11	227.63	255.76
95	482.31	540.20	610.38	683.63	112.67	126.19	304.20	341.80	88.92	99.91	231.82	260.47
96	490.35	549.19	620.54	695.00	114.55	128.29	309.32	347.55	90.40	101.58	235.69	264.82
97	498.51	558.36	630.86	706.60	116.45	130.42	314.44	353.30	91.91	103.27	239.61	269.23
98	506.84	567.66	641.42	718.36	118.39	132.60	319.65	359.16	93.44	104.99	243.61	273.72
99+	515.30	577.12	652.10	730.33	120.37	134.80	324.97	365.13	95.00	106.74	247.67	278.28

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 2.76% to Monthly Bank Draft Rates (refer to Monthly Credit Card rate sheet)

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

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

PREMIUM INFORMATION

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

Premiums 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 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 Assurance 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 Remainder of Charges	 $0 $0	 $0 80% to a lifetime maximum of $50,000	 $250 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

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 [$2,870] deductible. Benefits from the high deductible Plan G 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 G

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

*Once you have been billed $[257] of Medicare Approved Amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

**This high deductible plan pays the same benefits as Plan G after you have paid a calendar year [$2,870] deductible. Benefits from the high deductible Plan G 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	$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

HIGH DEDUCTIBLE PLAN G

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 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