Liberty Bankers Life Insurance Company

Outline of Coverage

Medicare Supplement Benefit Plans A, F, G and N

This chart show the benefits included in each of the standard Medicare Supplement plans. Every insurer must make available Plan "A." Some plans may not be available in your state. See Outlines of Coverage sections for details about ALL plans. **"Basic Benefits"** are:

- Hospitalization – Part A coinsurance plus coverage for 365 additional days after Medicare Benefits end.
- Medical Expenses – Part B coinsurance (generally 20% of Medicare approved amounts) or copayments for hospital outpatient services. Plans K, L, and N require insured's to pay a portion of Part B coinsurance or copayments.
- Blood – First three pints of blood each year.
- Hospice – Part A coinsurance
- Only Medicare Supplement Benefit Plans A, F, G, and N are offered by Liberty Bankers Life Insurance Company.

A	B	C	D	F / F*	G	K	L	M	N
Basic including 100% Part B Coinsurance	Basic including 100% Part B Coinsurance	Basic including 100% Part B Coinsurance	Basic including 100% Part B Coinsurance	Basic including 100% Part B Coinsurance	Basic including 100% Part B Coinsurance	Hospitalization and preventative care paid at 100%; other Basic Benefits paid at 50%	Hospitalization and preventative care paid at 100%; other Basic Benefits paid at 75%	Basic including 100% Part B Coinsurance	Basic including 100% Part B Coinsurance, except up to $20 copayment for office visit, and up to $50 copayment for Emergency Room that don't result in inpatient admission.
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Part B Deductible		Part B Deductible					
				Part B Excess 100%	Part B Excess 100%				
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency			Foreign Travel Emergency	Foreign Travel Emergency
						Out of Pocket limit $5,120; paid at 100% after limit reached.	Out of Pocket limit $2,560; paid at 100% after limit reached.		

*Plan F also has an option called a high Deductible Plan F. This high Deductible plan pays the same benefits as Plan F after one has paid a calendar years $2,200 Deductible. Benefits from high Deductible Plan F will not begin until out-of-pocket expenses exceed $2,200. Out-of-pocket expenses for this Deductible are expenses that would have ordinarily been paid by the Policy. These expenses include the Medicare Deductibles for Part A and Part B, but do not include the plans separate foreign travel emergency Deductible.

Liberty Bankers Life Insurance Company
Outline of Coverage
Monthly Premium Rates*
ZIP Codes starting with: 663-671, 673-679
Standard Plans - Preferred

FEMALE					MALE			
Plan A	Plan F	Plan G	Plan N	Attained Age	Plan A	Plan F	Plan G	Plan N
100.38	131.96	106.81	91.07	<65	115.44	151.75	122.83	104.73
100.38	131.96	106.81	91.07	65	115.44	151.75	122.83	104.73
100.38	131.96	106.81	91.07	66	115.44	151.75	122.83	104.73
100.38	131.96	106.81	91.07	67	115.44	151.75	122.83	104.73
100.38	131.96	106.81	91.07	68	115.44	151.75	122.83	104.73
102.84	135.03	109.79	93.47	69	118.27	155.29	126.25	107.49
106.68	139.73	114.04	97.01	70	122.68	160.69	131.15	111.56
109.87	144.29	118.17	100.57	71	126.35	165.93	135.89	115.65
113.07	148.84	122.29	104.12	72	130.03	171.16	140.64	119.74
116.26	153.39	126.42	107.68	73	133.70	176.40	145.38	123.83
119.45	157.94	130.54	111.23	74	137.37	181.63	150.12	127.92
122.64	162.49	134.67	114.79	75	141.04	186.87	154.87	132.01
125.52	167.42	139.00	118.67	76	144.35	192.53	159.85	136.48
127.79	171.55	142.68	122.00	77	146.96	197.28	164.08	140.30
130.86	176.76	147.26	126.11	78	150.49	203.28	169.35	145.02
135.34	183.92	153.47	131.61	79	155.64	211.51	176.50	151.35
141.48	193.40	161.63	138.79	80	162.70	222.41	185.88	159.61
146.58	202.21	169.25	145.70	81	168.56	232.55	194.64	167.56
150.12	208.96	175.15	151.15	82	172.64	240.31	201.42	173.82
153.57	215.63	180.99	156.55	83	176.60	247.98	208.14	180.03
156.77	222.02	186.59	161.76	84	180.29	255.32	214.58	186.02
159.74	228.09	191.95	166.76	85	183.70	262.31	220.74	191.77
162.77	234.20	197.27	171.70	86	187.18	269.33	226.86	197.45
165.68	240.19	202.49	176.56	87	190.53	276.22	232.86	203.05
168.32	245.84	207.43	181.19	88	193.57	282.72	238.54	208.37
170.71	251.15	212.08	185.57	89	196.31	288.82	243.90	213.41
173.10	256.51	216.79	190.01	90	199.07	294.99	249.31	218.51
175.54	262.17	221.71	194.67	91	201.87	301.50	254.97	223.87
177.98	267.89	226.69	199.39	92	204.67	308.08	260.70	229.30
180.42	273.68	231.73	204.17	93	207.48	314.73	266.49	234.80
183.01	279.73	237.00	209.17	94	210.46	321.69	272.55	240.54
185.60	285.86	242.33	214.22	95	213.44	328.73	278.68	246.36
189.58	291.98	247.52	218.81	96	218.02	335.78	284.65	251.64
193.70	298.32	252.90	223.57	97	222.75	343.07	290.83	257.10
197.82	304.67	258.28	228.32	98	227.49	350.36	297.02	262.57
202.08	311.23	263.84	233.24	99	232.39	357.91	303.41	268.22

* To obtain annual, semiannual, or quarterly premiums, multiply the Monthly Premium Amount by 12, 6, or 3, respectively
Add a One-Time Policy Fee of $25. A 7% household discount is available if between 2 and 4 adults residing at the same address

Liberty Bankers Life Insurance Company
Outline of Coverage
Monthly Premium Rates*
ZIP Codes starting with: 663-671, 673-679
Standard Plans - Standard

FEMALE					MALE			
Plan A	Plan F	Plan G	Plan N	Attained Age	Plan A	Plan F	Plan G	Plan N
115.44	151.75	122.83	104.73	<65	132.75	174.51	141.25	120.44
115.44	151.75	122.83	104.73	65	132.75	174.51	141.25	120.44
115.44	151.75	122.83	104.73	66	132.75	174.51	141.25	120.44
115.44	151.75	122.83	104.73	67	132.75	174.51	141.25	120.44
115.44	151.75	122.83	104.73	68	132.75	174.51	141.25	120.44
118.27	155.29	126.25	107.49	69	136.01	178.58	145.19	123.61
122.68	160.69	131.15	111.56	70	141.09	184.80	150.82	128.30
126.35	165.93	135.89	115.65	71	145.31	190.82	156.28	133.00
130.03	171.16	140.64	119.74	72	149.53	196.84	161.73	137.70
133.70	176.40	145.38	123.83	73	153.75	202.86	167.19	142.40
137.37	181.63	150.12	127.92	74	157.97	208.88	172.64	147.11
141.04	186.87	154.87	132.01	75	162.19	214.90	178.10	151.81
144.35	192.53	159.85	136.48	76	166.00	221.41	183.83	156.95
146.96	197.28	164.08	140.30	77	169.01	226.88	188.69	161.35
150.49	203.28	169.35	145.02	78	173.06	233.77	194.76	166.78
155.64	211.51	176.50	151.35	79	178.98	243.24	202.97	174.05
162.70	222.41	185.88	159.61	80	187.11	255.77	213.76	183.55
168.56	232.55	194.64	167.56	81	193.85	267.43	223.83	192.69
172.64	240.31	201.42	173.82	82	198.53	276.35	231.63	199.89
176.60	247.98	208.14	180.03	83	203.09	285.17	239.36	207.03
180.29	255.32	214.58	186.02	84	207.33	293.62	246.77	213.93
183.70	262.31	220.74	191.77	85	211.25	301.65	253.85	220.54
187.18	269.33	226.86	197.45	86	215.26	309.74	260.88	227.07
190.53	276.22	232.86	203.05	87	219.11	317.65	267.79	233.50
193.57	282.72	238.54	208.37	88	222.61	325.13	274.33	239.63
196.31	288.82	243.90	213.41	89	225.76	332.14	280.48	245.42
199.07	294.99	249.31	218.51	90	228.93	339.23	286.70	251.28
201.87	301.50	254.97	223.87	91	232.15	346.72	293.22	257.45
204.67	308.08	260.70	229.30	92	235.37	354.29	299.80	263.70
207.48	314.73	266.49	234.80	93	238.61	361.94	306.46	270.02
210.46	321.69	272.55	240.54	94	242.03	369.95	313.43	276.62
213.44	328.73	278.68	246.36	95	245.46	378.04	320.48	283.31
218.02	335.78	284.65	251.64	96	250.72	386.14	327.35	289.38
222.75	343.07	290.83	257.10	97	256.16	394.53	334.46	295.67
227.49	350.36	297.02	262.57	98	261.61	402.92	341.57	301.95
232.39	357.91	303.41	268.22	99	267.25	411.60	348.93	308.46

* To obtain annual, semiannual, or quarterly premiums, multiply the Monthly Premium Amount by 12, 6, or 3, respectively
Add a One-Time Policy Fee of $25. A 7% household discount is available if between 2 and 4 adults residing at the same address

Liberty Bankers Life Insurance Company
Outline of Coverage
Monthly Premium Rates*
ZIP Codes starting with: 660-662, 672
Standard Plans - Preferred

FEMALE					MALE			
Plan A	Plan F	Plan G	Plan N	Attained Age	Plan A	Plan F	Plan G	Plan N
107.94	141.89	114.84	97.93	<65	124.13	163.17	132.07	112.61
107.94	141.89	114.84	97.93	65	124.13	163.17	132.07	112.61
107.94	141.89	114.84	97.93	66	124.13	163.17	132.07	112.61
107.94	141.89	114.84	97.93	67	124.13	163.17	132.07	112.61
107.94	141.89	114.84	97.93	68	124.13	163.17	132.07	112.61
110.58	145.20	118.05	100.50	69	127.17	166.98	135.76	115.58
114.71	150.25	122.63	104.31	70	131.92	172.79	141.02	119.96
118.14	155.15	127.06	108.14	71	135.87	178.42	146.12	124.36
121.58	160.04	131.50	111.96	72	139.81	184.05	151.22	128.75
125.01	164.94	135.93	115.78	73	143.76	189.68	156.32	133.15
128.44	169.83	140.37	119.61	74	147.71	195.30	161.42	137.55
131.87	174.72	144.80	123.43	75	151.65	200.93	166.52	141.95
134.97	180.02	149.46	127.61	76	155.21	207.02	171.88	146.75
137.41	184.46	153.42	131.19	77	158.02	212.13	176.43	150.86
140.71	190.07	158.35	135.60	78	161.81	218.58	182.10	155.94
145.52	197.77	165.03	141.52	79	167.35	227.43	189.78	162.74
152.13	207.95	173.80	149.24	80	174.95	239.15	199.87	171.63
157.61	217.43	181.99	156.67	81	181.25	250.05	209.29	180.17
161.42	224.69	188.33	162.52	82	185.63	258.39	216.58	186.90
165.12	231.86	194.61	168.33	83	189.89	266.64	223.80	193.58
168.57	238.73	200.64	173.93	84	193.86	274.53	230.73	200.02
171.76	245.26	206.40	179.31	85	197.52	282.05	237.35	206.21
175.02	251.83	212.11	184.62	86	201.27	289.61	243.93	212.32
178.15	258.27	217.73	189.85	87	204.87	297.01	250.39	218.33
180.99	264.35	223.04	194.83	88	208.14	304.00	256.50	224.05
183.56	270.05	228.05	199.54	89	211.09	310.56	262.25	229.47
186.13	275.82	233.11	204.31	90	214.05	317.19	268.07	234.95
188.75	281.91	238.40	209.32	91	217.06	324.19	274.16	240.72
191.37	288.06	243.76	214.40	92	220.08	331.27	280.32	246.56
194.00	294.28	249.17	219.54	93	223.10	338.42	286.55	252.47
196.78	300.79	254.84	224.91	94	226.30	345.91	293.07	258.65
199.57	307.37	260.57	230.35	95	229.51	353.48	299.66	264.90
203.85	313.96	266.15	235.28	96	234.43	361.05	306.08	270.58
208.28	320.78	271.93	240.39	97	239.52	368.89	312.72	276.45
212.70	327.60	277.72	245.51	98	244.61	376.74	319.37	282.33
217.29	334.65	283.70	250.79	99	249.88	384.85	326.25	288.41

* To obtain annual, semiannual, or quarterly premiums, multiply the Monthly Premium Amount by 12, 6, or 3, respectively
Add a One-Time Policy Fee of $25. A 7% household discount is available if between 2 and 4 adults residing at the same address

Liberty Bankers Life Insurance Company
Outline of Coverage
Monthly Premium Rates*
ZIP Codes starting with: 660-662, 672
Standard Plans - Standard

FEMALE					MALE			
Plan A	Plan F	Plan G	Plan N	Attained Age	Plan A	Plan F	Plan G	Plan N
124.13	163.17	132.07	112.61	<65	142.75	187.65	151.88	129.51
124.13	163.17	132.07	112.61	65	142.75	187.65	151.88	129.51
124.13	163.17	132.07	112.61	66	142.75	187.65	151.88	129.51
124.13	163.17	132.07	112.61	67	142.75	187.65	151.88	129.51
124.13	163.17	132.07	112.61	68	142.75	187.65	151.88	129.51
127.17	166.98	135.76	115.58	69	146.25	192.02	156.12	132.92
131.92	172.79	141.02	119.96	70	151.71	198.71	162.18	137.95
135.87	178.42	146.12	124.36	71	156.24	205.18	168.04	143.01
139.81	184.05	151.22	128.75	72	160.78	211.65	173.91	148.07
143.76	189.68	156.32	133.15	73	165.32	218.13	179.77	153.12
147.71	195.30	161.42	137.55	74	169.86	224.60	185.64	158.18
151.65	200.93	166.52	141.95	75	174.40	231.07	191.50	163.24
155.21	207.02	171.88	146.75	76	178.49	238.08	197.66	168.76
158.02	212.13	176.43	150.86	77	181.73	243.95	202.90	173.49
161.81	218.58	182.10	155.94	78	186.09	251.37	209.42	179.33
167.35	227.43	189.78	162.74	79	192.46	261.54	218.25	187.15
174.95	239.15	199.87	171.63	80	201.19	275.02	229.85	197.37
181.25	250.05	209.29	180.17	81	208.44	287.56	240.68	207.19
185.63	258.39	216.58	186.90	82	213.48	297.15	249.07	214.94
189.89	266.64	223.80	193.58	83	218.38	306.64	257.37	222.62
193.86	274.53	230.73	200.02	84	222.94	315.72	265.34	230.03
197.52	282.05	237.35	206.21	85	227.15	324.36	272.96	237.14
201.27	289.61	243.93	212.32	86	231.46	333.05	280.52	244.16
204.87	297.01	250.39	218.33	87	235.60	341.56	287.95	251.08
208.14	304.00	256.50	224.05	88	239.37	349.60	294.97	257.66
211.09	310.56	262.25	229.47	89	242.75	357.14	301.59	263.89
214.05	317.19	268.07	234.95	90	246.16	364.77	308.28	270.20
217.06	324.19	274.16	240.72	91	249.62	372.82	315.29	276.83
220.08	331.27	280.32	246.56	92	253.09	380.96	322.37	283.55
223.10	338.42	286.55	252.47	93	256.56	389.18	329.53	290.34
226.30	345.91	293.07	258.65	94	260.25	397.79	337.03	297.45
229.51	353.48	299.66	264.90	95	263.94	406.50	344.60	304.64
234.43	361.05	306.08	270.58	96	269.59	415.21	351.99	311.16
239.52	368.89	312.72	276.45	97	275.45	424.23	359.63	317.92
244.61	376.74	319.37	282.33	98	281.30	433.25	367.28	324.68
249.88	384.85	326.25	288.41	99	287.36	442.58	375.19	331.67

* To obtain annual, semiannual, or quarterly premiums, multiply the Monthly Premium Amount by 12, 6, or 3, respectively
Add a One-Time Policy Fee of $25. A 7% household discount is available if between 2 and 4 adults residing at the same address

Liberty Bankers Life Insurance Company
Outline of Coverage
Medicare Supplement Benefit Plans A, F, G and N

Disclosures. Use this outline to compare benefits and premiums among policies.

Premium Information. Liberty Bankers Life Insurance Company can only raise your premium if we raise the premium for all policies like yours in the same geographic area of the state where you live. Until you are age 99, your premium may change each year. Schedules of rates may vary depending upon your policy date.

Household Premium Discount. If you resided with at least one, but no more than three, other adults who are age 18 or older for the past year, you will be eligible for a household premium discount. The discounted premium will be priced 7% lower than the rates illustrated. Your policy's household premium discount will be removed if the other adult no longer resides with you (other than in the case of his or her death).

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 us.

Right to Return Policy. If you find that you are not satisfied with your policy, you may return it to us at our Medicare Supplement Administrative Office PO Box 15357, Clearwater, FL 33766-5357. 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.

Renewal Conditions. You may renew this Policy as long as You live by paying the premium on time. We cannot cancel or refuse to renew Your Policy, or place any restrictions on it, other than for non-payment or for fraudulent misstatements made by You in Your application for this Policy.

Cancellation by You. You may cancel this Policy at any time by giving Us written notice. It will be effective when We receive notice or on a later date that You may specify. Upon cancellation or upon death, We will promptly return any unearned premium which will be based on a pro rata cancellation. Cancellation will not affect an existing claim.

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. The policy may not fully cover all of your medical costs. Neither we nor our agents are connected with Medicare. This outline does not give all the details of Medicare coverage. Contact your local Social Security office or consult "Medicare & 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. We 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.

PLEASE REFER TO YOUR POLICY FOR DETAILS.

You have selected Plan _____ and the premium for that plan is $_____ monthly.

_____
Agent's Name (Print)

_____
Agent's Address

Liberty Bankers Life Insurance Company
Outline of Coverage
Medicare Supplement Benefit Plans A, F, G and N

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 A Pays	You Pay
Hospitalization Semiprivate room and board, general nursing and miscellaneous services and supplies.			
First 60 days	All but $1,316	$0	$1,316 Part A Deductible
61st thru 90th day	All but $329 a day	$329 a day	$0
91st day and after			
- While using 60 lifetime reserve days	All but $658 a day	$658 a day	$0
- Once lifetime reserve days are used			
▪ Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
▪ Beyond the additional 365 days	$0	$0	All Costs
Skilled Nursing Facility Care You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st thru 100th days	All but $164.50 a day	$0	Up to $164.50 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

*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 $183 of Medicare Eligible Expenses for covered services (which are noted with an asterisk), your Medicare Part B Deductible will have been met for the calendar year.

Services	Medicare Pays	Plan A Pays	You Pay
Medical Expenses In or out of the hospital and outpatient hospital treatment, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $183 of Medicare approved amounts*	$0	$0	$183 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 $183 of Medicare approved amounts*	$0	$0	$183 Part B Deductible
Remainder of Medicare approved amounts	80%	20%	$0
Clinical Laboratory Services – Tests for diagnostic services	100%	$0	$0

Parts A & B

Services	Medicare Pays	Plan A Pays	You Pay
Home Health Care Medicare Eligible Services			
- Medically necessary skilled care services and medical supplies	100%	$0	$0
- Durable medical equipment			
▪ First $183 of Medicare approved amounts*	$0	$0	$183 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 F Pays	You Pay
Hospitalization Semiprivate room and board, general nursing and miscellaneous services and supplies.			
First 60 days	All but $1,316	$1,316 Part A Deductible	$0
61st thru 90th day	All but $329 a day	$329 a day	$0
91st day and after			
- While using 60 lifetime reserve days	All but $658 a day	$658 a day	$0
- Once lifetime reserve days are used			
▪ Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
▪ Beyond the additional 365 days	$0	$0	All Costs
Skilled Nursing Facility Care You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st thru 100th days	All but $164.50 a day	Up to $164.50 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

**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 $183 of Medicare Approved amounts for covered services (which are noted with an asterisk), your Medicare Part B Deductible will have been met for the calendar year.

Services	Medicare Pays	Plan F Pays	You Pay
Medical Expenses In or out of the hospital and outpatient hospital treatment, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First $183 of Medicare approved amounts* Remainder of Medicare approved amounts	 $0 Generally 80%	 $183 Part B Deductible Generally 20%	 $0 $0
Part B Excess Charges (above Medicare approved amounts)	$0	100%	$0
Blood First 3 pints Next $183 of Medicare approved amounts* Remainder of Medicare approved amounts	 $0 $0 80%	 All costs $183 Part B Deductible $20%	 $0 $0 $0
Clinical Laboratory Services – Tests for Diagnostic services	100%	$0	$0

Parts A & B

Services	Medicare Pays	Plan F Pays	You Pay
Home Health Care Medicare Eligible Services - Medically necessary skilled care services and medical supplies - Durable medical equipment ▪ First $183 of Medicare approved amounts* ▪ Remainder of Medicare approved amounts	 100% $0 80%	 $0 $183 Part B Deductible 20%	 $0 $0 $0

Other Benefits Not Covered by Medicare

Services	Medicare Pays	Plan F Pays	You Pay
Foreign Travel Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA. First $250 each calendar year Remainder of charges	 $0 $0	 $0 80% to a lifetime maximum benefit of $50,000.	 $250 20% and amounts over the $50,000 lifetime maximum.

Liberty Bankers Life Insurance Company
Outline of Coverage
Medicare Supplement Benefit Plans A, F, G and N

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 G Pays	You Pay
Hospitalization Semiprivate room and board, general nursing and miscellaneous services and supplies.			
First 60 days	All but $1,316	$1,316 Part A Deductible	$0
61st thru 90th day	All but $329 a day	$329 a day	$0
91st day and after			
- While using 60 lifetime reserve days	All but $658 a day	$658 a day	$0
- Once lifetime reserve days are used			
▪ Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
▪ Beyond the additional 365 days	$0	$0	All Costs
Skilled Nursing Facility Care You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st thru 100 days	All but $164.50 a day	Up to $164.50 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

**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 $183 of Medicare approved amounts for covered services (which are noted with an asterisk), your Medicare Part B Deductible will have been met for the calendar year.

Services	Medicare Pays	Plan G Pays	You Pay
Medical Expenses In or out of the hospital and outpatient hospital treatment, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $183 of Medicare approved amounts* Remainder of Medicare approved amounts	$0 Generally 80%	$0 Generally 20%	$183 Part B Deductible $0
Part B Excess Charges (above Medicare approved amounts)	$0	100%	$0
Blood First 3 pints Next $183 of Medicare approved amounts* Remainder of Medicare approved amounts	 $0 $0 80%	 All costs $0 $20%	 $0 $183 Part B Deductible $0
Clinical Laboratory Services – Tests for Diagnostic services	100%	$0	$0

Parts A & B

Services	Medicare Pays	Plan G Pays	You Pay
Home Health Care Medicare Eligible Services - Medically necessary skilled care services and medical supplies - Durable medical equipment ▪ First $183 of Medicare approved amounts* ▪ Remainder of Medicare approved amounts	 100% $0 80%	 $0 $0 20%	 $0 $183 Part B Deductible $0

Plan G

Other Benefits Not Covered by Medicare

Services	Medicare Pays	Plan G Pays	You Pay
Foreign Travel Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA. First $250 each calendar year Remainder of Charges	 $0 $0	 $0 80% to a lifetime maximum benefit of $50,000.	 $250 20% and amounts over the $50,000 lifetime maximum.

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 N Pays	You Pay
Hospitalization Semiprivate room and board, general nursing and miscellaneous services and supplies.			
First 60 days	All but $1,316	$1,316 Part A Deductible	$0
61st thru 90th day	All but $329 a day	$329 a day	$0
91st day and after			
- While using 60 lifetime reserve days	All but $658 a day	$658 a day	$0
- Once lifetime reserve days are used			
▪ Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
▪ Beyond the additional 365 days	$0	$0	All Costs
Skilled Nursing Facility Care You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st thru 100 days	All but $164.50 a day	Up to $164.50 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

**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 $183 of Medicare Approved amounts for covered services (which are noted with an asterisk), your Medicare Part B Deductible will have been met for the calendar year.

Services	Medicare Pays	Plan N Pays	You Pay
Medical Expenses In or out of the hospital and outpatient hospital treatment, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $183 of Medicare approved amounts*	$0	$0	$183 Part B Deductible
Remainder of Medicare approved amounts	Generally 80%	Balance, other than up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
Part B Excess Charges (above Medicare approved amounts)	$0	$0	All costs
Blood			
First 3 pints	$0	All costs	$0
Next $183 of Medicare approved amounts*	$0	$0	$183 Part B Deductible
Remainder of Medicare approved amounts	80%	$20%	$0
Clinical Laboratory Services – Tests for diagnostic services	100%	$0	$0

Parts A & B

Services	Medicare Pays	Plan N Pays	You Pay
Home Health Care Medicare Eligible Services			
- Medically necessary skilled care services and medical supplies	100%	$0	$0
- Durable medical equipment			
▪ First $183 of Medicare approved amounts*	$0	$0	$183 Part B Deductible
▪ Remainder of Medicare approved amounts	80%	20%	$0

Plan N

Other Benefits Not Covered by Medicare

Services	Medicare Pays	Plan N Pays	You Pay
Foreign Travel Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA. First $250 each calendar year Remainder of charges	 $0 $0	 $0 80% to a lifetime maximum benefit of $50,000.	 $250 20% and amounts over the $50,000 lifetime maximum.