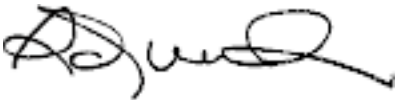
KANSAS FARM BUREAU®
Health Plans
MEDICARE SUPPLEMENT PLANS
Insured By Members Health Insurance Company

Outline of Coverage

Benefit charts • Medicare Supplement Plans • kfbhealthplans.com

Kansas Farm Bureau Health Plans

Randy Wilmore
Chief Marketing Officer



Date:_____

Premium:_____

PREMIUM INFORMATION

We, Kansas Farm Bureau Health Plans, can raise your premium at any time with 30-day notice. However, we can only raise your premium if we raise the premium for all persons of the same class and benefit plan insured under the group policy who reside in your state. Any premium increase must be approved by Kansas Department of Insurance. The Medicare Supplement Insurance coverage is age-rated. Your premium will be based on your current age and adjusted annually each birthday. For individuals eligible for Medicare based on disability status, the premium is not age-rated. Refer to the following premium chart for the premium applicable to the Medicare Supplement Insurance plans offered under the group policy.

KANSAS FARM BUREAU HEALTH PLANS
Home Office: P.O. Box 1424, Columbia, TN 38402-1424
1-833-282-5928; kfbhealthplans.com

Outline of Medicare Supplement Coverage-Cover Page:

Benefit Plans A, D, G and N

These charts show the benefits included in each of the standard Medicare Supplement Insurance plans. Every company must make available Plan A. Some of the other plans may not be available from every company.

BASIC BENEFITS
Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
Medical Expenses: Part B coinsurance (generally 20% of Medicare approved expenses) or copayments for hospital outpatient services. Plan N requires insureds to pay a portion of Part B coinsurance or copayments.
Blood: First three pints of blood each year.
Hospice: Part A coinsurance.

PLAN A	PLAN D	PLAN G	PLAN N
Basic Benefits, including 100% of Part B Coinsurance	Basic Benefits, including 100% of Part B Coinsurance	Basic Benefits, including 100% of Part B Coinsurance	Basic Benefits, including 100% of Part B Coinsurance except up to $20 copayment for office visit, and up to $50 copayment for ER
	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible
		Part B Excess (100%)	
	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency

Kansas Farm Bureau Group Medicare Supplement Insurance Policy
Group Medicare Supplement Insurance - Monthly Premiums*

AGE	PLAN A	PLAN D	PLAN G	PLAN N
65	$114.99	$120.89	$125.95	$97.91
66	$119.06	$124.02	$129.22	$100.35
67	$123.51	$128.08	$133.44	$103.58
68	$128.25	$132.95	$138.52	$107.50
69	$133.20	$138.44	$144.24	$111.96
70	$138.24	$144.34	$150.38	$116.78
71	$143.24	$150.46	$156.76	$121.80
72	$148.05	$156.62	$163.18	$126.87
73	$152.55	$162.72	$169.53	$131.92
74	$156.74	$168.75	$175.81	$136.93
75	$160.62	$174.73	$182.03	$141.91
76	$164.15	$180.61	$188.16	$146.85
77	$167.24	$186.35	$194.13	$151.70
78	$169.82	$191.87	$199.88	$156.39
79	$171.93	$197.24	$205.47	$161.00
80	$173.63	$202.52	$210.95	$165.55
81	$174.93	$207.70	$216.34	$170.06
82	$175.79	$212.73	$221.58	$174.48
83	$176.19	$217.58	$226.62	$178.78
84	$176.23	$222.36	$231.59	$183.05
85	$176.52	$227.17	$236.59	$187.38
86	$176.68	$232.03	$241.64	$191.76
87	$176.75	$236.82	$246.62	$196.10
88	$176.75	$241.29	$251.25	$200.15
89	$176.75	$245.08	$255.19	$203.62
90	$176.75	$247.95	$258.17	$206.29
91	$176.75	$250.04	$260.33	$208.28
92	$176.75	$251.61	$261.97	$209.83
93	$176.75	$252.83	$263.23	$211.08
94	$176.75	$253.50	$263.92	$211.90
95	$176.75	$253.54	$263.94	$212.19
96	$176.75	$253.88	$264.30	$212.18
97	$176.75	$253.88	$264.30	$212.51
98	$176.75	$253.88	$264.30	$212.70
99	$176.75	$253.88	$264.30	$212.70
100	$176.75	$253.88	$264.30	$212.70
Under Age 65 (Disability)	$114.99	$120.89	$125.95	$97.91

* Your Premium is effective on your Certificate Effective Date and is based on your attained age as of your Certificate Effective Date. After the Certificate Effective Date, your Premium will be adjusted each year on your birthday to the Premium indicated above for your newly attained age for that year.

DISCLOSURE

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY

This is only an outline describing your Certificate's most important features. The Certificate is your insurance contract. You must read the Certificate 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 Certificate for any reason, you may return it to

Kansas Farm Bureau Health Plans
P.O. Box 1424
Columbia, Tennessee 38402-1424

If you send the Certificate back to us within 30 days after you receive it, we will treat the Certificate 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 Certificate and are sure you want to keep it.

NOTICE

The Certificate may not fully cover all of your medical costs. Neither Kansas Farm Bureau Health Plans or Members Health Insurance Company 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 The Medicare Handbook (*Medicare and You*) for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT

When you fill out the application for the new Certificate, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your Certificate and refuse to pay any claims if you leave out or falsify important medical information.

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

PLAN A

Medicare (Part A) - Hospital Services - Per Benefit Period

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,484	$0	$1,484 (Part A deductible)
61st thru 90th day	All but $371 a day	$371 a day	$0
91st day and after: -While using 60 lifetime reserve days	All but $742 a day	$742 a day	$0
Once lifetime reserve days are used: -Additional 365 days	$0	100% of Medicare eligible expenses	$0**
-Beyond 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 hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $185.50 a day	$0	Up to $185.50 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 Plan 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.

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Medicare (Part B) - Medical Services - Per Calendar Year

* Once you have been billed $203 of Medicare approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $203 of Medicare Approved Amounts*	$0	$0	$203 (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 $203 of Medicare Approved Amounts*	$0	$0	$203 (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 PAYS	YOU PAY
HOME HEALTH CARE			
MEDICARE APPROVED SERVICES - Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment - first $203 of Medicare Approved Amounts*	$0	$0	$203 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

PLAN D

Medicare (Part A) - Hospital Services - Per Benefit Period

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,484	$1,484 (Part A deductible)	$0
61st thru 90th day	All but $371 a day	$371 a day	$0
91st day and after: -While using 60 lifetime reserve days	All but $742 a day	$742 a day	$0
Once lifetime reserve days are used: -Additional 365 days	$0	100% of Medicare eligible expenses	$0**
-Beyond 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 hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $185.50 a day	Up to $185.50 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 Plan 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.

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PLAN D *(continued)*

Medicare (Part B) - Medical Services - Per Calendar Year

* Once you have been billed $203 of Medicare approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $203 of Medicare Approved Amounts*	$0	$0	$203 (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 $203 of Medicare Approved Amounts*	$0	$0	$203 (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 PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES - Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment - first $203 of Medicare Approved Amounts*	$0	$0	$203 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS - NOT COVERED BY MEDICARE

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

PLAN G

Medicare (Part A) - Hospital Services - Per Benefit Period

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,484	$1,484 (Part A deductible)	$0
61st thru 90th day	All but $371 a day	$371 a day	$0
91st day and after: -While using 60 lifetime reserve days	All but $742 a day	$742 a day	$0
Once lifetime reserve days are used: -Additional 365 days	$0	100% of Medicare eligible expenses	$0**
-Beyond 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 hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $185.50 a day	Up to $185.50 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 Plan 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.

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Medicare (Part B) - Medical Services - Per Calendar Year

* Once you have been billed $203 of Medicare approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $203 of Medicare Approved Amounts*	$0	$0	$203 (Part B deductible)
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 $203 of Medicare Approved Amounts*	$0	$0	$203 (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 PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES - Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment - first $203 of Medicare Approved Amounts*	$0	$0	$203 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS - NOT COVERED BY MEDICARE

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

PLAN N

Medicare (Part A) - Hospital Services - Per Benefit Period

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,484	$1,484 (Part A deductible)	$0
61st thru 90th day	All but $371 a day	$371 a day	$0
91st day and after: -While using 60 lifetime reserve days	All but $742 a day	$742 a day	$0
Once lifetime reserve days are used: -Additional 365 days	$0	100% of Medicare eligible expenses	$0**
-Beyond 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 hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $185.50 a day	Up to $185.50 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 Plan 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.

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Medicare (Part B) - Medical Services - Per Calendar Year

* Once you have been billed $203 of Medicare approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $203 of Medicare Approved Amounts*	$0	$0	$203 (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Balance, other than up to $20 per office visit and up to $50 per ER 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 ER 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 $203 of Medicare Approved Amounts*	$0	$0	$203 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

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PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES - Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment - first $203 of Medicare Approved Amounts*	$0	$0	$203 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS - NOT COVERED BY MEDICARE

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

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Visit us at kfbhealthplans.com for a rate quote and more details.

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As of 11/2020