SHENANDOAH LIFE INSURANCE COMPANY

♦ ROANOKE, VIRGINIA 24029 ♦

Outline of Medicare Supplement Coverage – Cover Page: 1 of 2

Benefit Plans A, B, C, D, E, F AND G

These charts show the benefits included in each Medicare supplement plan. Every company must make available Plan "A". Some plans may not be available in your state.

See Outlines of Coverage sections for details on ALL plans.

Basic Benefits for Plans A-J:

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.
Blood: First three pints of blood each year.

A	B	C	D	E	F	F*	G	H	I	J	J*
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits		Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance		Skilled Nursing Facility Coinsurance	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		Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	
		Part B Deductible			Part B Deductible					Part B Deductible	
					Part B Excess (100%)		Part B Excess (80%)		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	Foreign Travel Emergency	Foreign Travel Emergency	
			At-Home Recovery				At-Home Recovery		At-Home Recovery	At-Home Recovery	
				Preventive Care NOT covered by Medicare						Preventive Care NOT covered by Medicare	

*Plans F and J also have an option called a high deductible Plan F and a high deductible Plan J. These high deductible plans pay the same or offer the same benefits as Plans F and J after one has paid a calendar year $1900 deductible. Benefits from high deductible Plans F and J will not begin until out-of-pocket expenses exceed $1900. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare Deductibles for Part A and Part B, but do not include the plan's separate foreign emergency deductible.

Form 5762-Rev. 1/08 OK

SHENANDOAH LIFE INSURANCE COMPANY

Outline of Medicare Supplement Coverage – Cover Page: 2 of 2

Basic Benefits for Plans K and L include similar services as plans A-J, but cost-sharing for the basic benefits is at different levels.

J	K**	L**
Basic Benefits	100% of Part A Hospitalization Coinsurance plus coverage for 365 Days after Medicare Benefits End 50% Hospice cost-sharing 50% of Medicare-eligible expenses for the first three pints of blood 50% Part B Coinsurance, except 100% Coinsurance for Part B Preventive Services	100% of Part A Hospitalization Coinsurance plus coverage for 365 Days after Medicare Benefits End 75% Hospice cost-sharing 75% of Medicare-eligible expenses for the first three pints of blood 75% Part B Coinsurance, except 100% Coinsurance for Part B Preventive Services
Skilled Nursing Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance
Part A Deductible	50% Part A Deductible	75% Part A Deductible
Part B Deductible		
Part B Excess (100%)		
Foreign Travel Emergency		
At-Home Recovery		
Preventative Care NOT covered by Medicare		
	$4440 Out of Pocket Annual Limit ***	$2220 Out of Policy Annual Limit ***

**** Plans K and L provide for different cost-sharing for items and services than Plans A-J.**
Once you reach the annual limit, the plans pays 100% of the Medicare copayments, coinsurances, and deductibles for the rest of the calendar year. The out-of-pocket annual limit does NOT include charges from your provider that exceed Medicare-approved amounts, called "Excess Charges." You will be responsible for paying excess charges.

*****The out-of-pocket annual limit will increase each year for inflation.**
See Outlines of Coverage for details and exceptions.

SHENANDOAH LIFE INSURANCE COMPANY
ANNUAL PREFERRED PREMIUM RATES
FOR USE IN OKLAHOMA ZIP CODES
730-731, 740-741

Attained	Plan A		Plan B		Plan C		Plan D		Plan E		Plan F		Plan G	
Age	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male
0-64	1,434	1,650	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
65	923	1,061	1,162	1,337	1,308	1,504	1,175	1,350	1,184	1,363	1,350	1,553	1,201	1,382
66	923	1,061	1,162	1,337	1,308	1,504	1,175	1,350	1,184	1,363	1,350	1,553	1,201	1,382
67	923	1,061	1,162	1,337	1,308	1,504	1,175	1,350	1,184	1,363	1,350	1,553	1,201	1,382
68	961	1,106	1,211	1,393	1,366	1,571	1,224	1,407	1,235	1,418	1,407	1,617	1,251	1,439
69	1,005	1,156	1,266	1,455	1,422	1,635	1,278	1,471	1,289	1,483	1,463	1,681	1,308	1,504
70	1,045	1,201	1,317	1,514	1,475	1,697	1,329	1,528	1,340	1,543	1,516	1,743	1,359	1,563
71	1,085	1,247	1,366	1,571	1,527	1,756	1,380	1,587	1,392	1,601	1,568	1,803	1,412	1,623
72	1,121	1,290	1,414	1,625	1,575	1,812	1,427	1,642	1,441	1,656	1,617	1,860	1,461	1,679
73	1,157	1,332	1,458	1,677	1,620	1,862	1,473	1,694	1,486	1,709	1,661	1,911	1,507	1,733
74	1,191	1,369	1,501	1,725	1,662	1,912	1,516	1,742	1,528	1,758	1,704	1,959	1,550	1,782
75	1,220	1,404	1,538	1,769	1,702	1,958	1,553	1,787	1,567	1,802	1,742	2,003	1,589	1,828
76	1,248	1,436	1,573	1,810	1,738	1,998	1,589	1,828	1,603	1,843	1,775	2,041	1,625	1,869
77	1,276	1,467	1,607	1,849	1,775	2,041	1,624	1,868	1,637	1,883	1,807	2,078	1,661	1,910
78	1,301	1,496	1,639	1,884	1,807	2,078	1,654	1,903	1,670	1,920	1,834	2,110	1,693	1,947
79	1,323	1,522	1,667	1,917	1,838	2,112	1,683	1,937	1,698	1,953	1,860	2,139	1,722	1,980
80	1,345	1,546	1,694	1,949	1,861	2,140	1,711	1,967	1,725	1,985	1,884	2,166	1,750	2,012
81	1,364	1,568	1,719	1,976	1,885	2,167	1,735	1,996	1,751	2,012	1,909	2,195	1,775	2,041
82	1,382	1,589	1,742	2,003	1,908	2,194	1,759	2,022	1,774	2,040	1,932	2,223	1,799	2,068
83	1,400	1,610	1,764	2,029	1,930	2,219	1,781	2,048	1,797	2,066	1,957	2,249	1,822	2,095
84	1,418	1,630	1,786	2,053	1,950	2,244	1,804	2,075	1,819	2,092	1,979	2,275	1,844	2,121
85	1,434	1,650	1,807	2,078	1,971	2,267	1,824	2,099	1,841	2,117	2,001	2,300	1,867	2,147
86	1,451	1,667	1,827	2,101	1,991	2,289	1,845	2,121	1,861	2,140	2,021	2,325	1,887	2,170
87	1,465	1,685	1,847	2,124	2,009	2,310	1,865	2,145	1,881	2,164	2,041	2,347	1,907	2,193
88	1,481	1,702	1,865	2,145	2,028	2,332	1,883	2,166	1,900	2,185	2,060	2,369	1,927	2,216
89	1,494	1,719	1,883	2,165	2,046	2,352	1,901	2,186	1,918	2,206	2,078	2,390	1,944	2,237
90	1,508	1,733	1,899	2,184	2,062	2,372	1,918	2,206	1,934	2,225	2,095	2,408	1,962	2,256
91	1,520	1,748	1,914	2,201	2,078	2,390	1,933	2,224	1,950	2,244	2,111	2,426	1,978	2,274
92	1,532	1,761	1,930	2,219	2,094	2,408	1,949	2,240	1,966	2,260	2,125	2,444	1,993	2,292
93	1,543	1,773	1,943	2,235	2,108	2,424	1,962	2,256	1,979	2,276	2,138	2,459	2,007	2,308
94	1,553	1,785	1,956	2,248	2,120	2,438	1,976	2,271	1,992	2,291	2,150	2,473	2,020	2,323
95	1,562	1,795	1,967	2,263	2,131	2,452	1,986	2,284	2,003	2,304	2,161	2,485	2,031	2,336
96	1,571	1,805	1,978	2,275	2,144	2,465	1,998	2,298	2,016	2,318	2,172	2,498	2,043	2,350
97	1,580	1,817	1,990	2,289	2,156	2,478	2,010	2,310	2,028	2,332	2,183	2,511	2,056	2,364
98	1,589	1,827	2,002	2,302	2,167	2,492	2,021	2,325	2,039	2,345	2,194	2,524	2,068	2,378
99	1,598	1,838	2,013	2,316	2,179	2,506	2,033	2,338	2,051	2,359	2,206	2,536	2,080	2,392

Premium payable other than annual will be determined according to the following factors:

Semi-Annual	Quarterly	Monthly
0.5000	0.2500	Divide by 12

There is a one time $25 application fee

SHENANDOAH LIFE INSURANCE COMPANY
ANNUAL STANDARD PREMIUM RATES
FOR USE IN OKLAHOMA ZIP CODES
730-731, 740-741

Attained	Plan A		Plan B		Plan C		Plan D		Plan E		Plan F		Plan G	
Age	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male
0-64	1,593	1,832	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
65	1,026	1,179	1,292	1,486	1,454	1,671	1,305	1,500	1,316	1,514	1,501	1,725	1,335	1,535
66	1,026	1,179	1,292	1,486	1,454	1,671	1,305	1,500	1,316	1,514	1,501	1,725	1,335	1,535
67	1,026	1,179	1,292	1,486	1,454	1,671	1,305	1,500	1,316	1,514	1,501	1,725	1,335	1,535
68	1,068	1,229	1,346	1,548	1,517	1,745	1,359	1,563	1,372	1,577	1,563	1,798	1,390	1,599
69	1,117	1,284	1,407	1,617	1,580	1,817	1,421	1,634	1,433	1,647	1,625	1,868	1,453	1,671
70	1,160	1,335	1,463	1,682	1,640	1,885	1,477	1,699	1,490	1,714	1,684	1,937	1,511	1,738
71	1,205	1,386	1,518	1,746	1,697	1,951	1,534	1,763	1,546	1,778	1,742	2,003	1,568	1,804
72	1,247	1,434	1,571	1,807	1,751	2,012	1,586	1,824	1,600	1,841	1,797	2,066	1,623	1,867
73	1,286	1,479	1,621	1,863	1,800	2,070	1,636	1,882	1,651	1,899	1,845	2,122	1,674	1,924
74	1,323	1,522	1,667	1,918	1,848	2,125	1,684	1,937	1,698	1,953	1,893	2,177	1,722	1,980
75	1,356	1,561	1,710	1,967	1,891	2,174	1,726	1,985	1,742	2,003	1,936	2,227	1,765	2,030
76	1,388	1,596	1,749	2,011	1,931	2,220	1,766	2,030	1,781	2,048	1,972	2,268	1,805	2,077
77	1,418	1,631	1,786	2,055	1,972	2,268	1,804	2,075	1,820	2,092	2,008	2,309	1,844	2,121
78	1,445	1,661	1,821	2,094	2,008	2,309	1,839	2,115	1,854	2,132	2,039	2,345	1,881	2,162
79	1,471	1,691	1,852	2,130	2,041	2,347	1,870	2,151	1,887	2,170	2,067	2,377	1,913	2,200
80	1,494	1,718	1,882	2,165	2,068	2,378	1,901	2,186	1,918	2,205	2,093	2,407	1,944	2,236
81	1,516	1,742	1,910	2,196	2,094	2,408	1,929	2,218	1,946	2,237	2,120	2,438	1,972	2,268
82	1,535	1,766	1,936	2,226	2,120	2,437	1,954	2,247	1,971	2,267	2,147	2,469	1,999	2,299
83	1,555	1,789	1,960	2,255	2,144	2,465	1,979	2,276	1,997	2,296	2,174	2,500	2,025	2,328
84	1,575	1,811	1,984	2,282	2,167	2,493	2,003	2,305	2,021	2,325	2,199	2,528	2,049	2,357
85	1,593	1,832	2,008	2,309	2,190	2,518	2,028	2,332	2,046	2,353	2,223	2,556	2,075	2,385
86	1,611	1,852	2,030	2,335	2,211	2,543	2,050	2,357	2,068	2,378	2,246	2,583	2,097	2,412
87	1,629	1,872	2,051	2,359	2,233	2,567	2,072	2,383	2,090	2,404	2,268	2,609	2,119	2,437
88	1,644	1,891	2,072	2,383	2,253	2,591	2,093	2,407	2,111	2,427	2,289	2,633	2,140	2,462
89	1,661	1,909	2,092	2,406	2,273	2,613	2,112	2,429	2,130	2,451	2,309	2,655	2,160	2,485
90	1,675	1,926	2,111	2,426	2,291	2,635	2,131	2,452	2,149	2,472	2,327	2,677	2,180	2,507
91	1,689	1,941	2,128	2,446	2,309	2,656	2,148	2,471	2,167	2,493	2,345	2,696	2,198	2,527
92	1,702	1,957	2,144	2,465	2,327	2,675	2,165	2,490	2,184	2,512	2,362	2,714	2,215	2,546
93	1,714	1,970	2,159	2,483	2,342	2,693	2,180	2,507	2,199	2,530	2,376	2,732	2,229	2,564
94	1,724	1,983	2,174	2,498	2,355	2,709	2,194	2,524	2,214	2,545	2,389	2,748	2,245	2,581
95	1,734	1,995	2,185	2,514	2,368	2,723	2,207	2,538	2,227	2,561	2,401	2,761	2,257	2,596
96	1,744	2,007	2,198	2,527	2,381	2,739	2,219	2,553	2,239	2,575	2,414	2,775	2,270	2,611
97	1,755	2,018	2,210	2,543	2,395	2,753	2,234	2,568	2,253	2,590	2,426	2,790	2,284	2,626
98	1,765	2,030	2,225	2,558	2,408	2,769	2,246	2,583	2,266	2,606	2,438	2,804	2,298	2,642
99	1,776	2,042	2,237	2,573	2,421	2,784	2,259	2,599	2,279	2,621	2,451	2,819	2,310	2,657

Premium payable other than annual will be determined according to the following factors:

Semi-Annual	Quarterly	Monthly
0.5000	0.2500	Divide by 12

There is a one time $25 application fee

SHENANDOAH LIFE INSURANCE COMPANY
ANNUAL PREFERRED PREMIUM RATES
FOR USE IN OKLAHOMA ZIP CODES
EXCEPT 730-731, 740-741

Attained	Plan A		Plan B		Plan C		Plan D		Plan E		Plan F		Plan G	
Age	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male
0-64	1,354	1,558	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
65	871	1,002	1,097	1,262	1,235	1,420	1,109	1,275	1,119	1,287	1,275	1,467	1,134	1,305
66	871	1,002	1,097	1,262	1,235	1,420	1,109	1,275	1,119	1,287	1,275	1,467	1,134	1,305
67	871	1,002	1,097	1,262	1,235	1,420	1,109	1,275	1,119	1,287	1,275	1,467	1,134	1,305
68	908	1,045	1,144	1,316	1,290	1,484	1,156	1,329	1,166	1,340	1,329	1,527	1,182	1,359
69	949	1,091	1,196	1,374	1,343	1,544	1,207	1,389	1,217	1,401	1,381	1,588	1,235	1,420
70	987	1,134	1,244	1,430	1,393	1,602	1,255	1,443	1,266	1,457	1,431	1,646	1,284	1,476
71	1,024	1,178	1,290	1,484	1,442	1,658	1,303	1,499	1,315	1,512	1,481	1,703	1,334	1,533
72	1,059	1,218	1,335	1,535	1,488	1,711	1,348	1,550	1,361	1,564	1,527	1,757	1,380	1,586
73	1,093	1,258	1,377	1,584	1,530	1,759	1,391	1,600	1,403	1,614	1,569	1,805	1,423	1,636
74	1,125	1,293	1,418	1,629	1,570	1,805	1,431	1,646	1,443	1,660	1,609	1,850	1,464	1,683
75	1,153	1,326	1,453	1,671	1,607	1,849	1,467	1,688	1,480	1,702	1,646	1,892	1,501	1,726
76	1,179	1,357	1,486	1,709	1,641	1,887	1,501	1,726	1,514	1,741	1,676	1,928	1,535	1,765
77	1,205	1,386	1,518	1,746	1,676	1,928	1,533	1,764	1,546	1,778	1,707	1,963	1,568	1,804
78	1,228	1,413	1,548	1,779	1,707	1,963	1,562	1,797	1,577	1,813	1,732	1,992	1,599	1,839
79	1,250	1,437	1,574	1,811	1,736	1,995	1,590	1,829	1,604	1,845	1,757	2,020	1,626	1,870
80	1,270	1,460	1,600	1,840	1,758	2,021	1,616	1,858	1,629	1,875	1,779	2,046	1,652	1,901
81	1,289	1,481	1,624	1,867	1,780	2,047	1,639	1,885	1,653	1,901	1,803	2,073	1,676	1,928
82	1,306	1,501	1,645	1,891	1,802	2,072	1,661	1,910	1,675	1,927	1,825	2,100	1,699	1,953
83	1,322	1,521	1,666	1,916	1,822	2,095	1,682	1,935	1,697	1,952	1,848	2,124	1,720	1,979
84	1,339	1,539	1,686	1,939	1,842	2,119	1,703	1,959	1,718	1,975	1,869	2,149	1,742	2,003
85	1,354	1,558	1,707	1,963	1,862	2,141	1,723	1,982	1,738	1,999	1,890	2,173	1,763	2,027
86	1,370	1,574	1,726	1,984	1,880	2,162	1,743	2,003	1,758	2,021	1,909	2,196	1,782	2,049
87	1,384	1,591	1,744	2,006	1,897	2,182	1,761	2,026	1,777	2,043	1,928	2,217	1,801	2,071
88	1,398	1,607	1,761	2,026	1,915	2,202	1,778	2,046	1,794	2,064	1,946	2,237	1,820	2,093
89	1,411	1,624	1,778	2,045	1,932	2,221	1,795	2,065	1,811	2,083	1,963	2,257	1,836	2,112
90	1,424	1,637	1,794	2,063	1,947	2,240	1,811	2,083	1,827	2,101	1,979	2,275	1,853	2,131
91	1,436	1,651	1,808	2,079	1,963	2,257	1,826	2,100	1,842	2,119	1,993	2,292	1,868	2,148
92	1,447	1,663	1,822	2,095	1,978	2,274	1,840	2,116	1,856	2,134	2,007	2,308	1,882	2,165
93	1,457	1,675	1,835	2,111	1,991	2,289	1,853	2,131	1,869	2,150	2,020	2,322	1,896	2,179
94	1,466	1,686	1,847	2,123	2,002	2,303	1,866	2,145	1,881	2,163	2,031	2,336	1,907	2,194
95	1,475	1,695	1,858	2,137	2,013	2,315	1,876	2,157	1,892	2,176	2,041	2,347	1,918	2,207
96	1,483	1,705	1,868	2,149	2,025	2,328	1,887	2,170	1,904	2,189	2,051	2,359	1,930	2,219
97	1,492	1,716	1,879	2,162	2,036	2,340	1,898	2,182	1,915	2,202	2,062	2,372	1,941	2,233
98	1,501	1,726	1,890	2,174	2,047	2,354	1,909	2,196	1,926	2,215	2,072	2,383	1,953	2,246
99	1,509	1,736	1,901	2,187	2,058	2,366	1,920	2,208	1,937	2,228	2,083	2,395	1,964	2,259

Premium payable other than annual will be determined according to the following factors:

Semi-Annual	Quarterly	Monthly
0.5000	0.2500	Divide by 12

There is a one time $25 application fee

SHENANDOAH LIFE INSURANCE COMPANY
ANNUAL STANDARD PREMIUM RATES
FOR USE IN OKLAHOMA ZIP CODES
EXCEPT 730-731, 740-741

Attained	Plan A		Plan B		Plan C		Plan D		Plan E		Plan F		Plan G	
Age	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male
0-64	1,505	1,731	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
65	969	1,114	1,221	1,403	1,373	1,578	1,233	1,417	1,243	1,430	1,418	1,629	1,261	1,449
66	969	1,114	1,221	1,403	1,373	1,578	1,233	1,417	1,243	1,430	1,418	1,629	1,261	1,449
67	969	1,114	1,221	1,403	1,373	1,578	1,233	1,417	1,243	1,430	1,418	1,629	1,261	1,449
68	1,009	1,160	1,272	1,462	1,433	1,648	1,284	1,476	1,295	1,489	1,476	1,698	1,312	1,510
69	1,055	1,213	1,329	1,527	1,493	1,716	1,342	1,543	1,353	1,556	1,534	1,765	1,372	1,578
70	1,096	1,261	1,381	1,589	1,549	1,780	1,395	1,605	1,408	1,618	1,590	1,829	1,427	1,641
71	1,138	1,309	1,434	1,649	1,602	1,843	1,448	1,665	1,460	1,680	1,646	1,892	1,481	1,703
72	1,177	1,354	1,484	1,707	1,653	1,901	1,498	1,723	1,511	1,738	1,697	1,952	1,533	1,763
73	1,215	1,397	1,531	1,760	1,700	1,955	1,545	1,777	1,559	1,794	1,743	2,004	1,581	1,817
74	1,250	1,437	1,574	1,811	1,745	2,007	1,590	1,829	1,604	1,845	1,788	2,056	1,626	1,870
75	1,281	1,474	1,615	1,857	1,786	2,054	1,630	1,875	1,645	1,891	1,828	2,103	1,667	1,918
76	1,311	1,507	1,652	1,899	1,823	2,097	1,668	1,918	1,682	1,935	1,862	2,142	1,705	1,962
77	1,339	1,540	1,686	1,941	1,862	2,142	1,703	1,959	1,719	1,975	1,896	2,180	1,742	2,003
78	1,365	1,569	1,720	1,978	1,896	2,180	1,737	1,998	1,751	2,014	1,925	2,214	1,777	2,042
79	1,389	1,597	1,749	2,012	1,928	2,217	1,766	2,032	1,782	2,049	1,952	2,245	1,806	2,077
80	1,411	1,623	1,777	2,045	1,953	2,246	1,795	2,065	1,811	2,083	1,976	2,273	1,836	2,111
81	1,431	1,646	1,804	2,074	1,978	2,274	1,822	2,094	1,838	2,112	2,003	2,303	1,862	2,142
82	1,450	1,668	1,828	2,102	2,002	2,302	1,845	2,122	1,862	2,141	2,028	2,332	1,888	2,171
83	1,469	1,690	1,851	2,129	2,025	2,328	1,869	2,150	1,886	2,168	2,053	2,361	1,913	2,199
84	1,488	1,710	1,873	2,156	2,047	2,355	1,892	2,177	1,909	2,196	2,077	2,388	1,935	2,226
85	1,505	1,731	1,896	2,180	2,068	2,378	1,915	2,202	1,932	2,222	2,100	2,414	1,959	2,253
86	1,522	1,749	1,918	2,205	2,088	2,402	1,936	2,226	1,953	2,246	2,122	2,440	1,981	2,278
87	1,539	1,768	1,937	2,228	2,109	2,424	1,957	2,251	1,974	2,270	2,142	2,464	2,001	2,302
88	1,553	1,786	1,957	2,251	2,128	2,447	1,976	2,273	1,993	2,292	2,162	2,486	2,021	2,325
89	1,568	1,803	1,975	2,272	2,146	2,468	1,995	2,294	2,012	2,315	2,180	2,508	2,040	2,347
90	1,582	1,819	1,993	2,292	2,163	2,489	2,013	2,315	2,030	2,335	2,198	2,528	2,059	2,367
91	1,595	1,833	2,009	2,310	2,181	2,508	2,029	2,334	2,047	2,355	2,214	2,547	2,076	2,387
92	1,607	1,848	2,025	2,328	2,197	2,526	2,045	2,352	2,063	2,372	2,230	2,564	2,092	2,405
93	1,618	1,861	2,039	2,345	2,212	2,543	2,059	2,368	2,077	2,389	2,244	2,581	2,105	2,422
94	1,629	1,873	2,053	2,360	2,224	2,559	2,072	2,383	2,091	2,404	2,256	2,595	2,120	2,438
95	1,638	1,884	2,064	2,374	2,236	2,572	2,084	2,397	2,103	2,418	2,268	2,608	2,132	2,451
96	1,647	1,896	2,076	2,387	2,249	2,587	2,096	2,411	2,115	2,432	2,280	2,621	2,144	2,466
97	1,658	1,906	2,088	2,401	2,262	2,600	2,110	2,425	2,128	2,446	2,291	2,635	2,157	2,480
98	1,667	1,917	2,101	2,416	2,274	2,615	2,122	2,440	2,140	2,461	2,303	2,648	2,170	2,496
99	1,677	1,929	2,113	2,430	2,287	2,629	2,134	2,455	2,152	2,475	2,315	2,662	2,182	2,509

Premium payable other than annual will be determined according to the following factors:

Semi-Annual	Quarterly	Monthly
0.5000	0.2500	Divide by 12

There is a one time $25 application fee

PREMIUM INFORMATION

Shenandoah Life Insurance Company can only raise your premium if we raise the premium for all policies like yours in this state.

Premiums are based on your attained age and will change on Your Policy Anniversary Date.

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to our Administrative Office at P.O. Box 10855, Clearwater, Florida 33757-8855. 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 Shenandoah Life Insurance Company nor its agents are connected with Medicare. This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult *Medicare and You* for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT

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

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

Please refer to your policy for details.

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 $1024	$0	$1024 (Part A deductible)
61st thru 90th day	All but $256 a day	$256 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $512 a day	$512 a day	$0
— Once lifetime reserve days are used:			
— Additional 365 days	$0	100% of Medicare eligible expenses	$0**
— Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $128 a day	$0	Up to $128 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 Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

****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 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 $135 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 $135 of Medicare Approved Amounts*	$0	$0	$135 (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 $135 of Medicare Approved Amounts*	$0	$0	$135 (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 $135 of Medicare Approved Amounts*	$0	$0	$135 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

PLAN B

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 $1024	$1024 (Part A deductible)	$0
61st thru 90th day	All but $256 a day	$256 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $512 a day	$512 a day	$0
— Once lifetime reserve days are used:			
— Additional 365 days	$0	100% of Medicare eligible expenses	$0**
— Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $128 a day	$0	Up to $128 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 Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

****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 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 B

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

*Once you have been billed $135 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 $135 of Medicare Approved Amounts*	$0	$0	$135 (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 $135 of Medicare Approved Amounts*	$0	$0	$135 (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 $135 of Medicare Approved Amounts*	$0	$0	$135 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

PLAN C

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 $1024	$1024 (Part A deductible)	$0
61st thru 90th day	All but $256 a day	$256 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $512 a day	$512 a day	$0
— Once lifetime reserve days are used:			
— Additional 365 days	$0	100% of Medicare eligible expenses	$0**
— Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $128 a day	Up to $128 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 Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

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

*Once you have been billed $135 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 $135 of Medicare Approved Amounts*	$0	$135 (Part B deductible)	$0
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 $135 of Medicare Approved Amounts*	$0	$135 (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 $135 of Medicare Approved Amounts*	$0	$135 (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 benefit of $50,000.	20% and amounts over the $50,000 lifetime maximum.

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 $1024	$1024 (Part A deductible)	$0
61st thru 90th day	All but $256 a day	$256 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $512 a day	$512 a day	$0
— Once lifetime reserve days are used:			
— Additional 365 days	$0	100% of Medicare eligible expenses	$0**
— Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $128 a day	Up to $128 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 Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

****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 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 D

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

*Once you have been billed $135 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 $135 of Medicare Approved Amounts*	$0	$0	$135 (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 $135 of Medicare Approved Amounts*	$0	$0	$135 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

PLAN D

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 $135 of Medicare Approved Amounts*	$0	$0	$135 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
AT HOME RECOVERY SERVICES – NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
— Benefit for each visit	$0	Actual charges to $40 a visit	Balance
— Number of visits covered (Must be received within 8 weeks of last Medicare Approved visit)	$0	Up to the number of Medicare approved visits, not to exceed 7 each week	
— Calendar Year maximum	$0	$1,600	

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

PLAN E

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 $1024	$1024 (Part A deductible)	$0
61st thru 90th day	All but $256 a day	$256 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $512 a day	$512 a day	$0
— Once lifetime reserve days are used:			
— Additional 365 days	$0	100% of Medicare eligible expenses	$0**
— Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $128 a day	Up to $128 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 Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

****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 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 E

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

*Once you have been billed $135 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 $135 of Medicare Approved Amounts*	$0	$0	$135 (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 $135 of Medicare Approved Amounts*	$0	$0	$135 (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 $135 of Medicare Approved Amounts*	$0	$0	$135 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

(continued)

PLAN E

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First 250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000.	20% and amounts over the $50,000 lifetime maximum.
***PREVENTIVE MEDICAL CARE BENEFIT – NOT COVERED BY MEDICARE** Some annual physical and preventive tests and services administered or ordered by your doctor when not covered by Medicare			
First $120 each calendar year	$0	$120	$0
Additional Charges	$0	$0	All costs

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

PLAN F

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1024	$1024 (Part A deductible)	$0
61st thru 90th day	All but $256 a day	$256 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $512 a day	$512 a day	$0
— Once lifetime reserve days are used:			
— Additional 365 days	$0	100% of Medicare eligible expenses	$0**
— Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $128 a day	Up to $128 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 Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

****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 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 $135 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 $135 of Medicare Approved Amounts*	$0	$135 (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 $135 of Medicare Approved amounts*	$0	$135 (Part B deductible)	$0
Remainder of Medicare Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

PLAN F

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
— Medically necessary skilled care services and medical supplies	100%	$0	$0
— Durable medical equipment			
First $135 of Medicare Approved Amounts*	$0	$135 (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER SERVICES – NOT COVERED BY MEDICARE

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

PLAN G

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1024	$1024 (Part A deductible)	$0
61st thru 90th day	All but $256 a day	$256 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $512 a day	$512 a day	$0
— Once lifetime reserve days are used:			
— Additional 365 days	$0	100% of Medicare eligible expenses	$0**
— Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $128 a day	Up to $128 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 Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	$0	Balance

****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 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 $135 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 $135 of Medicare Approved Amounts*	$0	$0	$135 (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	80%	20%
BLOOD			
First 3 pints	$0	All costs	$0
Next $135 of Medicare Approved Amounts*	$0	$0	$135 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

PLAN G

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
— Medically necessary skilled care services and medical supplies	100%	$0	$0
— Durable medical equipment			
First $135 of Medicare Approved Amounts*	$0	$0	$135 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
AT HOME RECOVERY SERVICES – NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
— Benefit for each visit	$0	Actual charges to $40 a visit	Balance
— Number of visits covered (Must be received within 8 weeks of last Medicare Approved visit)	$0	Up to the number of Medicare approved visits, not to exceed 7 each week	
— Calendar Year maximum	$0	$1600	

OTHER BENEFITS – NOT COVERED BY MEDICARE

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