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 of the standard Medicare supplement plan. Every company must make available Plan "A" & "B". 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 PA

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 PENNSYLVANIA ZIP CODES
189-194

Attained Age	Plan A		Plan B		Plan C		Plan D		Plan E		Plan F		Plan G	
	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male
0-64 (Underwritten)	1,816	2,089	2,289	2,632	2,497	2,872	2,311	2,659	2,331	2,681	2,509	2,884	2,323	2,671
0-64 (Open Enrollee)	1,058	1,217	1,333	1,533	1,519	1,747	1,346	1,549	1,359	1,562	1,531	1,759	1,360	1,561
65	1,058	1,217	1,333	1,533	1,519	1,747	1,346	1,549	1,359	1,562	1,531	1,759	1,360	1,561
66	1,112	1,279	1,403	1,613	1,584	1,822	1,416	1,628	1,428	1,642	1,596	1,835	1,428	1,640
67	1,168	1,344	1,472	1,693	1,657	1,905	1,487	1,711	1,499	1,726	1,669	1,917	1,499	1,723
68	1,218	1,400	1,535	1,764	1,730	1,990	1,550	1,782	1,564	1,797	1,744	2,003	1,562	1,794
69	1,273	1,463	1,604	1,844	1,801	2,071	1,619	1,862	1,632	1,879	1,813	2,085	1,631	1,874
70	1,323	1,521	1,668	1,917	1,869	2,149	1,684	1,936	1,698	1,954	1,881	2,162	1,696	1,949
71	1,373	1,580	1,730	1,990	1,935	2,224	1,748	2,010	1,763	2,027	1,947	2,237	1,761	2,023
72	1,421	1,634	1,791	2,059	1,995	2,295	1,808	2,079	1,825	2,098	2,008	2,308	1,821	2,092
73	1,466	1,686	1,847	2,124	2,052	2,358	1,866	2,146	1,882	2,165	2,064	2,372	1,879	2,158
74	1,508	1,735	1,901	2,186	2,105	2,421	1,920	2,207	1,936	2,226	2,118	2,434	1,933	2,220
75	1,547	1,779	1,949	2,241	2,156	2,479	1,968	2,264	1,986	2,283	2,168	2,492	1,980	2,276
76	1,582	1,819	1,992	2,292	2,201	2,531	2,013	2,314	2,031	2,335	2,213	2,543	2,025	2,328
77	1,616	1,858	2,036	2,341	2,248	2,586	2,057	2,365	2,075	2,385	2,261	2,598	2,069	2,377
78	1,648	1,895	2,076	2,386	2,289	2,632	2,096	2,410	2,114	2,431	2,301	2,644	2,108	2,422
79	1,675	1,927	2,112	2,428	2,328	2,676	2,132	2,453	2,151	2,474	2,340	2,688	2,144	2,465
80	1,703	1,959	2,146	2,468	2,357	2,712	2,167	2,492	2,186	2,515	2,371	2,724	2,179	2,505
81	1,728	1,987	2,177	2,503	2,388	2,745	2,198	2,528	2,218	2,550	2,400	2,758	2,211	2,541
82	1,750	2,013	2,206	2,537	2,417	2,779	2,228	2,562	2,247	2,585	2,429	2,792	2,240	2,574
83	1,773	2,039	2,234	2,570	2,444	2,811	2,256	2,595	2,276	2,617	2,456	2,823	2,268	2,607
84	1,795	2,064	2,263	2,600	2,471	2,841	2,285	2,627	2,303	2,650	2,483	2,855	2,297	2,640
85	1,816	2,089	2,289	2,632	2,497	2,872	2,311	2,659	2,331	2,681	2,509	2,884	2,323	2,671
86	1,837	2,112	2,313	2,661	2,522	2,900	2,338	2,687	2,357	2,712	2,534	2,912	2,350	2,699
87	1,856	2,134	2,339	2,690	2,544	2,927	2,363	2,716	2,383	2,740	2,556	2,939	2,375	2,729
88	1,874	2,156	2,363	2,716	2,569	2,954	2,385	2,743	2,407	2,768	2,581	2,966	2,398	2,757
89	1,892	2,177	2,385	2,742	2,591	2,979	2,408	2,769	2,429	2,794	2,604	2,991	2,420	2,782
90	1,910	2,196	2,406	2,767	2,613	3,003	2,429	2,794	2,451	2,818	2,625	3,016	2,442	2,806
91	1,925	2,213	2,426	2,789	2,632	3,027	2,449	2,816	2,471	2,841	2,644	3,039	2,462	2,829
92	1,940	2,231	2,444	2,811	2,652	3,049	2,468	2,838	2,489	2,863	2,665	3,062	2,481	2,850
93	1,954	2,246	2,462	2,830	2,670	3,070	2,485	2,858	2,507	2,883	2,682	3,082	2,498	2,870
94	1,967	2,261	2,477	2,848	2,685	3,089	2,501	2,877	2,523	2,902	2,697	3,101	2,515	2,890
95	1,978	2,274	2,492	2,866	2,699	3,105	2,516	2,893	2,538	2,918	2,713	3,117	2,528	2,905
96	1,989	2,287	2,506	2,882	2,715	3,123	2,531	2,911	2,553	2,936	2,728	3,135	2,543	2,923
97	2,000	2,301	2,520	2,900	2,730	3,138	2,545	2,927	2,569	2,954	2,742	3,152	2,559	2,939
98	2,013	2,313	2,536	2,916	2,745	3,156	2,561	2,945	2,583	2,971	2,758	3,169	2,573	2,957
99	2,024	2,328	2,551	2,933	2,760	3,174	2,576	2,962	2,598	2,989	2,773	3,187	2,588	2,974

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 PENNSYLVANIA ZIP CODES
189-194

Attained Age	Plan A		Plan B		Plan C		Plan D		Plan E		Plan F		Plan G	
	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male
0-64 (Underwritten)	2,017	2,321	2,543	2,924	2,774	3,190	2,569	2,954	2,591	2,980	2,786	3,203	2,581	2,966
0-64 (Open Enrollee)	1,176	1,352	1,481	1,704	1,687	1,942	1,496	1,720	1,510	1,736	1,701	1,954	1,508	1,733
65	1,176	1,352	1,481	1,704	1,687	1,942	1,496	1,720	1,510	1,736	1,701	1,954	1,508	1,733
66	1,236	1,422	1,558	1,792	1,761	2,024	1,573	1,810	1,586	1,825	1,773	2,036	1,585	1,822
67	1,299	1,494	1,637	1,882	1,841	2,116	1,653	1,900	1,667	1,917	1,854	2,130	1,665	1,913
68	1,353	1,557	1,705	1,961	1,923	2,211	1,722	1,980	1,737	1,998	1,935	2,223	1,735	1,992
69	1,415	1,627	1,782	2,049	2,001	2,301	1,800	2,069	1,815	2,087	2,014	2,313	1,812	2,081
70	1,470	1,691	1,852	2,131	2,077	2,388	1,871	2,152	1,888	2,170	2,089	2,400	1,883	2,165
71	1,526	1,756	1,924	2,212	2,149	2,472	1,943	2,233	1,959	2,252	2,162	2,484	1,955	2,246
72	1,579	1,816	1,990	2,289	2,218	2,550	2,009	2,311	2,026	2,331	2,230	2,562	2,022	2,323
73	1,629	1,873	2,053	2,360	2,280	2,622	2,072	2,384	2,090	2,406	2,292	2,635	2,086	2,397
74	1,675	1,927	2,112	2,429	2,340	2,691	2,133	2,453	2,151	2,474	2,353	2,704	2,146	2,465
75	1,718	1,977	2,166	2,490	2,395	2,753	2,187	2,515	2,206	2,537	2,408	2,767	2,200	2,527
76	1,758	2,022	2,214	2,547	2,445	2,813	2,237	2,572	2,256	2,595	2,457	2,825	2,250	2,585
77	1,795	2,066	2,263	2,603	2,498	2,873	2,285	2,627	2,305	2,650	2,510	2,885	2,297	2,640
78	1,830	2,104	2,306	2,652	2,543	2,924	2,329	2,679	2,349	2,702	2,555	2,937	2,341	2,691
79	1,862	2,142	2,346	2,698	2,586	2,973	2,368	2,725	2,390	2,749	2,598	2,985	2,382	2,738
80	1,892	2,176	2,384	2,742	2,619	3,012	2,408	2,769	2,429	2,793	2,632	3,025	2,420	2,782
81	1,920	2,207	2,419	2,782	2,652	3,049	2,443	2,809	2,464	2,833	2,665	3,062	2,455	2,822
82	1,945	2,237	2,452	2,819	2,685	3,088	2,475	2,847	2,497	2,872	2,697	3,100	2,488	2,859
83	1,970	2,266	2,483	2,856	2,715	3,123	2,507	2,883	2,529	2,908	2,728	3,135	2,519	2,895
84	1,995	2,294	2,514	2,891	2,745	3,158	2,538	2,919	2,561	2,945	2,758	3,170	2,551	2,932
85	2,017	2,321	2,543	2,924	2,774	3,190	2,569	2,954	2,591	2,980	2,786	3,203	2,581	2,966
86	2,041	2,346	2,572	2,957	2,802	3,222	2,597	2,985	2,619	3,012	2,814	3,234	2,609	2,999
87	2,063	2,372	2,598	2,989	2,828	3,252	2,625	3,018	2,648	3,045	2,840	3,264	2,637	3,031
88	2,083	2,395	2,625	3,018	2,853	3,281	2,651	3,048	2,673	3,075	2,866	3,295	2,663	3,061
89	2,103	2,418	2,650	3,047	2,878	3,309	2,676	3,078	2,698	3,104	2,891	3,322	2,688	3,090
90	2,122	2,439	2,673	3,073	2,902	3,339	2,699	3,105	2,723	3,132	2,914	3,351	2,713	3,117
91	2,140	2,460	2,695	3,099	2,926	3,365	2,721	3,130	2,745	3,158	2,938	3,377	2,734	3,143
92	2,156	2,478	2,715	3,123	2,947	3,388	2,742	3,154	2,767	3,181	2,959	3,401	2,756	3,167
93	2,170	2,496	2,735	3,145	2,966	3,411	2,761	3,177	2,785	3,204	2,979	3,423	2,774	3,189
94	2,185	2,511	2,752	3,165	2,983	3,431	2,779	3,197	2,804	3,224	2,995	3,443	2,792	3,209
95	2,197	2,527	2,768	3,183	3,000	3,450	2,795	3,215	2,820	3,243	3,012	3,463	2,807	3,227
96	2,210	2,542	2,784	3,201	3,016	3,468	2,812	3,234	2,837	3,262	3,028	3,482	2,824	3,246
97	2,223	2,555	2,801	3,221	3,034	3,487	2,829	3,253	2,853	3,280	3,046	3,500	2,841	3,266
98	2,236	2,571	2,818	3,241	3,049	3,508	2,846	3,271	2,870	3,300	3,062	3,520	2,858	3,285
99	2,250	2,587	2,834	3,259	3,066	3,527	2,861	3,292	2,886	3,320	3,079	3,539	2,874	3,304

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 PENNSYLVANIA ZIP CODES
150-154, 156

Attained Age	Plan A		Plan B		Plan C		Plan D		Plan E		Plan F		Plan G	
	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male
0-64 (Underwritten)	1,651	1,899	2,081	2,393	2,270	2,611	2,101	2,417	2,119	2,437	2,281	2,622	2,112	2,428
0-64 (Open Enrollee)	962	1,106	1,212	1,394	1,381	1,588	1,224	1,408	1,235	1,420	1,392	1,599	1,236	1,419
65	962	1,106	1,212	1,394	1,381	1,588	1,224	1,408	1,235	1,420	1,392	1,599	1,236	1,419
66	1,011	1,163	1,275	1,466	1,440	1,656	1,287	1,480	1,298	1,493	1,451	1,668	1,298	1,491
67	1,062	1,222	1,338	1,539	1,506	1,732	1,352	1,555	1,363	1,569	1,517	1,743	1,363	1,566
68	1,107	1,273	1,395	1,604	1,573	1,809	1,409	1,620	1,422	1,634	1,585	1,821	1,420	1,631
69	1,157	1,330	1,458	1,676	1,637	1,883	1,472	1,693	1,484	1,708	1,648	1,895	1,483	1,704
70	1,203	1,383	1,516	1,743	1,699	1,954	1,531	1,760	1,544	1,776	1,710	1,965	1,542	1,772
71	1,248	1,436	1,573	1,809	1,759	2,022	1,589	1,827	1,603	1,843	1,770	2,034	1,601	1,839
72	1,292	1,485	1,628	1,872	1,814	2,086	1,644	1,890	1,659	1,907	1,825	2,098	1,655	1,902
73	1,333	1,533	1,679	1,931	1,865	2,144	1,696	1,951	1,711	1,968	1,876	2,156	1,708	1,962
74	1,371	1,577	1,728	1,987	1,914	2,201	1,745	2,006	1,760	2,024	1,925	2,213	1,757	2,018
75	1,406	1,617	1,772	2,037	1,960	2,254	1,789	2,058	1,805	2,075	1,971	2,265	1,800	2,069
76	1,438	1,654	1,811	2,084	2,001	2,301	1,830	2,104	1,846	2,123	2,012	2,312	1,841	2,116
77	1,469	1,689	1,851	2,128	2,044	2,351	1,870	2,150	1,886	2,168	2,055	2,362	1,881	2,161
78	1,498	1,723	1,887	2,169	2,081	2,393	1,905	2,191	1,922	2,210	2,092	2,404	1,916	2,202
79	1,523	1,752	1,920	2,207	2,116	2,433	1,938	2,230	1,955	2,249	2,127	2,444	1,949	2,241
80	1,548	1,781	1,951	2,244	2,143	2,465	1,970	2,265	1,987	2,286	2,155	2,476	1,981	2,277
81	1,571	1,806	1,979	2,275	2,171	2,495	1,998	2,298	2,016	2,318	2,182	2,507	2,010	2,310
82	1,591	1,830	2,005	2,306	2,197	2,526	2,025	2,329	2,043	2,350	2,208	2,538	2,036	2,340
83	1,612	1,854	2,031	2,336	2,222	2,555	2,051	2,359	2,069	2,379	2,233	2,566	2,062	2,370
84	1,632	1,876	2,057	2,364	2,246	2,583	2,077	2,388	2,094	2,409	2,257	2,595	2,088	2,400
85	1,651	1,899	2,081	2,393	2,270	2,611	2,101	2,417	2,119	2,437	2,281	2,622	2,112	2,428
86	1,670	1,920	2,103	2,419	2,293	2,636	2,125	2,443	2,143	2,465	2,304	2,647	2,136	2,454
87	1,687	1,940	2,126	2,445	2,313	2,661	2,148	2,469	2,166	2,491	2,324	2,672	2,159	2,481
88	1,704	1,960	2,148	2,469	2,335	2,685	2,168	2,494	2,188	2,516	2,346	2,696	2,180	2,506
89	1,720	1,979	2,168	2,493	2,355	2,708	2,189	2,517	2,208	2,540	2,367	2,719	2,200	2,529
90	1,736	1,996	2,187	2,515	2,375	2,730	2,208	2,540	2,228	2,562	2,386	2,742	2,220	2,551
91	1,750	2,012	2,205	2,535	2,393	2,752	2,226	2,560	2,246	2,583	2,404	2,763	2,238	2,572
92	1,764	2,028	2,222	2,555	2,411	2,772	2,244	2,580	2,263	2,603	2,423	2,784	2,255	2,591
93	1,776	2,042	2,238	2,573	2,427	2,791	2,259	2,598	2,279	2,621	2,438	2,802	2,271	2,609
94	1,788	2,055	2,252	2,589	2,441	2,808	2,274	2,615	2,294	2,638	2,452	2,819	2,286	2,627
95	1,798	2,067	2,265	2,605	2,454	2,823	2,287	2,630	2,307	2,653	2,466	2,834	2,298	2,641
96	1,808	2,079	2,278	2,620	2,468	2,839	2,301	2,646	2,321	2,669	2,480	2,850	2,312	2,657
97	1,818	2,092	2,291	2,636	2,482	2,853	2,314	2,661	2,335	2,685	2,493	2,865	2,326	2,672
98	1,830	2,103	2,305	2,651	2,495	2,869	2,328	2,677	2,348	2,701	2,507	2,881	2,339	2,688
99	1,840	2,116	2,319	2,666	2,509	2,885	2,342	2,693	2,362	2,717	2,521	2,897	2,353	2,704

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 PENNSYLVANIA ZIP CODES
150-154, 156

Attained Age	Plan A		Plan B		Plan C		Plan D		Plan E		Plan F		Plan G	
	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male
0-64 (Underwritten)	1,834	2,110	2,312	2,658	2,522	2,900	2,335	2,685	2,355	2,709	2,533	2,912	2,346	2,696
0-64 (Open Enrollee)	1,069	1,229	1,346	1,549	1,534	1,765	1,360	1,564	1,373	1,578	1,546	1,776	1,371	1,575
65	1,069	1,229	1,346	1,549	1,534	1,765	1,360	1,564	1,373	1,578	1,546	1,776	1,371	1,575
66	1,124	1,293	1,416	1,629	1,601	1,840	1,430	1,645	1,442	1,659	1,612	1,851	1,441	1,656
67	1,181	1,358	1,488	1,711	1,674	1,924	1,503	1,727	1,515	1,743	1,685	1,936	1,514	1,739
68	1,230	1,415	1,550	1,783	1,748	2,010	1,565	1,800	1,579	1,816	1,759	2,021	1,577	1,811
69	1,286	1,479	1,620	1,863	1,819	2,092	1,636	1,881	1,650	1,897	1,831	2,103	1,647	1,892
70	1,336	1,537	1,684	1,937	1,888	2,171	1,701	1,956	1,716	1,973	1,899	2,182	1,712	1,968
71	1,387	1,596	1,749	2,011	1,954	2,247	1,766	2,030	1,781	2,047	1,965	2,258	1,777	2,042
72	1,435	1,651	1,809	2,081	2,016	2,318	1,826	2,101	1,842	2,119	2,027	2,329	1,838	2,112
73	1,481	1,703	1,866	2,145	2,073	2,384	1,884	2,167	1,900	2,187	2,084	2,395	1,896	2,179
74	1,523	1,752	1,920	2,208	2,127	2,446	1,939	2,230	1,955	2,249	2,139	2,458	1,951	2,241
75	1,562	1,797	1,969	2,264	2,177	2,503	1,988	2,286	2,005	2,306	2,189	2,515	2,000	2,297
76	1,598	1,838	2,013	2,315	2,223	2,557	2,034	2,338	2,051	2,359	2,234	2,568	2,045	2,350
77	1,632	1,878	2,057	2,366	2,271	2,612	2,077	2,388	2,095	2,409	2,282	2,623	2,088	2,400
78	1,664	1,913	2,096	2,411	2,312	2,658	2,117	2,435	2,135	2,456	2,323	2,670	2,128	2,446
79	1,693	1,947	2,133	2,453	2,351	2,703	2,153	2,477	2,173	2,499	2,362	2,714	2,165	2,489
80	1,720	1,978	2,167	2,493	2,381	2,738	2,189	2,517	2,208	2,539	2,393	2,750	2,200	2,529
81	1,745	2,006	2,199	2,529	2,411	2,772	2,221	2,554	2,240	2,575	2,423	2,784	2,232	2,565
82	1,768	2,034	2,229	2,563	2,441	2,807	2,250	2,588	2,270	2,611	2,452	2,818	2,262	2,599
83	1,791	2,060	2,257	2,596	2,468	2,839	2,279	2,621	2,299	2,644	2,480	2,850	2,290	2,632
84	1,814	2,085	2,285	2,628	2,495	2,871	2,307	2,654	2,328	2,677	2,507	2,882	2,319	2,665
85	1,834	2,110	2,312	2,658	2,522	2,900	2,335	2,685	2,355	2,709	2,533	2,912	2,346	2,696
86	1,855	2,133	2,338	2,688	2,547	2,929	2,361	2,714	2,381	2,738	2,558	2,940	2,372	2,726
87	1,875	2,156	2,362	2,717	2,571	2,956	2,386	2,744	2,407	2,768	2,582	2,967	2,397	2,755
88	1,894	2,177	2,386	2,744	2,594	2,983	2,410	2,771	2,430	2,795	2,605	2,995	2,421	2,783
89	1,912	2,198	2,409	2,770	2,616	3,008	2,433	2,798	2,453	2,822	2,628	3,020	2,444	2,809
90	1,929	2,217	2,430	2,794	2,638	3,035	2,454	2,823	2,475	2,847	2,649	3,046	2,466	2,834
91	1,945	2,236	2,450	2,817	2,660	3,059	2,474	2,845	2,495	2,871	2,671	3,070	2,485	2,857
92	1,960	2,253	2,468	2,839	2,679	3,080	2,493	2,867	2,515	2,892	2,690	3,092	2,505	2,879
93	1,973	2,269	2,486	2,859	2,696	3,101	2,510	2,888	2,532	2,913	2,708	3,112	2,522	2,899
94	1,986	2,283	2,502	2,877	2,712	3,119	2,526	2,906	2,549	2,931	2,723	3,130	2,538	2,917
95	1,997	2,297	2,516	2,894	2,727	3,136	2,541	2,923	2,564	2,948	2,738	3,148	2,552	2,934
96	2,009	2,311	2,531	2,910	2,742	3,153	2,556	2,940	2,579	2,965	2,753	3,165	2,567	2,951
97	2,021	2,323	2,546	2,928	2,758	3,170	2,572	2,957	2,594	2,982	2,769	3,182	2,583	2,969
98	2,033	2,337	2,562	2,946	2,772	3,189	2,587	2,974	2,609	3,000	2,784	3,200	2,598	2,986
99	2,045	2,352	2,576	2,963	2,787	3,206	2,601	2,993	2,624	3,018	2,799	3,217	2,613	3,004

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 PENNSYLVANIA ZIP CODES
ALL EXCEPT 150-154, 156, 189-194

Attained Age	Plan A		Plan B		Plan C		Plan D		Plan E		Plan F		Plan G	
	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male
0-64 (Underwritten)	1,486	1,709	1,873	2,154	2,043	2,350	1,891	2,175	1,907	2,193	2,053	2,360	1,901	2,185
0-64 (Open Enrollee)	866	995	1,091	1,255	1,243	1,429	1,102	1,267	1,112	1,278	1,253	1,439	1,112	1,277
65	866	995	1,091	1,255	1,243	1,429	1,102	1,267	1,112	1,278	1,253	1,439	1,112	1,277
66	910	1,047	1,148	1,319	1,296	1,490	1,158	1,332	1,168	1,344	1,306	1,501	1,168	1,342
67	956	1,100	1,204	1,385	1,355	1,559	1,217	1,400	1,227	1,412	1,365	1,569	1,227	1,409
68	996	1,146	1,256	1,444	1,416	1,628	1,268	1,458	1,280	1,471	1,427	1,639	1,278	1,468
69	1,041	1,197	1,312	1,508	1,473	1,695	1,325	1,524	1,336	1,537	1,483	1,706	1,335	1,534
70	1,083	1,245	1,364	1,569	1,529	1,759	1,378	1,584	1,390	1,598	1,539	1,769	1,388	1,595
71	1,123	1,292	1,416	1,628	1,583	1,820	1,430	1,644	1,443	1,659	1,593	1,831	1,441	1,655
72	1,163	1,337	1,465	1,685	1,633	1,877	1,480	1,701	1,493	1,716	1,643	1,888	1,490	1,712
73	1,200	1,380	1,511	1,738	1,679	1,930	1,526	1,756	1,540	1,771	1,688	1,940	1,537	1,766
74	1,234	1,419	1,555	1,788	1,723	1,981	1,571	1,805	1,584	1,822	1,733	1,992	1,581	1,816
75	1,265	1,455	1,595	1,833	1,764	2,029	1,610	1,852	1,625	1,868	1,774	2,039	1,620	1,862
76	1,294	1,489	1,630	1,876	1,801	2,071	1,647	1,894	1,661	1,911	1,811	2,081	1,657	1,904
77	1,322	1,520	1,666	1,915	1,840	2,116	1,683	1,935	1,697	1,951	1,850	2,126	1,693	1,945
78	1,348	1,551	1,698	1,952	1,873	2,154	1,715	1,972	1,730	1,989	1,883	2,164	1,724	1,982
79	1,371	1,577	1,728	1,986	1,904	2,190	1,744	2,007	1,760	2,024	1,914	2,200	1,754	2,017
80	1,393	1,603	1,756	2,020	1,929	2,219	1,773	2,039	1,788	2,057	1,940	2,228	1,783	2,049
81	1,414	1,625	1,781	2,048	1,954	2,246	1,798	2,068	1,814	2,086	1,964	2,256	1,809	2,079
82	1,432	1,647	1,805	2,075	1,977	2,273	1,823	2,096	1,839	2,115	1,987	2,284	1,832	2,106
83	1,451	1,669	1,828	2,102	2,000	2,300	1,846	2,123	1,862	2,141	2,010	2,309	1,856	2,133
84	1,469	1,688	1,851	2,128	2,021	2,325	1,869	2,149	1,885	2,168	2,031	2,336	1,879	2,160
85	1,486	1,709	1,873	2,154	2,043	2,350	1,891	2,175	1,907	2,193	2,053	2,360	1,901	2,185
86	1,503	1,728	1,893	2,177	2,064	2,372	1,913	2,199	1,929	2,219	2,074	2,382	1,922	2,209
87	1,518	1,746	1,913	2,201	2,082	2,395	1,933	2,222	1,949	2,242	2,092	2,405	1,943	2,233
88	1,534	1,764	1,933	2,222	2,102	2,417	1,951	2,245	1,969	2,264	2,111	2,426	1,962	2,255
89	1,548	1,781	1,951	2,244	2,120	2,437	1,970	2,265	1,987	2,286	2,130	2,447	1,980	2,276
90	1,562	1,796	1,968	2,264	2,138	2,457	1,987	2,286	2,005	2,306	2,147	2,468	1,998	2,296
91	1,575	1,811	1,985	2,282	2,154	2,477	2,003	2,304	2,021	2,325	2,164	2,487	2,014	2,315
92	1,588	1,825	2,000	2,300	2,170	2,495	2,020	2,322	2,037	2,343	2,181	2,506	2,030	2,332
93	1,598	1,838	2,014	2,316	2,184	2,512	2,033	2,338	2,051	2,359	2,194	2,522	2,044	2,348
94	1,609	1,850	2,027	2,330	2,197	2,527	2,047	2,354	2,065	2,374	2,207	2,537	2,057	2,364
95	1,618	1,860	2,039	2,345	2,209	2,541	2,058	2,367	2,076	2,388	2,219	2,551	2,068	2,377
96	1,627	1,871	2,050	2,358	2,221	2,555	2,071	2,381	2,089	2,402	2,232	2,565	2,081	2,391
97	1,636	1,883	2,062	2,372	2,234	2,568	2,083	2,395	2,102	2,417	2,244	2,579	2,093	2,405
98	1,647	1,893	2,075	2,386	2,246	2,582	2,095	2,409	2,113	2,431	2,256	2,593	2,105	2,419
99	1,656	1,904	2,087	2,399	2,258	2,597	2,108	2,424	2,126	2,445	2,269	2,607	2,118	2,434

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 PENNSYLVANIA ZIP CODES
ALL EXCEPT 150-154, 156, 189-194

Attained Age	Plan A		Plan B		Plan C		Plan D		Plan E		Plan F		Plan G	
	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male
0-64 (Underwritten)	1,651	1,899	2,081	2,392	2,270	2,610	2,102	2,417	2,120	2,438	2,280	2,621	2,111	2,426
0-64 (Open Enrollee)	962	1,106	1,211	1,394	1,381	1,589	1,224	1,408	1,236	1,420	1,391	1,598	1,234	1,418
65	962	1,106	1,211	1,394	1,381	1,589	1,224	1,408	1,236	1,420	1,391	1,598	1,234	1,418
66	1,012	1,164	1,274	1,466	1,441	1,656	1,287	1,481	1,298	1,493	1,451	1,666	1,297	1,490
67	1,063	1,222	1,339	1,540	1,507	1,732	1,353	1,554	1,364	1,569	1,517	1,742	1,363	1,565
68	1,107	1,274	1,395	1,605	1,573	1,809	1,409	1,620	1,421	1,634	1,583	1,819	1,419	1,630
69	1,157	1,331	1,458	1,677	1,637	1,883	1,472	1,693	1,485	1,707	1,648	1,893	1,482	1,703
70	1,202	1,383	1,516	1,743	1,699	1,954	1,531	1,760	1,544	1,776	1,709	1,964	1,541	1,771
71	1,248	1,436	1,574	1,810	1,759	2,022	1,589	1,827	1,603	1,842	1,769	2,032	1,599	1,838
72	1,292	1,486	1,628	1,873	1,814	2,086	1,643	1,891	1,658	1,907	1,824	2,096	1,654	1,901
73	1,333	1,533	1,679	1,931	1,866	2,146	1,696	1,950	1,710	1,968	1,876	2,156	1,706	1,961
74	1,371	1,577	1,728	1,987	1,914	2,201	1,745	2,007	1,760	2,024	1,925	2,212	1,756	2,017
75	1,406	1,617	1,772	2,038	1,959	2,253	1,789	2,057	1,805	2,075	1,970	2,264	1,800	2,067
76	1,438	1,654	1,812	2,084	2,001	2,301	1,831	2,104	1,846	2,123	2,011	2,311	1,841	2,115
77	1,469	1,690	1,851	2,129	2,044	2,351	1,869	2,149	1,886	2,168	2,054	2,361	1,879	2,160
78	1,498	1,722	1,886	2,170	2,081	2,392	1,905	2,192	1,922	2,210	2,091	2,403	1,915	2,201
79	1,524	1,752	1,920	2,208	2,116	2,433	1,938	2,229	1,956	2,249	2,126	2,443	1,949	2,240
80	1,548	1,780	1,950	2,244	2,143	2,464	1,970	2,265	1,987	2,285	2,154	2,475	1,980	2,276
81	1,571	1,805	1,979	2,276	2,170	2,495	1,999	2,299	2,016	2,318	2,181	2,506	2,009	2,309
82	1,591	1,831	2,006	2,307	2,197	2,526	2,025	2,329	2,043	2,350	2,207	2,536	2,036	2,339
83	1,612	1,854	2,031	2,336	2,221	2,555	2,051	2,359	2,069	2,380	2,232	2,565	2,061	2,369
84	1,633	1,877	2,057	2,365	2,246	2,584	2,076	2,389	2,095	2,409	2,256	2,594	2,087	2,399
85	1,651	1,899	2,081	2,392	2,270	2,610	2,102	2,417	2,120	2,438	2,280	2,621	2,111	2,426
86	1,670	1,920	2,104	2,419	2,292	2,636	2,125	2,443	2,143	2,464	2,302	2,646	2,135	2,453
87	1,688	1,940	2,126	2,445	2,314	2,660	2,147	2,470	2,166	2,491	2,324	2,670	2,157	2,480
88	1,705	1,959	2,147	2,470	2,335	2,685	2,169	2,494	2,187	2,516	2,345	2,696	2,179	2,505
89	1,721	1,978	2,168	2,493	2,354	2,707	2,190	2,518	2,208	2,540	2,365	2,718	2,200	2,528
90	1,736	1,995	2,187	2,515	2,374	2,732	2,209	2,541	2,228	2,562	2,384	2,741	2,219	2,551
91	1,751	2,012	2,205	2,535	2,394	2,753	2,227	2,561	2,246	2,584	2,404	2,763	2,237	2,571
92	1,764	2,028	2,221	2,555	2,411	2,772	2,244	2,580	2,264	2,603	2,421	2,783	2,255	2,591
93	1,776	2,042	2,237	2,573	2,426	2,791	2,259	2,599	2,279	2,622	2,437	2,801	2,270	2,609
94	1,787	2,055	2,252	2,589	2,441	2,807	2,273	2,615	2,294	2,638	2,451	2,817	2,284	2,625
95	1,797	2,067	2,264	2,605	2,454	2,822	2,287	2,631	2,308	2,653	2,464	2,833	2,297	2,641
96	1,808	2,080	2,278	2,619	2,468	2,838	2,300	2,646	2,321	2,669	2,478	2,849	2,310	2,656
97	1,819	2,091	2,291	2,635	2,482	2,853	2,315	2,661	2,335	2,684	2,492	2,864	2,325	2,672
98	1,830	2,103	2,306	2,651	2,495	2,870	2,328	2,677	2,348	2,700	2,506	2,880	2,338	2,687
99	1,841	2,117	2,318	2,667	2,508	2,885	2,341	2,694	2,362	2,716	2,519	2,895	2,352	2,704

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