

♦ 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	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 A Deductible
		Part B 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%)	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	Foreign Travel Emergency
			At-Home Recovery				At-Home Recovery		At-Home Recovery	At-Home Recovery	At-Home Recovery
				Preventive Care NOT covered by Medicare						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.

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 TENNESSEE ZIP CODES 372, 374, 379, 381

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
65	932	1,072	1,174	1,350	1,321	1,519	1,186	1,364	1,196	1,376	1,364	1,569	1,213	1,395
66	932	1,072	1,174	1,350	1,321	1,519	1,186	1,364	1,196	1,376	1,364	1,569	1,213	1,395
67	932	1,072	1,174	1,350	1,321	1,519	1,186	1,364	1,196	1,376	1,364	1,569	1,213	1,395
68	971	1,117	1,224	1,407	1,380	1,587	1,236	1,421	1,247	1,433	1,421	1,634	1,264	1,454
69	1,015	1,167	1,279	1,470	1,436	1,652	1,291	1,485	1,302	1,498	1,477	1,698	1,321	1,519
70	1,055	1,213	1,330	1,529	1,490	1,714	1,343	1,544	1,354	1,558	1,531	1,761	1,373	1,579
71	1,095	1,260	1,380	1,587	1,543	1,774	1,394	1,603	1,406	1,617	1,584	1,821	1,426	1,639
72	1,133	1,303	1,428	1,642	1,591	1,830	1,442	1,658	1,455	1,673	1,634	1,879	1,475	1,696
73	1,169	1,345	1,473	1,694	1,636	1,881	1,488	1,711	1,501	1,726	1,678	1,930	1,522	1,750
74	1,203	1,383	1,516	1,743	1,679	1,931	1,531	1,760	1,544	1,775	1,721	1,979	1,565	1,800
75	1,233	1,418	1,554	1,787	1,719	1,977	1,569	1,805	1,583	1,820	1,760	2,024	1,605	1,846
76	1,261	1,451	1,589	1,828	1,755	2,018	1,605	1,846	1,619	1,862	1,793	2,062	1,642	1,888
77	1,289	1,482	1,624	1,867	1,793	2,062	1,640	1,886	1,654	1,902	1,825	2,099	1,677	1,929
78	1,314	1,511	1,655	1,903	1,825	2,099	1,671	1,922	1,686	1,939	1,853	2,131	1,710	1,966
79	1,336	1,537	1,684	1,936	1,856	2,134	1,700	1,956	1,715	1,973	1,879	2,161	1,739	2,000
80	1,358	1,562	1,711	1,968	1,880	2,162	1,728	1,987	1,743	2,005	1,903	2,188	1,767	2,033
81	1,378	1,584	1,736	1,996	1,904	2,189	1,753	2,016	1,768	2,033	1,928	2,217	1,793	2,062
82	1,396	1,605	1,759	2,023	1,927	2,216	1,776	2,043	1,792	2,061	1,952	2,245	1,817	2,089
83	1,414	1,626	1,782	2,049	1,949	2,241	1,799	2,069	1,815	2,087	1,976	2,272	1,840	2,116
84	1,432	1,646	1,804	2,074	1,970	2,266	1,822	2,095	1,837	2,113	1,999	2,298	1,863	2,143
85	1,448	1,666	1,825	2,099	1,991	2,290	1,843	2,120	1,859	2,138	2,021	2,324	1,885	2,168
86	1,465	1,684	1,845	2,122	2,011	2,312	1,864	2,143	1,880	2,162	2,042	2,348	1,906	2,192
87	1,480	1,702	1,865	2,145	2,029	2,334	1,884	2,166	1,900	2,185	2,062	2,371	1,926	2,215
88	1,495	1,719	1,884	2,166	2,048	2,355	1,902	2,188	1,919	2,207	2,081	2,393	1,946	2,238
89	1,509	1,736	1,902	2,187	2,066	2,375	1,920	2,208	1,937	2,228	2,099	2,414	1,964	2,259
90	1,523	1,751	1,918	2,206	2,083	2,395	1,937	2,228	1,954	2,247	2,116	2,433	1,982	2,279
91	1,535	1,765	1,934	2,224	2,099	2,414	1,953	2,246	1,970	2,266	2,132	2,451	1,998	2,297
92	1,547	1,779	1,949	2,241	2,115	2,432	1,968	2,263	1,985	2,283	2,146	2,468	2,013	2,315
93	1,558	1,791	1,963	2,257	2,129	2,448	1,982	2,279	1,999	2,299	2,160	2,484	2,027	2,331
94	1,568	1,803	1,975	2,271	2,141	2,463	1,995	2,294	2,012	2,314	2,172	2,498	2,040	2,346
95	1,577	1,813	1,987	2,285	2,153	2,476	2,006	2,307	2,024	2,327	2,183	2,510	2,052	2,360
96	1,586	1,824	1,998	2,298	2,165	2,490	2,018	2,321	2,036	2,341	2,194	2,523	2,064	2,374
97	1,595	1,835	2,010	2,312	2,177	2,503	2,030	2,334	2,048	2,355	2,205	2,536	2,076	2,388
98	1,605	1,845	2,022	2,325	2,189	2,517	2,042	2,348	2,060	2,369	2,216	2,549	2,089	2,402
99	1,614	1,856	2,034	2,339	2,201	2,531	2,054	2,362	2,072	2,383	2,228	2,562	2,101	2,416

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 TENNESSEE ZIP CODES 372, 374, 379, 381

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
65	1,036	1,191	1,305	1,501	1,468	1,688	1,318	1,515	1,329	1,529	1,516	1,743	1,348	1,550
66	1,036	1,191	1,305	1,501	1,468	1,688	1,318	1,515	1,329	1,529	1,516	1,743	1,348	1,550
67	1,036	1,191	1,305	1,501	1,468	1,688	1,318	1,515	1,329	1,529	1,516	1,743	1,348	1,550
68	1,079	1,241	1,360	1,564	1,533	1,763	1,373	1,579	1,385	1,593	1,579	1,816	1,404	1,615
69	1,128	1,297	1,421	1,634	1,596	1,835	1,435	1,650	1,447	1,664	1,641	1,887	1,467	1,688
70	1,172	1,348	1,477	1,699	1,656	1,904	1,492	1,716	1,505	1,731	1,701	1,956	1,526	1,755
71	1,217	1,400	1,534	1,764	1,714	1,971	1,549	1,781	1,562	1,796	1,760	2,024	1,584	1,822
72	1,259	1,448	1,587	1,825	1,768	2,033	1,602	1,843	1,616	1,859	1,815	2,087	1,639	1,885
73	1,299	1,494	1,637	1,882	1,818	2,091	1,653	1,901	1,667	1,918	1,864	2,144	1,691	1,944
74	1,336	1,537	1,684	1,937	1,866	2,146	1,701	1,956	1,715	1,973	1,912	2,199	1,739	2,000
75	1,370	1,576	1,727	1,986	1,910	2,196	1,744	2,005	1,759	2,023	1,955	2,249	1,783	2,051
76	1,402	1,612	1,766	2,031	1,950	2,243	1,784	2,051	1,799	2,069	1,992	2,291	1,824	2,098
77	1,432	1,647	1,804	2,075	1,992	2,291	1,822	2,095	1,838	2,113	2,028	2,332	1,863	2,143
78	1,460	1,678	1,839	2,115	2,028	2,332	1,857	2,136	1,873	2,154	2,059	2,368	1,900	2,184
79	1,485	1,708	1,871	2,152	2,062	2,371	1,889	2,173	1,906	2,192	2,088	2,401	1,932	2,222
80	1,509	1,735	1,901	2,187	2,089	2,402	1,920	2,208	1,937	2,227	2,114	2,431	1,964	2,258
81	1,531	1,760	1,929	2,218	2,115	2,432	1,948	2,240	1,965	2,259	2,142	2,463	1,992	2,291
82	1,551	1,784	1,955	2,248	2,141	2,462	1,974	2,270	1,991	2,290	2,169	2,494	2,019	2,322
83	1,571	1,807	1,980	2,277	2,165	2,490	1,999	2,299	2,017	2,319	2,195	2,525	2,045	2,352
84	1,591	1,829	2,004	2,305	2,189	2,518	2,024	2,328	2,042	2,348	2,221	2,554	2,070	2,381
85	1,609	1,851	2,028	2,332	2,212	2,544	2,048	2,355	2,066	2,376	2,245	2,582	2,095	2,409
86	1,627	1,871	2,051	2,358	2,234	2,569	2,071	2,381	2,089	2,402	2,269	2,609	2,118	2,436
87	1,645	1,891	2,072	2,383	2,255	2,593	2,093	2,407	2,111	2,428	2,291	2,635	2,140	2,462
88	1,661	1,910	2,093	2,407	2,275	2,617	2,114	2,431	2,132	2,452	2,312	2,659	2,162	2,486
89	1,677	1,928	2,113	2,430	2,295	2,639	2,134	2,454	2,152	2,475	2,332	2,682	2,182	2,510
90	1,692	1,945	2,132	2,451	2,314	2,662	2,153	2,476	2,171	2,497	2,351	2,704	2,202	2,532
91	1,706	1,961	2,149	2,471	2,333	2,683	2,170	2,496	2,189	2,518	2,368	2,724	2,220	2,553
92	1,719	1,976	2,165	2,490	2,350	2,702	2,187	2,515	2,206	2,537	2,385	2,742	2,237	2,572
93	1,731	1,990	2,181	2,508	2,365	2,720	2,202	2,533	2,221	2,555	2,400	2,760	2,252	2,590
94	1,742	2,003	2,195	2,524	2,379	2,736	2,216	2,549	2,236	2,571	2,413	2,775	2,267	2,607
95	1,752	2,015	2,207	2,539	2,392	2,751	2,229	2,564	2,249	2,586	2,425	2,789	2,280	2,622
96	1,762	2,027	2,220	2,553	2,405	2,766	2,242	2,579	2,262	2,601	2,438	2,803	2,293	2,637
97	1,773	2,038	2,233	2,568	2,419	2,781	2,256	2,594	2,275	2,616	2,450	2,818	2,307	2,653
98	1,783	2,050	2,247	2,584	2,432	2,797	2,269	2,609	2,289	2,632	2,463	2,832	2,321	2,669
99	1,794	2,063	2,260	2,599	2,445	2,812	2,282	2,625	2,302	2,647	2,475	2,847	2,334	2,684

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 ALL TENNESSEE ZIP CODES EXCEPT 372, 374, 379, 381

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
65	839	965	1,057	1,215	1,189	1,367	1,067	1,228	1,076	1,238	1,228	1,412	1,092	1,256
66	839	965	1,057	1,215	1,189	1,367	1,067	1,228	1,076	1,238	1,228	1,412	1,092	1,256
67	839	965	1,057	1,215	1,189	1,367	1,067	1,228	1,076	1,238	1,228	1,412	1,092	1,256
68	874	1,005	1,102	1,266	1,242	1,428	1,112	1,279	1,122	1,290	1,279	1,471	1,138	1,309
69	914	1,050	1,151	1,323	1,292	1,487	1,162	1,337	1,172	1,348	1,329	1,528	1,189	1,367
70	950	1,092	1,197	1,376	1,341	1,543	1,209	1,390	1,219	1,402	1,378	1,585	1,236	1,421
71	986	1,134	1,242	1,428	1,389	1,597	1,255	1,443	1,265	1,455	1,426	1,639	1,283	1,475
72	1,020	1,173	1,285	1,478	1,432	1,647	1,298	1,492	1,310	1,506	1,471	1,691	1,328	1,526
73	1,052	1,211	1,326	1,525	1,472	1,693	1,339	1,540	1,351	1,553	1,510	1,737	1,370	1,575
74	1,083	1,245	1,364	1,569	1,511	1,738	1,378	1,584	1,390	1,598	1,549	1,781	1,409	1,620
75	1,110	1,276	1,399	1,608	1,547	1,779	1,412	1,625	1,425	1,638	1,584	1,822	1,445	1,661
76	1,135	1,306	1,430	1,645	1,580	1,816	1,445	1,661	1,457	1,676	1,614	1,856	1,478	1,699
77	1,160	1,334	1,462	1,680	1,614	1,856	1,476	1,697	1,489	1,712	1,643	1,889	1,509	1,736
78	1,183	1,360	1,490	1,713	1,643	1,889	1,504	1,730	1,517	1,745	1,668	1,918	1,539	1,769
79	1,202	1,383	1,516	1,742	1,670	1,921	1,530	1,760	1,544	1,776	1,691	1,945	1,565	1,800
80	1,222	1,406	1,540	1,771	1,692	1,946	1,555	1,788	1,569	1,805	1,713	1,969	1,590	1,830
81	1,240	1,426	1,562	1,796	1,714	1,970	1,578	1,814	1,591	1,830	1,735	1,995	1,614	1,856
82	1,256	1,445	1,583	1,821	1,734	1,994	1,598	1,839	1,613	1,855	1,757	2,021	1,635	1,880
83	1,273	1,463	1,604	1,844	1,754	2,017	1,619	1,862	1,634	1,878	1,778	2,045	1,656	1,904
84	1,289	1,481	1,624	1,867	1,773	2,039	1,640	1,886	1,653	1,902	1,799	2,068	1,677	1,929
85	1,303	1,499	1,643	1,889	1,792	2,061	1,659	1,908	1,673	1,924	1,819	2,092	1,697	1,951
86	1,319	1,516	1,661	1,910	1,810	2,081	1,678	1,929	1,692	1,946	1,838	2,113	1,715	1,973
87	1,332	1,532	1,679	1,931	1,826	2,101	1,696	1,949	1,710	1,967	1,856	2,134	1,733	1,994
88	1,346	1,547	1,696	1,949	1,843	2,120	1,712	1,969	1,727	1,986	1,873	2,154	1,751	2,014
89	1,358	1,562	1,712	1,968	1,859	2,138	1,728	1,987	1,743	2,005	1,889	2,173	1,768	2,033
90	1,371	1,576	1,726	1,985	1,875	2,156	1,743	2,005	1,759	2,022	1,904	2,190	1,784	2,051
91	1,382	1,589	1,741	2,002	1,889	2,173	1,758	2,021	1,773	2,039	1,919	2,206	1,798	2,067
92	1,392	1,601	1,754	2,017	1,904	2,189	1,771	2,037	1,787	2,055	1,931	2,221	1,812	2,084
93	1,402	1,612	1,767	2,031	1,916	2,203	1,784	2,051	1,799	2,069	1,944	2,236	1,824	2,098
94	1,411	1,623	1,778	2,044	1,927	2,217	1,796	2,065	1,811	2,083	1,955	2,248	1,836	2,111
95	1,419	1,632	1,788	2,057	1,938	2,228	1,805	2,076	1,822	2,094	1,965	2,259	1,847	2,124
96	1,427	1,642	1,798	2,068	1,949	2,241	1,816	2,089	1,832	2,107	1,975	2,271	1,858	2,137
97	1,436	1,652	1,809	2,081	1,959	2,253	1,827	2,101	1,843	2,120	1,985	2,282	1,868	2,149
98	1,445	1,661	1,820	2,093	1,970	2,265	1,838	2,113	1,854	2,132	1,994	2,294	1,880	2,162
99	1,453	1,670	1,831	2,105	1,981	2,278	1,849	2,126	1,865	2,145	2,005	2,306	1,891	2,174

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

Semi-Annual	Quarterly	Monthly
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There is a one time \$25 application fee

**SHENANDOAH LIFE INSURANCE COMPANY
ANNUAL STANDARD PREMIUM RATES**

FOR USE IN ALL TENNESSEE ZIP CODES EXCEPT 372, 374, 379, 381

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
65	932	1,072	1,175	1,351	1,321	1,519	1,186	1,364	1,196	1,376	1,364	1,569	1,213	1,395
66	932	1,072	1,175	1,351	1,321	1,519	1,186	1,364	1,196	1,376	1,364	1,569	1,213	1,395
67	932	1,072	1,175	1,351	1,321	1,519	1,186	1,364	1,196	1,376	1,364	1,569	1,213	1,395
68	971	1,117	1,224	1,408	1,380	1,587	1,236	1,421	1,247	1,434	1,421	1,634	1,264	1,454
69	1,015	1,167	1,279	1,471	1,436	1,652	1,292	1,485	1,302	1,498	1,477	1,698	1,320	1,519
70	1,055	1,213	1,329	1,529	1,490	1,714	1,343	1,544	1,355	1,558	1,531	1,760	1,373	1,580
71	1,095	1,260	1,381	1,588	1,543	1,774	1,394	1,603	1,406	1,616	1,584	1,822	1,426	1,640
72	1,133	1,303	1,428	1,643	1,591	1,830	1,442	1,659	1,454	1,673	1,634	1,878	1,475	1,697
73	1,169	1,345	1,473	1,694	1,636	1,882	1,488	1,711	1,500	1,726	1,678	1,930	1,522	1,750
74	1,202	1,383	1,516	1,743	1,679	1,931	1,531	1,760	1,544	1,776	1,721	1,979	1,565	1,800
75	1,233	1,418	1,554	1,787	1,719	1,976	1,570	1,805	1,583	1,821	1,760	2,024	1,605	1,846
76	1,262	1,451	1,589	1,828	1,755	2,019	1,606	1,846	1,619	1,862	1,793	2,062	1,642	1,888
77	1,289	1,482	1,624	1,868	1,793	2,062	1,640	1,886	1,654	1,902	1,825	2,099	1,677	1,929
78	1,314	1,510	1,655	1,904	1,825	2,099	1,671	1,922	1,686	1,939	1,853	2,131	1,710	1,966
79	1,337	1,537	1,684	1,937	1,856	2,134	1,700	1,956	1,715	1,973	1,879	2,161	1,739	2,000
80	1,358	1,562	1,711	1,968	1,880	2,162	1,728	1,987	1,743	2,004	1,903	2,188	1,768	2,032
81	1,378	1,584	1,736	1,996	1,904	2,189	1,753	2,016	1,769	2,033	1,928	2,217	1,793	2,062
82	1,396	1,606	1,760	2,023	1,927	2,216	1,777	2,043	1,792	2,061	1,952	2,245	1,817	2,090
83	1,414	1,626	1,782	2,049	1,949	2,241	1,799	2,069	1,815	2,087	1,976	2,273	1,841	2,117
84	1,432	1,646	1,804	2,075	1,970	2,266	1,822	2,095	1,838	2,113	1,999	2,299	1,863	2,143
85	1,448	1,666	1,825	2,099	1,991	2,290	1,843	2,120	1,859	2,138	2,021	2,324	1,886	2,168
86	1,464	1,684	1,846	2,122	2,011	2,312	1,864	2,143	1,880	2,162	2,042	2,348	1,906	2,192
87	1,481	1,702	1,865	2,145	2,030	2,334	1,884	2,166	1,900	2,185	2,062	2,372	1,926	2,216
88	1,495	1,719	1,884	2,166	2,048	2,355	1,903	2,188	1,919	2,207	2,081	2,393	1,946	2,237
89	1,509	1,735	1,902	2,187	2,066	2,375	1,921	2,209	1,937	2,228	2,099	2,414	1,964	2,259
90	1,523	1,751	1,919	2,206	2,083	2,396	1,938	2,228	1,954	2,247	2,116	2,434	1,982	2,279
91	1,535	1,765	1,934	2,224	2,100	2,415	1,953	2,246	1,970	2,266	2,131	2,452	1,998	2,298
92	1,547	1,778	1,949	2,241	2,115	2,432	1,968	2,264	1,985	2,283	2,147	2,468	2,013	2,315
93	1,558	1,791	1,963	2,257	2,129	2,448	1,982	2,280	1,999	2,300	2,160	2,484	2,027	2,331
94	1,568	1,803	1,976	2,272	2,141	2,462	1,994	2,294	2,012	2,314	2,172	2,498	2,040	2,346
95	1,577	1,814	1,986	2,285	2,153	2,476	2,006	2,308	2,024	2,327	2,183	2,510	2,052	2,360
96	1,586	1,824	1,998	2,298	2,165	2,489	2,018	2,321	2,036	2,341	2,194	2,523	2,064	2,373
97	1,596	1,834	2,010	2,311	2,177	2,503	2,030	2,335	2,048	2,354	2,205	2,536	2,076	2,388
98	1,605	1,845	2,022	2,326	2,189	2,517	2,042	2,348	2,060	2,369	2,217	2,549	2,089	2,402
99	1,615	1,857	2,034	2,339	2,201	2,531	2,054	2,363	2,072	2,382	2,228	2,562	2,101	2,416

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 61 st thru 90 th day 91 st day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the additional 365 days	All but \$1024 All but \$256 a day All but \$512 a day \$0 \$0	\$0 \$256 a day \$512 a day 100% of Medicare eligible expenses \$0	\$1024 (Part A deductible) \$0 \$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 21 st thru 100 th day 101 st day and after	All approved amounts All but \$128 a day \$0	\$0 \$0 \$0	\$0 Up to \$128 a day All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$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* Remainder of Medicare Approved Amounts	\$0 Generally 80%	\$0 Generally 20%	\$135 (Part B deductible) \$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD First 3 pints Next \$135 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$135 (Part B deductible) \$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 — Durable medical equipment First \$135 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$135 (Part B deductible) \$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
<p>HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies</p> <p>First 60 days 61st thru 90th day 91st day and after:</p> <ul style="list-style-type: none"> — While using 60 lifetime reserve days — Once lifetime reserve days are used: <ul style="list-style-type: none"> — Additional 365 days — Beyond the additional 365 days 	<p>All but \$1024 All but \$256 a day</p> <p>All but \$512 a day</p> <p>\$0</p> <p>\$0</p>	<p>\$1024 (Part A deductible) \$256 a day</p> <p>\$512 a day</p> <p>100% of Medicare eligible expenses</p> <p>\$0</p>	<p>\$0 \$0</p> <p>\$0</p> <p>\$0**</p> <p>All costs</p>
<p>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</p> <p>First 20 days 21st thru 100th day 101st day and after</p>	<p>All approved amounts All but \$128 a day \$0</p>	<p>\$0 \$0 \$0</p>	<p>\$0 Up to \$128 a day All costs</p>
<p>BLOOD First 3 pints Additional amounts</p>	<p>\$0 100%</p>	<p>3 pints \$0</p>	<p>\$0 \$0</p>
<p>HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services</p>	<p>All but very limited coinsurance for out-patient drugs and inpatient respite care</p>	<p>\$0</p>	<p>Balance</p>

****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 61 st thru 90 th day 91 st day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the additional 365 days	All but \$1024 All but \$256 a day All but \$512 a day \$0 \$0	\$1024 (Part A deductible) \$256 a day \$512 a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$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 21 st thru 100 th day 101 st day and after	All approved amounts All but \$128 a day \$0	\$0 Up to \$128 a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$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* Remainder of Medicare Approved Amounts	\$0 Generally 80%	\$135 (Part B deductible) Generally 20%	\$0 \$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD First 3 pints Next \$135 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All costs \$135 (Part B deductible) 20%	\$0 \$0 \$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 — Durable medical equipment First \$135 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% \$0 80%	\$0 \$135 (Part B deductible) 20%	\$0 \$0 \$0
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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 Remainder of charges	\$0 \$0	\$0 80% to a lifetime maximum benefit of \$50,000.	\$250 20% and amounts over the \$50,000 lifetime maximum.
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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 61 st thru 90 th day 91 st day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the additional 365 days	All but \$1024 All but \$256 a day All but \$512 a day \$0 \$0	\$1024 (Part A deductible) \$256 a day \$512 a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$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 21 st thru 100 th day 101 st day and after	All approved amounts All but \$128 a day \$0	\$0 Up to \$128 a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$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* Remainder of Medicare Approved Amounts	 \$0 Generally 80%	 \$0 Generally 20%	 \$135 (Part B deductible) \$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD First 3 pints Next \$135 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$135 (Part B deductible) \$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 61 st thru 90 th day 91 st day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the additional 365 days	All but \$1024 All but \$256 a day All but \$512 a day \$0 \$0	\$1024 (Part A deductible) \$256 a day \$512 a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$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 21 st thru 100 th day 101 st day and after	All approved amounts All but \$128 a day \$0	\$0 Up to \$128 a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$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* Remainder of Medicare Approved Amounts	 \$0 Generally 80%	 \$0 Generally 20%	 \$135 (Part B deductible) \$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	\$0	\$0	All Costs
BLOOD First 3 pints Next \$135 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 \$0 \$0 80%	 All costs \$0 20%	 \$0 \$135 (Part B deductible) \$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 — Durable medical equipment First \$135 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 100% \$0 80%	 \$0 \$0 20%	 \$0 \$135 (Part B deductible) \$0
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PLAN E

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<p>FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First 250 each calendar year Remainder of charges</p>	<p>\$0 \$0</p>	<p>\$0 80% to a lifetime maximum benefit of \$50,000.</p>	<p>\$250 20% and amounts over the \$50,000 lifetime maximum.</p>
<p>*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 Additional Charges</p>	<p>\$0 \$0</p>	<p>\$120 \$0</p>	<p>\$0 All costs</p>

*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 61 st thru 90 th day 91 st day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the additional 365 days	All but \$1024 All but \$256 a day All but \$512 a day \$0 \$0	\$1024 (Part A deductible) \$256 a day \$512 a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$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 21 st thru 100 th day 101 st day and after	All approved amounts All but \$128 a day \$0	\$0 Up to \$128 a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$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* Remainder of Medicare Approved Amounts	 \$0 Generally 80%	 \$135 (Part B deductible) Generally 20%	 \$0 \$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	\$0	100%	\$0
BLOOD First 3 pints Next \$135 of Medicare Approved amounts* Remainder of Medicare Approved amounts	\$0 \$0 80%	All costs \$135 (Part B deductible) 20%	\$0 \$0 \$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
<p>HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the additional 365 days</p>	<p>All but \$1024 All but \$256 a day All but \$512 a day \$0 \$0</p>	<p>\$1024 (Part A deductible) \$256 a day \$512 a day 100% of Medicare eligible expenses \$0</p>	<p>\$0 \$0 \$0 \$0** All costs</p>
<p>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 21st thru 100th day 101st day and after</p>	<p>All approved amounts All but \$128 a day \$0</p>	<p>\$0 Up to \$128 a day \$0</p>	<p>\$0 \$0 All costs</p>
<p>BLOOD First 3 pints Additional amounts</p>	<p>\$0 100%</p>	<p>3 pints \$0</p>	<p>\$0 \$0</p>
<p>HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services</p>	<p>All but very limited coinsurance for out-patient drugs and inpatient respite care</p>	<p>\$0</p>	<p>Balance</p>

****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* Remainder of Medicare Approved Amounts	 \$0 Generally 80%	 \$0 Generally 20%	 \$135 (Part B deductible) \$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	\$0	80%	20%
BLOOD First 3 pints Next \$135 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 \$0 \$0 80%	 All costs \$0 20%	 \$0 \$135 (Part B deductible) \$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