SHENANDOAH LIFE INSURANCE COMPANY

♦ ROANOKE, VIRGINIA 24029 ♦

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

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

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

See Outlines of Coverage sections for details on ALL plans.

Basic Benefits for Plans A-J:

Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
Medical Expenses: Part B coinsurance (generally 20% of Medicare-approved expenses) or copayments for hospital outpatient services.
Blood: First three pints of blood each year.

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

*Plans F and J also have an option called a high deductible Plan F and a high deductible Plan J. These high deductible plans pay the same or offer the same benefits as Plans F and J after one has paid a calendar year $2,000 deductible. Benefits from high deductible Plans F and J will not begin until out-of-pocket expenses exceed $2,000. 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. 1/09 MS

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		
	$4620 Out of Pocket Annual Limit ***	$2310 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 MISSISSIPPI ZIP CODES 394-396

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	1,520	1,749	1,916	2,204	2,091	2,405	N/A	N/A	N/A	N/A	2,122	2,440	N/A	N/A
65	979	1,126	1,233	1,418	1,387	1,595	1,245	1,432	1,256	1,445	1,432	1,647	1,274	1,465
66	979	1,126	1,233	1,418	1,387	1,595	1,245	1,432	1,256	1,445	1,432	1,647	1,274	1,465
67	979	1,126	1,233	1,418	1,387	1,595	1,245	1,432	1,256	1,445	1,432	1,647	1,274	1,465
68	1,020	1,173	1,285	1,477	1,449	1,666	1,298	1,492	1,309	1,505	1,492	1,716	1,327	1,527
69	1,066	1,225	1,343	1,544	1,508	1,735	1,356	1,559	1,367	1,573	1,551	1,783	1,387	1,595
70	1,108	1,274	1,397	1,605	1,565	1,800	1,410	1,621	1,422	1,636	1,608	1,849	1,442	1,658
71	1,150	1,323	1,449	1,666	1,620	1,863	1,464	1,683	1,476	1,698	1,663	1,912	1,497	1,721
72	1,190	1,368	1,499	1,724	1,671	1,922	1,514	1,741	1,528	1,757	1,716	1,973	1,549	1,781
73	1,227	1,412	1,547	1,779	1,718	1,975	1,562	1,797	1,576	1,812	1,762	2,027	1,598	1,838
74	1,263	1,452	1,592	1,830	1,763	2,028	1,608	1,848	1,621	1,864	1,807	2,078	1,643	1,890
75	1,295	1,489	1,632	1,876	1,805	2,076	1,647	1,895	1,662	1,911	1,848	2,125	1,685	1,938
76	1,324	1,524	1,668	1,919	1,843	2,119	1,685	1,938	1,700	1,955	1,883	2,165	1,724	1,982
77	1,353	1,556	1,705	1,960	1,883	2,165	1,722	1,980	1,737	1,997	1,916	2,204	1,761	2,025
78	1,380	1,587	1,738	1,998	1,916	2,204	1,755	2,018	1,770	2,036	1,946	2,238	1,796	2,064
79	1,403	1,614	1,768	2,033	1,949	2,241	1,785	2,054	1,801	2,072	1,973	2,269	1,826	2,100
80	1,426	1,640	1,797	2,066	1,974	2,270	1,814	2,086	1,830	2,105	1,998	2,297	1,855	2,135
81	1,447	1,663	1,823	2,096	1,999	2,298	1,841	2,117	1,856	2,135	2,024	2,328	1,883	2,165
82	1,466	1,685	1,847	2,124	2,023	2,327	1,865	2,145	1,882	2,164	2,050	2,357	1,908	2,193
83	1,485	1,707	1,871	2,151	2,046	2,353	1,889	2,172	1,906	2,191	2,075	2,386	1,932	2,222
84	1,504	1,728	1,894	2,178	2,069	2,379	1,913	2,200	1,929	2,219	2,099	2,413	1,956	2,250
85	1,520	1,749	1,916	2,204	2,091	2,405	1,935	2,226	1,952	2,245	2,122	2,440	1,979	2,276
86	1,538	1,768	1,937	2,228	2,112	2,428	1,957	2,250	1,974	2,270	2,144	2,465	2,001	2,302
87	1,554	1,787	1,958	2,252	2,130	2,451	1,978	2,274	1,995	2,294	2,165	2,490	2,022	2,326
88	1,570	1,805	1,978	2,274	2,150	2,473	1,997	2,297	2,015	2,317	2,185	2,513	2,043	2,350
89	1,584	1,823	1,997	2,296	2,169	2,494	2,016	2,318	2,034	2,339	2,204	2,535	2,062	2,372
90	1,599	1,839	2,014	2,316	2,187	2,515	2,034	2,339	2,052	2,359	2,222	2,555	2,081	2,393
91	1,612	1,853	2,031	2,335	2,204	2,535	2,051	2,358	2,069	2,379	2,239	2,574	2,098	2,412
92	1,624	1,868	2,046	2,353	2,221	2,554	2,066	2,376	2,084	2,397	2,253	2,591	2,114	2,431
93	1,636	1,881	2,061	2,370	2,235	2,570	2,081	2,393	2,099	2,414	2,268	2,608	2,128	2,448
94	1,646	1,893	2,074	2,385	2,248	2,586	2,095	2,409	2,113	2,430	2,281	2,623	2,142	2,463
95	1,656	1,904	2,086	2,399	2,261	2,600	2,106	2,422	2,125	2,443	2,292	2,636	2,155	2,478
96	1,665	1,915	2,098	2,413	2,273	2,615	2,119	2,437	2,138	2,458	2,304	2,649	2,167	2,493
97	1,675	1,927	2,111	2,428	2,286	2,628	2,132	2,451	2,150	2,473	2,315	2,663	2,180	2,507
98	1,685	1,937	2,123	2,441	2,298	2,643	2,144	2,465	2,163	2,487	2,327	2,676	2,193	2,522
99	1,695	1,949	2,136	2,456	2,311	2,658	2,157	2,480	2,176	2,502	2,339	2,690	2,206	2,537

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 $6 application fee

SHENANDOAH LIFE INSURANCE COMPANY
ANNUAL STANDARD PREMIUM RATES
FOR USE IN MISSISSIPPI ZIP CODES 394-396

Attained	Plan A		Plan B		Plan C		Plan D		Plan E		Plan F		Plan G	
Age	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male
0-64	1,689	1,944	2,129	2,449	2,323	2,671	N/A	N/A	N/A	N/A	2,357	2,711	N/A	N/A
65	1,088	1,251	1,370	1,576	1,541	1,772	1,384	1,591	1,395	1,605	1,592	1,830	1,415	1,628
66	1,088	1,251	1,370	1,576	1,541	1,772	1,384	1,591	1,395	1,605	1,592	1,830	1,415	1,628
67	1,088	1,251	1,370	1,576	1,541	1,772	1,384	1,591	1,395	1,605	1,592	1,830	1,415	1,628
68	1,133	1,303	1,428	1,642	1,610	1,851	1,442	1,658	1,454	1,673	1,658	1,907	1,474	1,696
69	1,184	1,362	1,492	1,716	1,676	1,927	1,507	1,733	1,519	1,747	1,723	1,981	1,540	1,772
70	1,231	1,415	1,551	1,784	1,739	1,999	1,567	1,802	1,580	1,818	1,786	2,054	1,602	1,843
71	1,278	1,470	1,611	1,852	1,800	2,070	1,626	1,870	1,640	1,886	1,848	2,125	1,663	1,913
72	1,322	1,520	1,666	1,916	1,856	2,135	1,682	1,935	1,697	1,952	1,906	2,191	1,721	1,979
73	1,364	1,569	1,719	1,976	1,909	2,196	1,736	1,996	1,750	2,014	1,957	2,251	1,776	2,041
74	1,403	1,614	1,768	2,034	1,959	2,253	1,786	2,054	1,801	2,072	2,008	2,309	1,826	2,100
75	1,439	1,655	1,813	2,085	2,006	2,306	1,831	2,105	1,847	2,124	2,053	2,361	1,872	2,154
76	1,472	1,693	1,854	2,133	2,048	2,355	1,873	2,154	1,889	2,172	2,092	2,406	1,915	2,203
77	1,504	1,729	1,894	2,179	2,092	2,406	1,913	2,200	1,930	2,219	2,129	2,449	1,956	2,250
78	1,533	1,762	1,931	2,221	2,129	2,449	1,950	2,243	1,967	2,262	2,162	2,486	1,995	2,293
79	1,559	1,793	1,965	2,260	2,165	2,490	1,983	2,282	2,001	2,302	2,192	2,521	2,029	2,333
80	1,584	1,822	1,996	2,296	2,193	2,522	2,016	2,318	2,034	2,338	2,220	2,553	2,062	2,371
81	1,608	1,848	2,025	2,329	2,221	2,554	2,045	2,352	2,063	2,372	2,249	2,586	2,092	2,406
82	1,629	1,873	2,053	2,360	2,248	2,585	2,073	2,384	2,091	2,405	2,277	2,619	2,120	2,438
83	1,650	1,897	2,079	2,391	2,273	2,615	2,099	2,414	2,118	2,435	2,305	2,651	2,147	2,470
84	1,671	1,920	2,104	2,420	2,298	2,644	2,125	2,444	2,144	2,465	2,332	2,682	2,174	2,500
85	1,689	1,944	2,129	2,449	2,323	2,671	2,150	2,473	2,169	2,495	2,357	2,711	2,200	2,529
86	1,708	1,965	2,154	2,476	2,346	2,697	2,175	2,500	2,193	2,522	2,382	2,739	2,224	2,558
87	1,727	1,986	2,176	2,502	2,368	2,723	2,198	2,527	2,217	2,549	2,406	2,767	2,247	2,585
88	1,744	2,006	2,198	2,527	2,389	2,748	2,220	2,553	2,239	2,575	2,428	2,792	2,270	2,610
89	1,761	2,024	2,219	2,552	2,410	2,771	2,241	2,577	2,260	2,599	2,449	2,816	2,291	2,636
90	1,777	2,042	2,239	2,574	2,430	2,795	2,261	2,600	2,280	2,622	2,469	2,839	2,312	2,659
91	1,791	2,059	2,256	2,595	2,450	2,817	2,279	2,621	2,298	2,644	2,486	2,860	2,331	2,681
92	1,805	2,075	2,273	2,615	2,468	2,837	2,296	2,641	2,316	2,664	2,504	2,879	2,349	2,701
93	1,818	2,090	2,290	2,633	2,483	2,856	2,312	2,660	2,332	2,683	2,520	2,898	2,365	2,720
94	1,829	2,103	2,305	2,650	2,498	2,873	2,327	2,676	2,348	2,700	2,534	2,914	2,380	2,737
95	1,840	2,116	2,317	2,666	2,512	2,889	2,340	2,692	2,361	2,715	2,546	2,928	2,394	2,753
96	1,850	2,128	2,331	2,681	2,525	2,904	2,354	2,708	2,375	2,731	2,560	2,943	2,408	2,769
97	1,862	2,140	2,345	2,696	2,540	2,920	2,369	2,724	2,389	2,747	2,573	2,959	2,422	2,786
98	1,872	2,153	2,359	2,713	2,554	2,937	2,382	2,739	2,403	2,764	2,586	2,974	2,437	2,802
99	1,884	2,166	2,373	2,729	2,567	2,953	2,396	2,756	2,417	2,779	2,599	2,989	2,451	2,818

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 $6 application fee

SHENANDOAH LIFE INSURANCE COMPANY
ANNUAL PREFERRED PREMIUM RATES
FOR USE IN MISSISSIPPI ZIP CODES EXCEPT 394-396

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	1,444	1,662	1,820	2,094	1,986	2,285	N/A	N/A	N/A	N/A	2,016	2,318	N/A	N/A
65	930	1,070	1,171	1,347	1,318	1,515	1,183	1,360	1,193	1,373	1,360	1,565	1,210	1,392
66	930	1,070	1,171	1,347	1,318	1,515	1,183	1,360	1,193	1,373	1,360	1,565	1,210	1,392
67	930	1,070	1,171	1,347	1,318	1,515	1,183	1,360	1,193	1,373	1,360	1,565	1,210	1,392
68	969	1,114	1,221	1,403	1,377	1,583	1,233	1,417	1,244	1,430	1,417	1,630	1,261	1,451
69	1,013	1,164	1,276	1,467	1,433	1,648	1,288	1,481	1,299	1,494	1,473	1,694	1,318	1,515
70	1,053	1,210	1,327	1,525	1,487	1,710	1,340	1,540	1,351	1,554	1,528	1,757	1,370	1,575
71	1,093	1,257	1,377	1,583	1,539	1,770	1,391	1,599	1,402	1,613	1,580	1,816	1,422	1,635
72	1,131	1,300	1,424	1,638	1,587	1,826	1,438	1,654	1,452	1,669	1,630	1,874	1,472	1,692
73	1,166	1,341	1,470	1,690	1,632	1,876	1,484	1,707	1,497	1,721	1,674	1,926	1,518	1,746
74	1,200	1,379	1,512	1,739	1,675	1,927	1,528	1,756	1,540	1,771	1,717	1,974	1,561	1,796
75	1,230	1,415	1,550	1,782	1,715	1,972	1,565	1,800	1,579	1,815	1,756	2,019	1,601	1,841
76	1,258	1,448	1,585	1,823	1,751	2,013	1,601	1,841	1,615	1,857	1,789	2,057	1,638	1,883
77	1,285	1,478	1,620	1,862	1,789	2,057	1,636	1,881	1,650	1,897	1,820	2,094	1,673	1,924
78	1,311	1,508	1,651	1,898	1,820	2,094	1,667	1,917	1,682	1,934	1,849	2,126	1,706	1,961
79	1,333	1,533	1,680	1,931	1,852	2,129	1,696	1,951	1,711	1,968	1,874	2,156	1,735	1,995
80	1,355	1,558	1,707	1,963	1,875	2,157	1,723	1,982	1,739	2,000	1,898	2,182	1,762	2,028
81	1,375	1,580	1,732	1,991	1,899	2,183	1,749	2,011	1,763	2,028	1,923	2,212	1,789	2,057
82	1,393	1,601	1,755	2,018	1,922	2,211	1,772	2,038	1,788	2,056	1,948	2,239	1,813	2,083
83	1,411	1,622	1,777	2,043	1,944	2,235	1,795	2,063	1,811	2,081	1,971	2,267	1,835	2,111
84	1,429	1,642	1,799	2,069	1,966	2,260	1,817	2,090	1,833	2,108	1,994	2,292	1,858	2,138
85	1,444	1,662	1,820	2,094	1,986	2,285	1,838	2,115	1,854	2,133	2,016	2,318	1,880	2,162
86	1,461	1,680	1,840	2,117	2,006	2,307	1,859	2,138	1,875	2,157	2,037	2,342	1,901	2,187
87	1,476	1,698	1,860	2,139	2,024	2,328	1,879	2,160	1,895	2,179	2,057	2,366	1,921	2,210
88	1,492	1,715	1,879	2,160	2,043	2,349	1,897	2,182	1,914	2,201	2,076	2,387	1,941	2,233
89	1,505	1,732	1,897	2,181	2,061	2,369	1,915	2,202	1,932	2,222	2,094	2,408	1,959	2,253
90	1,519	1,747	1,913	2,200	2,078	2,389	1,932	2,222	1,949	2,241	2,111	2,427	1,977	2,273
91	1,531	1,760	1,929	2,218	2,094	2,408	1,948	2,240	1,966	2,260	2,127	2,445	1,993	2,291
92	1,543	1,775	1,944	2,235	2,110	2,426	1,963	2,257	1,980	2,277	2,140	2,461	2,008	2,309
93	1,554	1,787	1,958	2,252	2,123	2,442	1,977	2,273	1,994	2,293	2,155	2,478	2,022	2,326
94	1,564	1,798	1,970	2,266	2,136	2,457	1,990	2,289	2,007	2,309	2,167	2,492	2,035	2,340
95	1,573	1,809	1,982	2,279	2,148	2,470	2,001	2,301	2,019	2,321	2,177	2,504	2,047	2,354
96	1,582	1,819	1,993	2,292	2,159	2,484	2,013	2,315	2,031	2,335	2,189	2,517	2,059	2,368
97	1,591	1,831	2,005	2,307	2,172	2,497	2,025	2,328	2,043	2,349	2,199	2,530	2,071	2,382
98	1,601	1,840	2,017	2,319	2,183	2,511	2,037	2,342	2,055	2,363	2,211	2,542	2,083	2,396
99	1,610	1,852	2,029	2,333	2,195	2,525	2,049	2,356	2,067	2,377	2,222	2,556	2,096	2,410

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 $6 application fee

SHENANDOAH LIFE INSURANCE COMPANY
ANNUAL STANDARD PREMIUM RATES
FOR USE IN MISSISSIPPI ZIP CODES EXCEPT 394-396

Attained	Plan A		Plan B		Plan C		Plan D		Plan E		Plan F		Plan G	
Age	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male
0-64	1,605	1,847	2,023	2,327	2,207	2,537	N/A	N/A	N/A	N/A	2,239	2,575	N/A	N/A
65	1,034	1,188	1,302	1,497	1,464	1,683	1,315	1,511	1,325	1,525	1,512	1,739	1,344	1,547
66	1,034	1,188	1,302	1,497	1,464	1,683	1,315	1,511	1,325	1,525	1,512	1,739	1,344	1,547
67	1,034	1,188	1,302	1,497	1,464	1,683	1,315	1,511	1,325	1,525	1,512	1,739	1,344	1,547
68	1,076	1,238	1,357	1,560	1,530	1,758	1,370	1,575	1,381	1,589	1,575	1,812	1,400	1,611
69	1,125	1,294	1,417	1,630	1,592	1,831	1,432	1,646	1,443	1,660	1,637	1,882	1,463	1,683
70	1,169	1,344	1,473	1,695	1,652	1,899	1,489	1,712	1,501	1,727	1,697	1,951	1,522	1,751
71	1,214	1,397	1,530	1,759	1,710	1,967	1,545	1,777	1,558	1,792	1,756	2,019	1,580	1,817
72	1,256	1,444	1,583	1,820	1,763	2,028	1,598	1,838	1,612	1,854	1,811	2,081	1,635	1,880
73	1,296	1,491	1,633	1,877	1,814	2,086	1,649	1,896	1,663	1,913	1,859	2,138	1,687	1,939
74	1,333	1,533	1,680	1,932	1,861	2,140	1,697	1,951	1,711	1,968	1,908	2,194	1,735	1,995
75	1,367	1,572	1,722	1,981	1,906	2,191	1,739	2,000	1,755	2,018	1,950	2,243	1,778	2,046
76	1,398	1,608	1,761	2,026	1,946	2,237	1,779	2,046	1,795	2,063	1,987	2,286	1,819	2,093
77	1,429	1,643	1,799	2,070	1,987	2,286	1,817	2,090	1,834	2,108	2,023	2,327	1,858	2,138
78	1,456	1,674	1,834	2,110	2,023	2,327	1,853	2,131	1,869	2,149	2,054	2,362	1,895	2,178
79	1,481	1,703	1,867	2,147	2,057	2,366	1,884	2,168	1,901	2,187	2,082	2,395	1,928	2,216
80	1,505	1,731	1,896	2,181	2,083	2,396	1,915	2,202	1,932	2,221	2,109	2,425	1,959	2,252
81	1,528	1,756	1,924	2,213	2,110	2,426	1,943	2,234	1,960	2,253	2,137	2,457	1,987	2,286
82	1,548	1,779	1,950	2,242	2,136	2,456	1,969	2,265	1,986	2,285	2,163	2,488	2,014	2,316
83	1,568	1,802	1,975	2,271	2,159	2,484	1,994	2,293	2,012	2,313	2,190	2,518	2,040	2,347
84	1,587	1,824	1,999	2,299	2,183	2,512	2,019	2,322	2,037	2,342	2,215	2,548	2,065	2,375
85	1,605	1,847	2,023	2,327	2,207	2,537	2,043	2,349	2,061	2,370	2,239	2,575	2,090	2,403
86	1,623	1,867	2,046	2,352	2,229	2,562	2,066	2,375	2,083	2,396	2,263	2,602	2,113	2,430
87	1,641	1,887	2,067	2,377	2,250	2,587	2,088	2,401	2,106	2,422	2,286	2,629	2,135	2,456
88	1,657	1,906	2,088	2,401	2,270	2,611	2,109	2,425	2,127	2,446	2,307	2,652	2,157	2,480
89	1,673	1,923	2,108	2,424	2,290	2,632	2,129	2,448	2,147	2,469	2,327	2,675	2,176	2,504
90	1,688	1,940	2,127	2,445	2,309	2,655	2,148	2,470	2,166	2,491	2,346	2,697	2,196	2,526
91	1,701	1,956	2,143	2,465	2,328	2,676	2,165	2,490	2,183	2,512	2,362	2,717	2,214	2,547
92	1,715	1,971	2,159	2,484	2,345	2,695	2,181	2,509	2,200	2,531	2,379	2,735	2,232	2,566
93	1,727	1,986	2,176	2,501	2,359	2,713	2,196	2,527	2,215	2,549	2,394	2,753	2,247	2,584
94	1,738	1,998	2,190	2,518	2,373	2,729	2,211	2,542	2,231	2,565	2,407	2,768	2,261	2,600
95	1,748	2,010	2,201	2,533	2,386	2,745	2,223	2,557	2,243	2,579	2,419	2,782	2,274	2,615
96	1,758	2,022	2,214	2,547	2,399	2,759	2,236	2,573	2,256	2,594	2,432	2,796	2,288	2,631
97	1,769	2,033	2,228	2,561	2,413	2,774	2,251	2,588	2,270	2,610	2,444	2,811	2,301	2,647
98	1,778	2,045	2,241	2,577	2,426	2,790	2,263	2,602	2,283	2,626	2,457	2,825	2,315	2,662
99	1,790	2,058	2,254	2,593	2,439	2,805	2,276	2,618	2,296	2,640	2,469	2,840	2,328	2,677

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 $6 application fee

PREMIUM INFORMATION

Shenandoah Life Insurance Company may change your premium if a new table of rates is applicable to the policy. The change in the table of rates will apply to all covered persons in the same class on the date of change. Class is defined as attained age, underwriting class, state and zip code of residence.

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 $1068	$0	$1068 (Part A deductible)
61st thru 90th day	All but $267 a day	$267 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $534 a day	$534 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 $133.50 a day	$0	Up to $133.50 a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE 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 $1068	$1068 (Part A deductible)	$0
61st thru 90th day	All but $267 a day	$267 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $534 a day	$534 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 $133.50 a day	$0	Up to $133.50 a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
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 $1068	$1068 (Part A deductible)	$0
61st thru 90th day	All but $267 a day	$267 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $534 a day	$534 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 $133.50 a day	Up to $133.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
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 $1068	$1068 (Part A deductible)	$0
61st thru 90th day	All but $267 a day	$267 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $534 a day	$534 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 $133.50 a day	Up to $133.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
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 $1068	$1068 (Part A deductible)	$0
61st thru 90th day	All but $267 a day	$267 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $534 a day	$534 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 $133.50 a day	Up to $133.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
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 $1068	$1068 (Part A deductible)	$0
61st thru 90th day	All but $267 a day	$267 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $534 a day	$534 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 $133.50 a day	Up to $133.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
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 $1068	$1068 (Part A deductible)	$0
61st thru 90th day	All but $267 a day	$267 a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $534 a day	$534 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 $133.50 a day	Up to $133.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
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