

Shenandoah Life Insurance Company Administrative Office: P.O. Box 14558, Clearwater, FL 33766-4558 (855) 406- 9085
Outline of Medicare Supplement Coverage – Cover Page
Benefit Plans A, F, G and N

Benefit Chart of Medicare Supplement Plans Sold for Effective Dates on or After June 1, 2010

This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plan “A” available. Some plans may not be available in your state.

Basic Benefits:

Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.

Medical Expenses: Part B coinsurance (generally 20% of Medicare-approved expenses), or copayment for hospital outpatient services. Plans K, L and N require insured to pay a portion of Part B coinsurance or copayments.

Blood: First three pints of blood each year.

Hospice: Part A coinsurance.

A	B	C	D	F	F*	G	K	L	M	N
Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance		Basic, including 100% Part B coinsurance	Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, Including 100% Part B coinsurance	Basic, including 100% Part B coinsurance, except up to \$20 copayment for office visit, and up to \$50 copayment for ER
		Skilled Nursing Facility coinsurance	Skilled Nursing Facility coinsurance	Skilled Nursing Facility coinsurance		Skilled Nursing Facility coinsurance	50% Skilled Nursing Facility coinsurance	75% 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	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Part B Deductible		Part B Deductible						
				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
							Out-of-Pocket limit \$5,120; paid at 100% after limit reached	Out-of-Pocket limit \$2,560; paid at 100% after limit reached		

* Plan F also has an option called a high deductible Plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year \$2,200 deductible. Benefits from high deductible Plan F will not begin until out-of-pocket expenses exceed \$2,200. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include Medicare deductibles for Part A and Part B, but do not include the plan’s separate foreign travel emergency deductible.

PREMIUM INFORMATION

Your premium will increase each year because of the increase in Your attained age. Because the premium rate is based upon Your attained age, the premium will increase each year until You reach Age 99. This annual change will occur on each Policy Renewal Date. The Policy Renewal Date coincides with or follows the Policy Anniversary Date. We, Shenandoah Life Insurance Company, can also raise Your premium if (a) We change the premium rates which apply to all policies of this form issued by Us and in-force in Your state; (b) coverage under Medicare changes; or (c) You move to a different ZIP code location. We will send You the advance written notice required by your state when We change the premium rates for all policies of this form issued by Us and in-force in Your state.

There will be a one-time application fee of \$25.00 added to the first premium.

HOUSEHOLD PREMIUM DISCOUNT – You are eligible for a household premium discount if for the past year you have resided with at least one, but no more than three, other adults who are age 50 or older or if you live with another adult who is your legal spouse, including validly recognized civil union and domestic partners. We may request additional documentation to determine eligibility. The discount will be priced 5% lower than the rates illustrated. Your policy's household premium discount will be terminated if no other adult who is age 50 or over or your legal spouse continues to reside with you (other than in the case of his or her death).

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.

30-DAY RIGHT TO RETURN POLICY

If You find that You are not satisfied with your policy, You may return it to Shenandoah Life Insurance Company, P.O. Box 14558, Clearwater, FL 33766-4558. 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 premiums.

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 producers 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.

RENEWABILITY

This Policy is guaranteed renewable for life.

YOUR PREMIUM:

You have purchased Plan _____, and the premium for that plan is \$ _____, and you will pay the premium _____.

Producer's Name (print)

Date

Producer's Signature

SHENANDOAH LIFE INSURANCE COMPANY - MONTHLY RATES*
ZIP CODES: 664-669, 673-679
STANDARD PLANS - NON-TOBACCO

Female				Attained Age	Male			
Plan A	Plan F	Plan G	Plan N		Plan A	Plan F	Plan G	Plan N
95.74	127.50	98.89	81.03	under 65	110.05	146.55	113.67	93.14
95.74	127.50	98.89	81.03	65	110.05	146.55	113.67	93.14
95.74	127.50	98.89	81.03	66	110.05	146.55	113.67	93.14
95.74	127.50	98.89	81.03	67	110.05	146.55	113.67	93.14
97.79	130.22	100.84	82.64	68	112.40	149.68	115.91	94.99
101.69	135.41	104.86	85.93	69	116.88	155.64	120.53	98.77
105.78	140.87	109.08	89.39	70	121.59	161.92	125.38	102.75
110.07	146.60	113.52	93.02	71	126.52	168.50	130.48	106.92
114.38	152.32	117.95	96.66	72	131.47	175.08	135.57	111.10
118.81	158.22	122.52	100.41	73	136.56	181.86	140.83	115.41
122.77	163.50	126.61	103.75	74	141.11	187.93	145.53	119.25
126.60	168.60	130.56	106.98	75	145.52	193.79	150.07	122.97
130.29	173.51	134.36	110.11	76	149.76	199.44	154.44	126.56
133.72	178.07	137.90	113.00	77	153.70	204.68	158.51	129.88
136.95	182.38	141.22	115.72	78	157.41	209.63	162.32	133.01
140.17	186.66	144.54	118.45	79	161.11	214.55	166.14	136.15
142.99	190.42	147.45	120.83	80	164.36	218.87	169.48	138.89
145.68	194.00	150.23	123.11	81	167.45	222.99	172.68	141.50
148.22	197.39	152.87	125.26	82	170.37	226.89	175.71	143.98
150.58	200.53	155.29	127.25	83	173.08	230.49	178.49	146.26
152.73	203.39	157.50	129.06	84	175.55	233.78	181.04	148.34
154.88	206.25	159.71	130.87	85	178.02	237.07	183.58	150.43
156.70	208.66	161.59	132.41	86	180.11	239.84	185.74	152.20
158.51	211.08	163.46	133.95	87	182.19	242.62	187.88	153.96
160.31	213.49	165.33	135.48	88	184.27	245.39	190.03	155.72
161.65	215.28	166.71	136.62	89	185.81	247.45	191.62	157.03
162.87	216.90	167.95	137.63	90	187.21	249.31	193.05	158.20
163.87	218.24	168.99	138.49	91	188.36	250.85	194.24	159.18
164.88	219.58	170.04	139.34	92	189.52	252.39	195.45	160.16
165.75	220.75	170.94	140.07	93	190.52	253.73	196.48	161.00
166.56	221.81	171.77	140.76	94	191.45	254.95	197.44	161.79
167.17	222.62	172.39	141.27	95	192.15	255.88	198.15	162.38
167.77	223.42	173.01	141.78	96	192.84	256.81	198.86	162.96
168.24	224.05	173.50	142.18	97	193.38	257.53	199.42	163.42
168.85	224.85	174.12	142.68	98	194.08	258.45	200.14	164.00
169.11	225.22	174.41	142.91	99	194.38	258.87	200.47	164.26

* See PREMIUM INFORMATION regarding Household Premium Discount rating.
To obtain annual, semiannual, or quarterly premiums, multiply the Monthly Premium Amount by 12, 6, or 3, respectively.

SHENANDOAH LIFE INSURANCE COMPANY - MONTHLY RATES*
ZIP CODES: 664-669, 673-679
STANDARD PLANS - TOBACCO

Female				Attained Age	Male			
Plan A	Plan F	Plan G	Plan N		Plan A	Plan F	Plan G	Plan N
110.05	146.55	113.67	93.14	under 65	126.49	168.45	130.65	107.06
110.05	146.55	113.67	93.14	65	126.49	168.45	130.65	107.06
110.05	146.55	113.67	93.14	66	126.49	168.45	130.65	107.06
110.05	146.55	113.67	93.14	67	126.49	168.45	130.65	107.06
112.40	149.68	115.91	94.99	68	129.20	172.05	133.23	109.18
116.88	155.64	120.53	98.77	69	134.35	178.90	138.54	113.53
121.59	161.92	125.38	102.75	70	139.76	186.11	144.12	118.10
126.52	168.50	130.48	106.92	71	145.43	193.68	149.98	122.90
131.47	175.08	135.57	111.10	72	151.11	201.24	155.83	127.70
136.56	181.86	140.83	115.41	73	156.97	209.04	161.87	132.65
141.11	187.93	145.53	119.25	74	162.20	216.01	167.28	137.07
145.52	193.79	150.07	122.97	75	167.27	222.75	172.49	141.34
149.76	199.44	154.44	126.56	76	172.14	229.24	177.52	145.47
153.70	204.68	158.51	129.88	77	176.67	235.27	182.19	149.29
157.41	209.63	162.32	133.01	78	180.93	240.95	186.58	152.89
161.11	214.55	166.14	136.15	79	185.18	246.61	190.97	156.49
164.36	218.87	169.48	138.89	80	188.92	251.58	194.81	159.64
167.45	222.99	172.68	141.50	81	192.47	256.31	198.48	162.64
170.37	226.89	175.71	143.98	82	195.83	260.79	201.96	165.49
173.08	230.49	178.49	146.26	83	198.94	264.93	205.16	168.12
175.55	233.78	181.04	148.34	84	201.78	268.71	208.09	170.51
178.02	237.07	183.58	150.43	85	204.62	272.49	211.01	172.91
180.11	239.84	185.74	152.20	86	207.02	275.68	213.49	174.94
182.19	242.62	187.88	153.96	87	209.41	278.87	215.95	176.96
184.27	245.39	190.03	155.72	88	211.81	282.06	218.42	178.99
185.81	247.45	191.62	157.03	89	213.58	284.43	220.25	180.49
187.21	249.31	193.05	158.20	90	215.18	286.56	221.90	181.84
188.36	250.85	194.24	159.18	91	216.51	288.33	223.27	182.96
189.52	252.39	195.45	160.16	92	217.84	290.10	224.65	184.09
190.52	253.73	196.48	161.00	93	218.99	291.64	225.84	185.06
191.45	254.95	197.44	161.79	94	220.06	293.05	226.94	185.96
192.15	255.88	198.15	162.38	95	220.86	294.11	227.76	186.64
192.84	256.81	198.86	162.96	96	221.66	295.18	228.58	187.31
193.38	257.53	199.42	163.42	97	222.28	296.01	229.22	187.84
194.08	258.45	200.14	164.00	98	223.08	297.07	230.05	188.51
194.38	258.87	200.47	164.26	99	223.43	297.55	230.42	188.81

* See PREMIUM INFORMATION regarding Household Premium Discount rating.
 To obtain annual, semiannual, or quarterly premiums, multiply the Monthly Premium Amount by 12, 6, or 3, respectively.

SHENANDOAH LIFE INSURANCE COMPANY - MONTHLY RATES*
ZIP CODES: 660-662, 670-672
STANDARD PLANS - NON-TOBACCO

Female				Attained Age	Male			
Plan A	Plan F	Plan G	Plan N		Plan A	Plan F	Plan G	Plan N
106.27	141.52	109.77	89.95	under 65	122.15	162.67	126.17	103.39
106.27	141.52	109.77	89.95	65	122.15	162.67	126.17	103.39
106.27	141.52	109.77	89.95	66	122.15	162.67	126.17	103.39
106.27	141.52	109.77	89.95	67	122.15	162.67	126.17	103.39
108.55	144.55	111.93	91.73	68	124.77	166.15	128.66	105.44
112.87	150.30	116.40	95.39	69	129.74	172.76	133.79	109.64
117.42	156.36	121.08	99.22	70	134.96	179.72	139.17	114.05
122.18	162.72	126.01	103.26	71	140.44	187.03	144.84	118.69
126.96	169.08	130.92	107.29	72	145.93	194.34	150.48	123.32
131.88	175.63	136.00	111.45	73	151.59	201.87	156.32	128.10
136.27	181.48	140.54	115.16	74	156.63	208.60	161.54	132.37
140.53	187.15	144.92	118.75	75	161.53	215.11	166.57	136.49
144.63	192.60	149.14	122.22	76	166.24	221.38	171.43	140.48
148.43	197.66	153.07	125.43	77	170.61	227.20	175.94	144.17
152.01	202.43	156.76	128.46	78	174.72	232.68	180.18	147.65
155.58	207.19	160.45	131.47	79	178.83	238.15	184.42	151.12
158.72	211.37	163.67	134.12	80	182.44	242.95	188.13	154.16
161.71	215.34	166.75	136.64	81	185.87	247.52	191.67	157.06
164.53	219.11	169.68	139.03	82	189.11	251.85	195.04	159.81
167.14	222.58	172.37	141.24	83	192.11	255.84	198.13	162.35
169.53	225.76	174.83	143.25	84	194.86	259.49	200.95	164.66
171.91	228.93	177.28	145.27	85	197.60	263.14	203.77	166.98
173.93	231.61	179.36	146.98	86	199.92	266.22	206.16	168.94
175.94	234.30	181.43	148.67	87	202.23	269.31	208.54	170.89
177.96	236.98	183.51	150.38	88	204.55	272.39	210.93	172.85
179.44	238.97	185.05	151.64	89	206.25	274.68	212.70	174.30
180.79	240.76	186.43	152.77	90	207.80	276.73	214.29	175.60
181.91	242.24	187.58	153.72	91	209.09	278.44	215.61	176.69
183.02	243.73	188.74	154.67	92	210.37	280.15	216.94	177.78
183.99	245.03	189.74	155.49	93	211.48	281.64	218.09	178.72
184.88	246.21	190.66	156.24	94	212.51	283.00	219.15	179.59
185.55	247.10	191.35	156.81	95	213.28	284.02	219.94	180.24
186.22	248.00	192.04	157.37	96	214.05	285.06	220.74	180.88
186.75	248.70	192.57	157.82	97	214.66	285.86	221.35	181.40
187.42	249.59	193.28	158.38	98	215.43	286.88	222.16	182.05
187.72	249.99	193.59	158.63	99	215.77	287.34	222.52	182.33

* See PREMIUM INFORMATION regarding Household Premium Discount rating.
To obtain annual, semiannual, or quarterly premiums, multiply the Monthly Premium Amount by 12, 6, or 3, respectively.

SHENANDOAH LIFE INSURANCE COMPANY - MONTHLY RATES*
ZIP CODES: 660-662, 670-672
STANDARD PLANS - TOBACCO

Female				Attained Age	Male			
Plan A	Plan F	Plan G	Plan N		Plan A	Plan F	Plan G	Plan N
122.15	162.67	126.17	103.39	under 65	140.40	186.98	145.02	118.84
122.15	162.67	126.17	103.39	65	140.40	186.98	145.02	118.84
122.15	162.67	126.17	103.39	66	140.40	186.98	145.02	118.84
122.15	162.67	126.17	103.39	67	140.40	186.98	145.02	118.84
124.77	166.15	128.66	105.44	68	143.41	190.98	147.89	121.19
129.74	172.76	133.79	109.64	69	149.13	198.58	153.78	126.02
134.96	179.72	139.17	114.05	70	155.13	206.58	159.97	131.09
140.44	187.03	144.84	118.69	71	161.43	214.98	166.48	136.42
145.93	194.34	150.48	123.32	72	167.73	223.38	172.97	141.75
151.59	201.87	156.32	128.10	73	174.24	232.03	179.68	147.24
156.63	208.60	161.54	132.37	74	180.04	239.77	185.68	152.15
161.53	215.11	166.57	136.49	75	185.67	247.25	191.46	156.89
166.24	221.38	171.43	140.48	76	191.08	254.46	197.05	161.47
170.61	227.20	175.94	144.17	77	196.10	261.15	202.23	165.71
174.72	232.68	180.18	147.65	78	200.83	267.45	207.10	169.71
178.83	238.15	184.42	151.12	79	205.55	273.74	211.98	173.70
182.44	242.95	188.13	154.16	80	209.70	279.25	216.24	177.20
185.87	247.52	191.67	157.06	81	213.64	284.50	220.31	180.53
189.11	251.85	195.04	159.81	82	217.37	289.48	224.18	183.69
192.11	255.84	198.13	162.35	83	220.82	294.07	227.73	186.61
194.86	259.49	200.95	164.66	84	223.98	298.27	230.98	189.27
197.60	263.14	203.77	166.98	85	227.13	302.46	234.22	191.93
199.92	266.22	206.16	168.94	86	229.79	306.00	236.97	194.18
202.23	269.31	208.54	170.89	87	232.45	309.55	239.70	196.43
204.55	272.39	210.93	172.85	88	235.11	313.09	242.45	198.68
206.25	274.68	212.70	174.30	89	237.07	315.72	244.48	200.34
207.80	276.73	214.29	175.60	90	238.85	318.08	246.31	201.84
209.09	278.44	215.61	176.69	91	240.33	320.05	247.83	203.09
210.37	280.15	216.94	177.78	92	241.80	322.01	249.36	204.34
211.48	281.64	218.09	178.72	93	243.08	323.72	250.68	205.42
212.51	283.00	219.15	179.59	94	244.27	325.29	251.90	206.42
213.28	284.02	219.94	180.24	95	245.15	326.46	252.81	207.17
214.05	285.06	220.74	180.88	96	246.04	327.65	253.72	207.91
214.66	285.86	221.35	181.40	97	246.73	328.57	254.43	208.50
215.43	286.88	222.16	182.05	98	247.62	329.75	255.36	209.25
215.77	287.34	222.52	182.33	99	248.01	330.28	255.77	209.58

* See PREMIUM INFORMATION regarding Household Premium Discount rating.

To obtain annual, semiannual, or quarterly premiums, multiply the Monthly Premium Amount by 12, 6, or 3, respectively.

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: <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	All but \$1,316 All but \$329 a day All but \$658 a day \$0 \$0	\$0 \$329 a day \$658 a day 100% of Medicare Eligible Expenses \$0	\$1,316 (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 \$164.50 a day \$0	\$0 \$0 \$0	\$0 Up to \$164.50 a day All Costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

****NOTICE:** When Your Medicare Part A hospital benefits are exhausted, the insurer stands in place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing You for the balance based on any difference between its billed charges and the amount Medicare would have paid.

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

* Once You have been billed \$183 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 \$183 of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 Generally 80%	\$0 Generally 20%	\$183 (Part B Deductible) \$0
Part B Excess Charges (Above Medicare-approved amounts)	\$0	\$0	All costs
BLOOD First 3 pints Next \$183 of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 \$0 80%	All Costs \$0 20%	\$0 \$183 (Part B Deductible) \$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

HOME HEALTH CARE MEDICARE-APPROVED SERVICES <ul style="list-style-type: none"> • Medically necessary skilled care services and medical supplies • Durable medical equipment First \$183 of Medicare-approved amounts* Remainder of Medicare-approved amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$183 (Part B Deductible) \$0
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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: <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 <ul style="list-style-type: none"> - Beyond the additional 365 days 	All but \$1,316 All but \$329 a day All but \$658 a day \$0 \$0	\$1,316 (Part A Deductible) \$329 a day \$658 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 \$164.50 a day \$0	\$0 Up to \$164.50 a day \$0	\$0 \$0 All Costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

****NOTICE:** When Your Medicare Part A hospital benefits are exhausted, the insurer stands in place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing You for the balance based on any difference between its billed charges and the amount Medicare would have paid.

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

* Once You have been billed \$183 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 \$183 of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 Generally 80%	\$183 (Part B Deductible) Generally 20%	\$0 \$0
Part B Excess Charges (Above Medicare-approved amounts)	\$0	100%	\$0
BLOOD First 3 pints Next \$183 of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 \$0 80%	All Costs \$183 (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 <ul style="list-style-type: none"> • Medically necessary skilled care services and medical supplies • Durable medical equipment First \$183 of Medicare-approved amounts* Remainder of Medicare-approved amounts	100% \$0 80%	\$0 \$183 (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 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 61 st thru 90 th day 91 st day and after: <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 	All but \$1,316 All but \$329 a day All but \$658 a day \$0 \$0	\$1,316 (Part A Deductible) \$329 a day \$658 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 \$164.50 a day \$0	\$0 Up to \$164.50 a day \$0	\$0 \$0 All Costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

****NOTICE:** When Your Medicare Part A hospital benefits are exhausted, the insurer stands in place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing You for the balance based on any difference between its billed charges and the amount Medicare would have paid.

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

* Once You have been billed \$183 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 \$183 of Medicare-approved amounts* (the Part B Deductible) Remainder of Medicare-approved amounts	\$0 Generally 80%	\$0 Generally 20%	\$183 (Part B Deductible) \$0
Part B Excess Charges (Above Medicare-approved amounts)	\$0	100%	\$0
BLOOD First 3 pints Next \$183 of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 \$0 80%	All Costs \$0 20%	\$0 \$183 (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 \$183 of Medicare-approved amounts* Remainder of Medicare-approved amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$183 (Part B Deductible) \$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 N
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 st thru 90 th day 91 st day and after: <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 	All but \$1,316 All but \$329 a day All but \$658 a day \$0 \$0	\$1,316 (Part A Deductible) \$329 a day \$658 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 \$164.50 a day \$0	\$0 Up to \$164.50 a day \$0	\$0 \$0 All Costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

****NOTICE:** When Your Medicare Part A hospital benefits are exhausted, the insurer stands in place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing You for the balance based on any difference between its billed charges and the amount Medicare would have paid.

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

* Once You have been billed \$183 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 \$183 of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 Generally 80%	\$0 Balance, other than up to \$20 per office visit and up to \$50 per emergency room visit. The copayment of up to \$50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	\$183 (Part B Deductible) Up to \$20 per office visit and up to \$50 per emergency room visit. The copayment of up to \$50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
Part B Excess Charges (Above Medicare-approved amounts)	\$0	\$0	All Costs
BLOOD First 3 pints Next \$183 of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 \$0 80%	All Costs \$0 20%	\$0 \$183 (Part B Deductible) \$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PLAN N

PARTS A & B

<p>HOME HEALTH CARE MEDICARE-APPROVED SERVICES</p> <ul style="list-style-type: none"> • Medically necessary skilled care services and medical supplies • Durable medical equipment <ul style="list-style-type: none"> First \$183 of Medicare-approved amounts* Remainder of Medicare-approved amounts 	<p align="center">100%</p> <p align="center">\$0</p> <p align="center">80%</p>	<p align="center">\$0</p> <p align="center">\$0</p> <p align="center">20%</p>	<p align="center">\$0</p> <p align="center">\$183 (Part B Deductible)</p> <p align="center">\$0</p>
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OTHER BENEFITS – NOT COVERED BY MEDICARE

<p>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</p> <p>Medically necessary emergency care services during the first 60 days of each trip outside the USA</p> <ul style="list-style-type: none"> First \$250 each calendar year Remainder of charges 	<p align="center">\$0</p> <p align="center">\$0</p>	<p align="center">\$0</p> <p align="center">80% to a lifetime maximum benefit of \$50,000</p>	<p align="center">\$250</p> <p align="center">20% and amounts over the \$50,000 lifetime maximum</p>
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