Shenandoah Life Insurance Company Administrative Office: P.O. Box 14558, Clearwater, FL 33766-4558 (855) 406-9085

Outline of Medicare Supplement Coverage – Cover Page

The Commissioner of Insurance of the State of Minnesota has established three categories of Medicare Supplements and minimum standards for each, with the extended basic Medicare Supplement being the most comprehensive and the basic Medicare Supplement being the least comprehensive. This chart shows the benefits in each plan.

Basic— **Policy Form MS-BAS 1-14 MN**	**Extended Basic—** **Policy Form MS-EXT 1-14 MN**	**$20 and $50 Copayment—** **Policy Form MS-CPY 1-14 MN**
Hospitalization: Part A Coinsurance	Hospitalization: Part A Coinsurance	Hospitalization: Part A Coinsurance
Medical Expenses: Part B Coinsurance	Medical Expenses: Part B Coinsurance	Medical Expenses: Part B Coinsurance except up to $20 copayment for office visit, and up to $50 copayment for ER
Blood: First 3 pints of blood each year	Blood: First 3 pints of blood each year	Blood: First 3 pints of blood each year
Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance for the 21st through 100th day
______________________ *	Part A Deductible	Part A Deductible
______________________ *	Part B Deductible	
______________________ *	Part B Excess (100%)	
Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency
Hospice Care	Hospice Care	Hospice Care
______________________ *	Preventive Care	

Premium Information

We, Shenandoah Life Insurance Company, will renew the policy each time You pay Us the premium. It must be paid by the date it is due or during the 31 days that follow. Your policy stays in force during this 31-day period. Your premium cannot be changed unless We make the same change on all policies of this form owned by persons in Your classification which are renewed in the state where You live at the time We change the premium. Any such change can be made on any renewal date. Schedules of rates may vary depending on Your Policy Effective Date.

“Persons in Your Classification” means all persons having the same benefits.

* Optional Riders available for Part A Deductible, Part B Excess, Part B Deductible and Preventive Health Services.

MONTHLY PREMIUMS

ZIP CODES:
559-567

NON-TOBACCO - MONTHLY RATES

Basic - Policy Form MS-BAS 1-14 MN

ALL AGES	$142.12

Optional Riders

Rider	Rate
Medicare Part A Deductible Rider ADED RDR MN	23.57
Medicare Part B Deductible Rider BDED RDR MN	15.25
Preventive Medical Care Benefits Rider PREV RDR MN	5.07
Medicare Part B Excess Charges Rider BEXC RDR MN	3.93

Extended Basic - Policy Form MS-EXT 1-14 MN

ALL AGES	$325.85

$20 and $50 Copayment Plan - Policy Form MS-CPY 1-14 MN

ALL AGES	$142.74

TOBACCO - MONTHLY RATES

Basic - Policy Form MS-BAS 1-14 MN

ALL AGES	$163.36

Optional Riders

Rider	Rate
Medicare Part A Deductible Rider ADED RDR MN	27.09
Medicare Part B Deductible Rider BDED RDR MN	15.25
Preventive Medical Care Benefits Rider PREV RDR MN	5.83
Medicare Part B Excess Charges Rider BEXC RDR MN	4.52

Extended Basic - Policy Form MS-EXT 1-14 MN

ALL AGES	$374.54

$20 and $50 Copayment Plan - Policy Form MS-CPY 1-14 MN

ALL AGES	$164.07

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

The policy provides an anticipated loss ratio of 70%. This means that, on the average, Policyholders may expect that $70.00 of every $100.00 in premium will be returned as benefits to Policyholders over the life of the contract.

MONTHLY PREMIUMS

ZIP CODES:
550, 553, 555-558

NON-TOBACCO - MONTHLY RATES

Basic - Policy Form MS-BAS 1-14 MN

ALL AGES	$162.02
Optional Riders	
Medicare Part A Deductible Rider ADED RDR MN	26.87
Medicare Part B Deductible Rider BDED RDR MN	15.25
Preventive Medical Care Benefits Rider PREV RDR MN	5.79
Medicare Part B Excess Charges Rider BEXC RDR MN	4.48

Extended Basic - Policy Form MS-EXT 1-14 MN

ALL AGES	$371.47

$20 and $50 Copayment Plan - Policy Form MS-CPY 1-14 MN

ALL AGES	$162.72

TOBACCO - MONTHLY RATES

Basic - Policy Form MS-BAS 1-14 MN

ALL AGES	$186.23
Optional Riders	
Medicare Part A Deductible Rider ADED RDR MN	30.88
Medicare Part B Deductible Rider BDED RDR MN	15.25
Preventive Medical Care Benefits Rider PREV RDR MN	6.65
Medicare Part B Excess Charges Rider BEXC RDR MN	5.15

Extended Basic - Policy Form MS-EXT 1-14 MN

ALL AGES	$426.98

$20 and $50 Copayment Plan - Policy Form MS-CPY 1-14 MN

ALL AGES	$187.04

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

The policy provides an anticipated loss ratio of 70%. This means that, on the average, Policyholders may expect that $70.00 of every $100.00 in premium will be returned as benefits to Policyholders over the life of the contract.

MONTHLY PREMIUMS

ZIP CODES:
551, 554

NON-TOBACCO - MONTHLY RATES		TOBACCO - MONTHLY RATES	
Basic - Policy Form MS-BAS 1-14 MN		**Basic - Policy Form MS-BAS 1-14 MN**	
ALL AGES	$184.76	ALL AGES	$212.37
Optional Riders		Optional Riders	
Medicare Part A Deductible Rider ADED RDR MN	30.64	Medicare Part A Deductible Rider ADED RDR MN	35.22
Medicare Part B Deductible Rider BDED RDR MN	15.25	Medicare Part B Deductible Rider BDED RDR MN	15.25
Preventive Medical Care Benefits Rider PREV RDR MN	6.59	Preventive Medical Care Benefits Rider PREV RDR MN	7.58
Medicare Part B Excess Charges Rider BEXC RDR MN	5.12	Medicare Part B Excess Charges Rider BEXC RDR MN	5.88
Extended Basic - Policy Form MS-EXT 1-14 MN		**Extended Basic - Policy Form MS-EXT 1-14 MN**	
ALL AGES	$423.60	ALL AGES	$486.90
$20 and $50 Copayment Plan - Policy Form MS-CPY 1-14 MN		**$20 and $50 Copayment Plan - Policy Form MS-CPY 1-14 MN**	
ALL AGES	$185.56	ALL AGES	$213.29

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

The policy provides an anticipated loss ratio of 70%. This means that, on the average, Policyholders may expect that $70.00 of every $100.00 in premium will be returned as benefits to Policyholders over the life of the contract.

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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 Shenandoah Life Insurance Company.

Right To Return Policy
If You find that You are not satisfied with Your policy, You may return it to Shenandoah Life Insurance Company at our administrative office, 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 payments, within 10 days.

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

THE POLICY DOES NOT COVER ALL MEDICAL EXPENSES BEYOND THOSE COVERED BY MEDICARE. THE POLICY DOES NOT COVER ALL SKILLED NURSING HOME CARE EXPENSES AND DOES NOT COVER CUSTODIAL OR RESIDENTIAL NURSING CARE. READ YOUR POLICY CAREFULLY TO DETERMINE WHICH NURSING HOME FACILITIES AND EXPENSES ARE COVERED BY YOUR POLICY.

We will not pay for services for which a charge is normally not made when there is no insurance. In addition, no benefits are payable for expense incurred before the coverage effective date.

Limitation On Out-of-Pocket Expense
When Your out-of-pocket expense equals $1,000.00 in a calendar year, We will pay 100% of additional covered expense You incur during the remainder of such calendar year (MS-EXT 1-14 MN only).

BASIC PLAN – MS-BAS 1-14 MN
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 MSBA10-01-MN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,364	$0	$1,364 (Part A Deductible)
		$1,364 with Optional Benefit Rider ADED RDR MN	$0
61st thru 90th day	All but $341 a day	$341 a day	$0
91st day and after:			
• While using 60 lifetime reserve days	All but $682 a day	$682 a day	$0
• Beyond the additional 150 days	$0	100% of Medicare Eligible Expenses	$0
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 $170.50 a day	Up to $170.50 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			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and respite care	Medicare copayment/ coinsurance	$0

BASIC PLAN – MS-BAS 1-14 MNMEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

SERVICES	MEDICARE PAYS	BASIC 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 $185 of Medicare Approved amounts*	$0	$0	$185 (Part B Deductible)
		$185 with Optional Benefit Rider BDED RDR MN	$0
Remainder of Medicare Approved amounts	80%	20%**	$0
Part B Excess Charges			
(Above Medicare Approved amounts)	$0	$0	All costs
		$185 with Optional Benefit Rider BEXC RDR MN	$0
BLOOD			
First 3 pints	$0	All Costs	$0
Next $185 of Medicare Approved amounts*	$0	$0	$185 (Part B Deductible)
		$185 with Optional Benefit Rider BDED RDR MN	$0
Remainder of Medicare Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

* Once You have been billed $185 of Medicare Approved amounts for covered services, Your Part B Deductible will have been met for the calendar year.

** Part B coinsurance (generally 20% of Medicare approved expenses), or in the case of hospital outpatient department services under a prospective payment system, applicable copayments.

BASIC PLAN – MS-BAS 1-14 MN
PARTS A & B

SERVICES	MEDICARE PAYS	BASIC 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 $185 of Medicare Approved amounts	$0	$0	$185 (Part B Deductible)
		$185 with Optional Benefit Rider BDED RDR MN	$0
Remainder of Medicare Approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	BASIC PLAN PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during travel outside the USA (hospital, medical expense and supplies)	$0	80% of covered expenses	Expenses not paid by Medicare or the policy
PREVENTIVE MEDICAL CARE BENEFIT – NOT COVERED BY MEDICARE Annual physical and preventive tests and services administered or ordered by Your doctor when not covered by Medicare.			
First $120 each calendar year	$0	$0	$120
		$120 with Optional Benefit Rider PREV RDR MN	$0
Additional Charges	$0	$0	All Costs
		$0 with Optional Benefit Rider PREV RDR MN	All Costs

EXTENDED BASIC PLAN – MS-EXT 1-14 MN
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	EXTENDED BASIC PLAN PAYS	YOU PAY
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 • Beyond the additional 150 days	 All but $1,364 All but $341 a day All but $682 a day $0	 $1,364 (Part A Deductible) $341 a day $682 a day 100% of Medicare Eligible Expenses	 $0 $0 $0 $0
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	 All approved amounts All but $170.50 a day $0	 $0 Up to $170.50 a day 80% of covered expenses up to 120 days per year	 $0 $0 Expenses not paid by policy
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 respite care	 Medicare copayment/ coinsurance	 $0

EXTENDED BASIC PLAN - MS-EXT 1-14 MN
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

SERVICES	MEDICARE PAYS	EXTENDED BASIC 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 $185 of Medicare Approved amounts*	$0	$185 (Part B Deductible)	$0
Remainder of Medicare Approved amounts	80%	20%**	$0
Part B Excess Charges (Above Medicare Approved amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All Costs	$0
Next $185 of Medicare Approved amounts*	$0	$185 (Part B Deductible)	$0
Remainder of Medicare Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

* Once You have been billed $185 of Medicare Approved amounts for covered services, Your Part B Deductible will have been met for the calendar year.

** Part B coinsurance (generally 20% of Medicare approved expenses), or in the case of hospital outpatient department services under a prospective payment system, applicable copayments.

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

PARTS A & B

* Once You have been billed $185 of Medicare Approved amounts for covered services, Your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	EXTENDED BASIC 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 $185 of Medicare Approved amounts*	$0	$185 (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 services beginning during travel outside the USA (hospital, medical expense and supplies)	$0	80% of covered expenses	Expenses not paid by Medicare or the policy
PREVENTIVE MEDICAL CARE BENEFIT – NOT COVERED BY MEDICARE Annual physical and preventive tests such as: fecal occult blood test, digital rectal exam, mammogram, hearing screening, dipstick urinalysis, diabetes screening, thyroid function test, influenza shot, tetanus and diphtheria booster and education, 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

$20 AND $50 COPAYMENT – MS-CPY 1-14 MN
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	$20 AND $50 COPAYMENT PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,364	$1,364 (Part A Deductible)	$0
61st thru 90th day	All but $341 a day	$341 a day	$0
91st day and after:			
• While using 60 lifetime reserve days	All but $682 a day	$682 a day	$0
• Beyond the additional 150 days	$0	100% of Medicare Eligible Expenses	$0
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 $170.50 a day	Up to $170.50 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 You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and respite care	Medicare copayment/ coinsurance	$0

$20 AND $50 COPAYMENT – MS-CPY 1-14 MN
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

SERVICES	MEDICARE PAYS	$20 AND $50 COPAYMENT 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 $185 of Medicare Approved amounts*	$0	$0	$185 (Part B Deductible)
Remainder of Medicare Approved amounts	80%	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 room visit is covered as a Medicare Part A expense.	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 room 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	$0	All Costs	$0
Next $185 of Medicare Approved amounts*	$0	$0	$185 (Part B Deductible)
Remainder of Medicare Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

* Once You have been billed $185 of Medicare Approved amounts for covered services, Your Part B Deductible will have been met for the calendar year.

PARTS A & B

* Once You have been billed $185 of Medicare Approved amounts for covered services, Your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	$20 AND $50 COPAYMENT 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 $185 of Medicare Approved amounts*	$0	$0	$185 (Part B Deductible)
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 travel outside the USA (hospital, medical expense and supplies)	$0	80% of covered expenses	Expenses not paid by Medicare or the policy

The charts above summarizing the Medicare benefits only briefly describe the benefits. The Health Care Financing Administration or its Medicare publication should be consulted for further details and limitations.

ADDITIONAL BENEFITS

1. Alcoholism and Chemical Dependency Treatment Benefit. We will pay the Usual and Customary Charge for the treatment of alcoholism and chemical dependency on the same basis as any other Sickness or Injury when treatment is provided for: (a) outpatient alcoholism and chemical dependency services that must not place a greater financial burden on You, or be more restrictive than those requirements and limitations for outpatient medical services; and (b) inpatient hospital and residential alcoholism and chemical dependency services that must not place a greater financial burden on You, or be more restrictive than those requirements and limitations for inpatient hospital medical services. Benefits are not payable for that portion of expense paid by Medicare or paid under any other part of the policy.
2. Scalp Hair Prosthesis. We will pay the expense incurred on the same basis as any other Sickness or Injury and as if Medicare paid benefits for a scalp hair prosthesis needed because of hair loss suffered as a result of alopecia areata. We will pay the Usual and Customary Charge for a scalp hair prosthesis procedure as a result of alopecia areata, limited to one prosthesis per benefit year. Benefits are not payable for that portion of expense that is paid by Medicare or paid under any other part of this policy.
3. Routine Screening Procedures for Cancer. We will pay the expense incurred that is not paid by Medicare or paid under any other part of Your policy for routine screening procedures for cancer, including colorectal screening, mammogram and Pap smear.
4. Temporomandibular Joint Disorder and Craniomandibular Disorder. Benefits are payable for the surgical and nonsurgical treatment of temporomandibular joint disorder and craniomandibular disorder on the same basis as that for treatment to any other joint in the body. Such treatment must be administered or prescribed by a physician or dentist. Benefits are not payable under this part of Your policy for any expense payable under another part of the policy.
5. Reconstructive Surgery. Benefits are payable for reconstructive surgery on the same basis as that for any other surgery if the reconstructive surgery is incidental to or follows surgery resulting from Injury, Sickness or other disease of the involved part, including reconstructive surgery following a mastectomy if the mastectomy is medically necessary as determined by the attending Physician. Benefits are not payable under this part of Your policy for any expense payable under another part of the policy.
6. Surgical Center Services. Benefits are payable for surgical center services for health care treatment or service rendered by a freestanding ambulatory surgical center or facilities offering ambulatory medical service 24 hours a day, 7 days a week, which are not part of a hospital, but have been reviewed and approved by the state commissioner of commerce to provide treatment or service on the same basis as coverage provided for the same health care treatment or service rendered by a hospital. Benefits are not payable under this part of Your policy for an expense payable under another part of the policy.
7. Immunization Benefits. We will pay the expense incurred for an immunization received by You. Benefits are not payable for that portion of expense paid by Medicare or paid under any other part of the policy.
8. Phenylketonuria Treatment. Benefits are payable for special dietary treatment for phenylketonuria when recommended by a physician.
9. Diabetes Equipment and Supplies. We will pay the Usual and Customary Charge for expense incurred for all physician prescribed medically appropriate and necessary equipment and supplies used in the management and treatment of diabetes, not otherwise covered by Medicare or Part D of the Medicare Program. Coverage must include persons with gestational, type I or type II diabetes. Benefits will be limited to 80% of the Usual and Customary Charge not covered by Medicare or Part D of the Medicare Program.
10. Routine Prostate Cancer Screening. We will pay the expense incurred for prostate cancer screening. Benefits are limited to at least one screening per year for any insured male 50 years of age or older, and at least one screening per year for any insured male 40 years of age or older who is symptomatic.
11. Outpatient Mental Health Coverage. We will provide coverage for the coinsurance amount or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount, of Medicare eligible expenses under Medicare Part B regardless of hospital confinement, and the Medicare Part B deductible amount.
12. Physical and Occupational Therapy Services. We will pay the allowable amount not paid by Medicare, less the Part B Deductible if applicable.
13. Treatment of Lyme Disease. We will pay benefits for diagnosed Lyme Disease as any other medical service. Benefits are not payable for that portion of expense paid by Medicare or paid under any other part of the policy.

ADDITIONAL BENEFITS UNDER EXTENDED BASIC PLAN – MS-EXT 1-14 MN

We will pay 80% of the Usual and Customary Charges for the following articles and services prescribed by a physician which are not paid by Medicare or payable under any other provision of Your policy.

1. Hospital services.
2. Professional services for the diagnosis or treatment of Injuries, Sickness or conditions when such services are given by a physician or are under a physician's direction.
3. Services of a nursing home for not more than 120 days each year. Such services must qualify as reimbursable under Medicare.
4. Services of a home health agency. Such services must qualify as reimbursable under Medicare.
5. Use of radium or other radioactive materials.
6. Oxygen.
7. Anesthetics.
8. Prosthetic devises other than dental.
9. Rental or purchase, as appropriate, of durable medical equipment other than eyeglasses and hearing aids.
10. Diagnostic X-rays and lab tests.
11. Oral surgery for: (a) partially or completely unerupted impacted teeth, (b) a tooth root without the extraction of the entire root, or (c) the gums or tissues of the mouth when not performed in connection with the extraction or repair of teeth.
12. Services of a physical therapist.
13. Professional ambulance for service to the nearest facility qualified to treat the condition, or a reasonable mileage rate for transportation to a kidney dialysis center for treatment.
14. Well-baby care.
15. Up to $500.00 for a second surgical opinion. Not included is the repetition of diagnostic tests.
16. Services of an occupational therapist.

The above Additional Benefits are not payable for: (a) Injuries or Sickness for which any benefits are provided for by workers' compensation or employer's liability laws, (b) cosmetic surgery, except for repair of an Injury or a birth defect, (c) care which is primarily for custodial or for domiciliary purposes which would not qualify as eligible services under Medicare, (d) any charge for confinement in a private room to the extent it is in excess of the institution's charge for its most common semiprivate room unless the private room is prescribed as medically necessary by a physician, or (e) any charges for services or articles the provision of which is not within the scope of authorized practice of the institution or individual rendering the services or articles.

LIMITATIONS

The policy DOES NOT cover the following:

a) Private Duty Nursing.
b) Custodial nursing home care costs.
c) Intermediate nursing home care costs.
d) Physician's charges above Medicare's approved charges, except as explained in the Additional Benefits section of this outline.

OPTIONAL COVERAGE AVAILABLE FOR BASIC PLAN – MS-BAS 1-14 MN (check if applied for)

☐ **BEXC RDR MN – Medicare Part B Excess Charges Rider**

If You incur expenses for services or supplies that are eligible under Medicare Part B, We will pay that portion of the Usual and Customary Charge which:

a) Is in excess of the Medicare Part B approved charge and
b) You are required to pay.

☐ **ADED RDR MN – Medicare Part A Deductible Rider**

When You are hospital confined for a covered condition, We will pay the Medicare Part A Deductible of $1,364 that You incur.

☐ **PREV RDR MN – Preventive Medical Care Benefits Rider**

We will pay the Medicare-approved amount for each of the following preventive health services, as if Medicare were to cover the service, as identified in the American Medical Association's current procedural terminology (AMA CPT) codes to a maximum of $120.00 annually under this benefit:

a) An annually clinical preventive medical history and physical exam that may include tests and services from item (b) below and patient education to address preventive health care measures;
b) Any one or combination of the following preventive screening tests or preventive services, as often as medically necessary: fecal occult blood test and/or digital rectal exam; dipstick urinalysis for hematuria, bacteriurua, and proteinuria; pure tone (air only) hearing screening test, ordered or administered by a physician; serum cholesterol screening at a frequency determined to be medically appropriate by the attending physician; thyroid function test; diabetes screening; and/or any other tests or preventive measures determined appropriate by the attending physician.

Benefits for Preventive Health Services will not duplicate any payment for a procedure that is already covered by Medicare.

☐ **BDED RDR MN – Medicare Part B Deductible Rider**

When You incur expense that is applied to the Medicare Part B Deductible and Medicare does not pay the deductible, We will pay the entire Medicare Part B annual deductible.