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, C, D, F, G and N

Benefit Chart of Medicare Supplement Plans Sold for Effective Dates on or After January 1, 2020

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. Only applicants first eligible for Medicare before 2020 may purchase Plans C, F, and high deductible F.

Note: A ✓ means 100% of the benefit is paid.

Benefits	Plans Available to All Applicants									Medicare first eligible before 2020 only		
	Plan A	Plan B	Plan D	Plan G	G[1]	Plan K	Plan L	Plan M	Plan N	Plan C	Plan F	F[1]
Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	
Medicare Part B coinsurance or Copayment	✓	✓	✓	✓		50%	75%	✓	✓ copays apply [3]	✓	✓	
Blood (first three pints)	✓	✓	✓	✓		50%	75%	✓	✓	✓	✓	
Part A hospice care coinsurance or copayment	✓	✓	✓	✓		50%	75%	✓	✓	✓	✓	
Skilled nursing facility coinsurance			✓	✓		50%	75%	✓	✓	✓	✓	
Medicare Part A deductible		✓	✓	✓		50%	75%	50%	✓	✓	✓	
Medicare Part B deductible										✓	✓	
Medicare Part B excess Charges				✓							✓	
Foreign travel emergency (up to plan limits)			✓	✓				✓	✓	✓	✓	
Out-of-pocket limit in 2021[2]						$6,220[2]	$3,110[2]					

1 Plans F and G also have a high deductible option which require first paying a plan deductible of $2,370 before the plan begins to pay. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High deductible plan G does not cover the Medicare Part B deductible. However, high deductible plans F and G count your payment of the Medicare Part B deductible toward meeting the plan deductible.

2 Plans K and L pay 100% of covered services for the rest of the calendar year once you meet the out-of-pocket yearly limit.

3 Plan N pays 100% of the Part B coinsurance, except for a co-payment of up to $20 for some office visits and up to a $50 co-payment for emergency room visits that do not result in an inpatient admission.

PREMIUM INFORMATION
Your premium will increase each year because of the increase in Your attained age. 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; or (b) coverage under Medicare changes. 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 policy fee of $25.00 added to the first premium.

HOUSEHOLD PREMIUM DISCOUNT – If You resided with at least one, but no more than three, other Medicare eligible adults for the last consecutive twelve (12) months who also own a Medicare Supplement policy underwritten by Shenandoah Life Insurance Company after January 1, 2014, You will be eligible for a household premium discount. The discount will be priced 5% lower than the rates illustrated. Your policy's household premium discount will be removed if the other Medicare Supplement policyholder chooses to terminate his or her eligible Shenandoah Life Medicare supplement Policy or he or she no longer resides with You (other than in the case of his or her death); provided however, if one Policyholder terminates his or her coverage with the Company, your discount will not terminate if any other eligible Shenandoah Life Policyholder continues to reside with You.

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.

SHENANDOAH LIFE INSURANCE COMPANY - MONTHLY RATES*
STANDARD PLANS - NON-TOBACCO

Female							Male					
Plan A	Plan C	Plan D	Plan F	Plan G	Plan N	Attained Age	Plan A	Plan C	Plan D	Plan F	Plan G	Plan N
N/A	214.67	133.08	N/A	N/A	N/A	Under 65	N/A	246.86	152.97	N/A	N/A	N/A
137.28	214.67	133.08	169.26	140.30	111.22	65	157.88	246.86	152.97	194.64	161.35	127.91
137.28	214.67	133.08	169.26	140.30	111.22	66	157.88	246.86	152.97	194.64	161.35	127.91
137.28	214.67	133.08	169.26	140.30	111.22	67	157.88	246.86	152.97	194.64	161.35	127.91
140.22	219.26	135.71	172.87	143.07	113.42	68	161.25	252.15	155.98	198.80	164.53	130.43
145.81	227.99	141.11	179.76	148.76	117.93	69	167.68	262.20	162.20	206.73	171.08	135.62
151.69	237.18	146.80	187.01	154.75	122.69	70	174.44	272.76	168.73	215.06	177.97	141.09
157.85	246.82	152.76	194.60	161.04	127.67	71	181.53	283.84	175.59	223.79	185.20	146.82
164.01	256.45	158.73	202.19	167.33	132.66	72	188.61	294.92	182.44	232.53	192.43	152.56
170.37	266.39	164.88	210.03	173.82	137.80	73	195.92	306.36	189.51	241.53	199.89	158.47
176.05	275.27	170.38	217.04	179.62	142.39	74	202.46	316.56	195.83	249.60	206.56	163.75
181.54	283.87	175.69	223.81	185.22	146.83	75	208.77	326.44	201.94	257.38	213.00	168.86
186.84	292.14	180.82	230.33	190.62	151.12	76	214.86	335.96	207.84	264.89	219.22	173.79
191.75	299.82	185.57	236.39	195.64	155.09	77	220.51	344.80	213.30	271.86	224.98	178.35
196.37	307.05	190.04	242.09	200.35	158.83	78	225.83	353.11	218.44	278.40	230.40	182.65
200.99	314.28	194.52	247.79	205.07	162.57	79	231.14	361.42	223.58	284.96	235.83	186.95
205.45	321.25	198.83	253.28	209.61	166.17	80	236.27	369.43	228.54	291.28	241.06	191.10
209.31	327.29	202.57	258.04	213.55	169.29	81	240.71	376.37	232.84	296.74	245.58	194.69
213.24	333.43	206.37	262.89	217.56	172.47	82	245.22	383.44	237.21	302.32	250.19	198.35
217.24	339.70	210.25	267.82	221.64	175.72	83	249.83	390.65	241.66	308.00	254.89	202.07
221.33	346.08	214.19	272.86	225.81	179.02	84	254.53	397.98	246.20	313.79	259.68	205.87
224.49	351.01	217.25	276.76	229.03	181.57	85	258.16	403.67	249.71	318.27	263.39	208.81
227.69	356.03	220.35	280.71	232.30	184.16	86	261.84	409.43	253.28	322.81	267.15	211.79
230.95	361.10	223.50	284.71	235.62	186.79	87	265.58	415.27	256.90	327.42	270.97	214.81
234.24	366.27	226.69	288.77	238.99	189.46	88	269.37	421.20	260.56	332.09	274.83	217.88
237.58	371.48	229.93	292.89	242.39	192.16	89	273.21	427.21	264.28	336.83	278.75	220.99
240.97	376.78	233.21	297.08	245.85	194.90	90	277.12	433.31	268.06	341.64	282.73	224.14
243.73	381.10	235.88	300.47	248.67	197.13	91	280.29	438.27	271.12	345.55	285.96	226.70
246.52	385.46	238.57	303.91	251.51	199.39	92	283.49	443.27	274.22	349.50	289.24	229.30
249.34	389.87	241.30	307.39	254.39	201.67	93	286.74	448.34	277.36	353.50	292.54	231.92
252.18	394.32	244.06	310.91	257.30	203.98	94	290.01	453.48	280.53	357.54	295.89	234.57
253.11	395.76	244.95	312.03	258.23	204.72	95	291.07	455.12	281.55	358.83	296.96	235.42
254.02	397.19	245.84	313.17	259.17	205.46	96	292.12	456.78	282.57	360.14	298.04	236.28
254.95	398.64	246.73	314.30	260.11	206.20	97	293.18	458.43	283.59	361.45	299.13	237.14
255.87	400.08	247.62	315.44	261.06	206.95	98	294.24	460.10	284.62	362.75	300.21	238.00
256.79	401.53	248.53	316.59	262.00	207.70	99	295.31	461.77	285.66	364.08	301.30	238.86

* **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*
STANDARD PLANS - TOBACCO

Female							Male					
Plan A	Plan C	Plan D	Plan F	Plan G	Plan N	Attained Age	Plan A	Plan C	Plan D	Plan F	Plan G	Plan N
N/A	246.86	152.97	N/A	N/A	N/A	Under 65	N/A	283.89	175.83	N/A	N/A	N/A
157.88	246.86	152.97	194.64	161.35	127.91	65	181.57	283.89	175.83	223.84	185.55	147.09
157.88	246.86	152.97	194.64	161.35	127.91	66	181.57	283.89	175.83	223.84	185.55	147.09
157.88	246.86	152.97	194.64	161.35	127.91	67	181.57	283.89	175.83	223.84	185.55	147.09
161.25	252.15	155.98	198.80	164.53	130.43	68	185.44	289.97	179.29	228.62	189.20	149.99
167.68	262.20	162.20	206.73	171.08	135.62	69	192.83	301.53	186.43	237.73	196.74	155.97
174.44	272.76	168.73	215.06	177.97	141.09	70	200.60	313.67	193.95	247.31	204.67	162.25
181.53	283.84	175.59	223.79	185.20	146.82	71	208.75	326.41	201.82	257.36	212.98	168.85
188.61	294.92	182.44	232.53	192.43	152.56	72	216.91	339.16	209.70	267.41	221.30	175.44
195.92	306.36	189.51	241.53	199.89	158.47	73	225.31	352.30	217.83	277.77	229.87	182.24
202.46	316.56	195.83	249.60	206.56	163.75	74	232.82	364.06	225.10	287.03	237.54	188.32
208.77	326.44	201.94	257.38	213.00	168.86	75	240.09	375.41	232.12	295.99	244.95	194.19
214.86	335.96	207.84	264.89	219.22	173.79	76	247.09	386.36	238.90	304.63	252.10	199.85
220.51	344.80	213.30	271.86	224.98	178.35	77	253.59	396.52	245.17	312.63	258.73	205.11
225.83	353.11	218.44	278.40	230.40	182.65	78	259.70	406.08	251.08	320.17	264.96	210.05
231.14	361.42	223.58	284.96	235.83	186.95	79	265.81	415.63	256.99	327.70	271.20	215.00
236.27	369.43	228.54	291.28	241.06	191.10	80	271.70	424.84	262.69	334.97	277.21	219.76
240.71	376.37	232.84	296.74	245.58	194.69	81	276.82	432.83	267.63	341.26	282.42	223.89
245.22	383.44	237.21	302.32	250.19	198.35	82	282.01	440.96	272.65	347.68	287.72	228.10
249.83	390.65	241.66	308.00	254.89	202.07	83	287.31	449.24	277.78	354.20	293.13	232.38
254.53	397.98	246.20	313.79	259.68	205.87	84	292.71	457.69	282.99	360.86	298.63	236.75
258.16	403.67	249.71	318.27	263.39	208.81	85	296.89	464.21	287.03	366.00	302.89	240.13
261.84	409.43	253.28	322.81	267.15	211.79	86	301.12	470.85	291.13	371.23	307.22	243.56
265.58	415.27	256.90	327.42	270.97	214.81	87	305.43	477.56	295.29	376.53	311.61	247.03
269.37	421.20	260.56	332.09	274.83	217.88	88	309.78	484.38	299.50	381.91	316.05	250.56
273.21	427.21	264.28	336.83	278.75	220.99	89	314.20	491.29	303.77	387.35	320.56	254.13
277.12	433.31	268.06	341.64	282.73	224.14	90	318.68	498.30	308.11	392.89	325.14	257.76
280.29	438.27	271.12	345.55	285.96	226.70	91	322.33	504.00	311.63	397.37	328.86	260.71
283.49	443.27	274.22	349.50	289.24	229.30	92	326.01	509.77	315.19	401.93	332.62	263.69
286.74	448.34	277.36	353.50	292.54	231.92	93	329.75	515.60	318.81	406.51	336.43	266.71
290.01	453.48	280.53	357.54	295.89	234.57	94	333.52	521.50	322.45	411.17	340.27	269.76
291.07	455.12	281.55	358.83	296.96	235.42	95	334.73	523.38	323.62	412.66	341.51	270.74
292.12	456.78	282.57	360.14	298.04	236.28	96	335.95	525.29	324.80	414.16	342.75	271.72
293.18	458.43	283.59	361.45	299.13	237.14	97	337.16	527.19	325.97	415.67	343.99	272.71
294.24	460.10	284.62	362.75	300.21	238.00	98	338.39	529.11	327.15	417.17	345.24	273.70
295.31	461.77	285.66	364.08	301.30	238.86	99	339.61	531.02	328.35	418.69	346.50	274.69

* **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	All but $1,484	$0	$1,484 (Part A Deductible)
61st thru 90th day	All but $371 a day	$371 a day	$0
91st day and after:			
• While using 60 lifetime reserve days	All but $742 a day	$742 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 $185.50 a day	$0	Up to $185.50 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			
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 $203 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 $203 of Medicare-approved amounts*	$0	$0	$203 (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 $203 of Medicare-approved amounts*	$0	$0	$203 (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 $203 of Medicare-approved amounts*	$0	$0	$203 (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 $1,484	$1,484 (Part A Deductible)	$0
61st thru 90th day	All but $371 a day	$371 a day	$0
91st day and after:			
• While using 60 lifetime reserve days	All but $742 a day	$742 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 $185.50 a day	Up to $185.50 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 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 C
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

* Once You have been billed $203 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 $203 of Medicare-approved amounts*	$0	$203 (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 $203 of Medicare-approved amounts*	$0	$203 (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 $203 of Medicare-approved amounts*	$0	$203 (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 $1,484	$1,484 (Part A Deductible)	$0
61st thru 90th day	All but $371 a day	$371 a day	$0
91st day and after:			
• While using 60 lifetime reserve days	All but $742 a day	$742 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 $185.50 a day	Up to $185.50 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 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 D
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

* Once You have been billed $203 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 $203 of Medicare-approved amounts*	$0	$0	$203 (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 $203 of Medicare-approved amounts*	$0	$0	$203 (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 $203 of Medicare-approved amounts*	$0	$0	$203 (Part B Deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

PLAN D

OTHER BENEFITS – NOT COVERED BY MEDICARE

FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services 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 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 $1,484	$1,484 (Part A Deductible)	$0
61st thru 90th day	All but $371 a day	$371 a day	$0
91st day and after:			
• While using 60 lifetime reserve days	All but $742 a day	$742 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 $185.50 a day	Up to $185.50 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 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 $203 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 $203 of Medicare-approved amounts*	$0	$203 (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 $203 of Medicare-approved amounts*	$0	$203 (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 $203 of Medicare-approved amounts*	$0	$203 (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 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 $1,484	$1,484 (Part A Deductible)	$0
61st thru 90th day	All but $371 a day	$371 a day	$0
91st day and after:			
• While using 60 lifetime reserve days	All but $742 a day	$742 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 $185.50 a day	Up to $185.50 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 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 $203 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 $203 of Medicare-approved amounts*	$0	$0	$203 (Unless Part B deductible has been met)
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 $203 of Medicare-approved amounts*	$0	$0	$203 (Unless Part B deductible has been met)
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 $203 of Medicare-approved amounts*	$0	$0	$203 (Unless Part B deductible has been met)
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 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	All but $1,484	$1,484 (Part A Deductible)	$0
61st thru 90th day	All but $371 a day	$371 a day	$0
91st day and after:			
• While using 60 lifetime reserve days	All but $742 a day	$742 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 $185.50 a day	Up to $185.50 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 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 $203 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 $203 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.	$203 (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 $203 of Medicare-approved amounts* Remainder of Medicare-approved amounts	$0 $0 80%	All Costs $0 20%	$0 $203 (Part B Deductible) $0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN N

PARTS A & B

HOME HEALTH CARE MEDICARE-APPROVED SERVICES • Medically necessary skilled care services and medical supplies • Durable medical equipment First $203 of Medicare-approved amounts* Remainder of Medicare-approved amounts	100% $0 80%	$0 $0 20%	$0 $203 (Part B Deductible) $0

OTHER BENEFITS – NOT COVERED BY MEDICARE

FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services 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