

SERFF Tracking Number: WKLY-125853049 State: Arkansas
Filing Company: Genworth Life and Annuity Insurance Company State Tracking Number: 40499
Company Tracking Number: GLAIC 2009 OC
TOI: MS06 Medicare Supplement - Other Sub-TOI: MS06.000 Medicare Supplement - Other
Product Name: Genworth Life and Annuity Insurance Company 2009 Outline of Medicare Supplement Coverage Filing
Project Name/Number: /

Filing at a Glance

Company: Genworth Life and Annuity Insurance Company

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SERFF Status: Closed

State Tr Num: 40499

Co Tr Num: GLAIC 2009 OC

State Status: Approved-Closed

Reviewer(s): Stephanie Fowler

Filing Type: Form

Co Status:

Disposition Date: 11/07/2008

Author: Jeffrey McGinn

Date Submitted: 10/10/2008

Disposition Status: Approved

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name:

Status of Filing in Domicile: Not Filed

Project Number:

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Group Market Size:

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 11/07/2008

State Status Changed: 11/07/2008

Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

The attached outline of coverage has been revised to comply with the 2009 Medicare Supplement Deductibles and Copayments. It replaces form GOCMS8071 AR 1/08.

The outline will be used with policy form numbers GCMSPA06 AR et al, originally approved by your Department on November 10, 2005.

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Company and Contact

Filing Contact Information

(This filing was made by a third party - WAI01)

Jeffrey McGinn, Compliance Analyst jeffrey.mcginn@wakelyinc.com
Wakely and Associates, Inc. (727) 584-8128 [Phone]
Largo, FL 33773-1502 (727) 584-5613[FAX]

Filing Company Information

Genworth Life and Annuity Insurance Company CoCode: 65536 State of Domicile: Virginia
6610 West Broad Street Group Code: 4011 Company Type:
Richmond, VA 23230 Group Name: State ID Number:
(804) 662-2400 ext. [Phone] FEIN Number: 54-0283385

Filing Fees

Fee Required? Yes
Fee Amount: \$20.00
Retaliatory? No
Fee Explanation:
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Genworth Life and Annuity Insurance Company	\$20.00	10/10/2008	23106454

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Stephanie Fowler	11/07/2008	11/07/2008

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Disposition Date: 11/07/2008

Implementation Date:

Status: Approved

Comment:

Rate data does NOT apply to filing.

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Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice		Yes
Supporting Document	Application		Yes
Supporting Document	Health - Actuarial Justification		Yes
Supporting Document	Outline of Coverage		Yes
Supporting Document	Third Party Authorization Letter		Yes
Form	Outline of Medicare Supplement Coverage	Approved	Yes

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Form Schedule

Lead Form Number: GOCMS8071 AR 1/09

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved	GOCMS8071 AR 1/09	Outline of Coverage	Outline of Medicare Supplement Coverage	Revised	Replaced Form #: GOCMS8071 AR 1/08 Previous Filing #: 37274		GOCMS8071 AR0109.pdf

MEDICARE SUPPLEMENT OUTLINE OF COVERAGE

ARKANSAS

**Benefit Plans A, B, C, D, E, F, G
& High Deductible F**

Genworth Life and Annuity Insurance Company

P.O. Box 10824
Clearwater, Florida 33757-8824
Telephone Number: (877) 825-9337

GENWORTH LIFE AND ANNUITY INSURANCE COMPANY
OUTLINE OF MEDICARE SUPPLEMENT COVERAGE COVER PAGE: Page 1 of 2
BENEFIT PLANS AVAILABLE: A, B, C, D, E, F, G AND HIGH DEDUCTIBLE F

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

See Outlines of Coverage sections for details about ALL Plans

Basic Benefits: Included in All Plans:

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

Medical Expenses: Part B coinsurance (generally 20% of Medicare-Approved expenses) or, copayments for hospital outpatient services

Blood: First three pints of blood each year.

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

*Plans F and J also have an option called a high deductible plan F and a high deductible plan J. These high deductible plans pay the same benefits as Plans F and J after one has paid a calendar year \$2000 deductible. Benefits from high deductible plans F and J will not begin until out-of-pocket expenses exceed \$2000. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

GENWORTH LIFE AND ANNUITY INSURANCE COMPANY
Outline of Medicare Supplement Coverage-Cover Page: Page 2

Basic Benefits for Plans K and L include similar services as Plans A-J, but cost sharing for the basic benefits is at different levels.

J	K**	L**
Basic Benefits	100% of Part A Hospitalization Coinsurance plus coverage for 365 Days after Medicare Benefits end. 50% Hospice cost-sharing 50% of Medicare-eligible expenses for the first three pints of blood. 50% Part B Coinsurance, except 100% Coinsurance for Part B Preventive Services.	100% of Part A Hospitalization Coinsurance plus coverage for 365 Days after Medicare Benefits end. 75% Hospice cost-sharing 75% of Medicare-eligible expenses for the first three pints of blood. 75% Part B Coinsurance, except 100% Coinsurance for Part B Preventive Services.
Skilled Nursing Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance
Part A Deductible	50% Part A Deductible	75% Part A Deductible
Part B Deductible		
Part B Excess		
Foreign Travel Emergency		
At-Home Recovery		
Preventive Care NOT covered by Medicare		
	\$4620 Out of Pocket Annual Limit***	\$2310 Out of Pocket Annual Limit***

** Plans K and L provide for different cost-sharing for items and services than Plans A-J. Once you reach the annual limit, the plan pays 100% of the Medicare copayments, coinsurance, and deductibles for the rest of the calendar year. The out-of-pocket annual limit does NOT include charges from your provider that exceed Medicare-approved amounts, called "Excess Charges". You will be responsible for paying excess charges.

*** The out-of-pocket annual limit will increase each year for inflation.

See Outlines of Coverage for details and exceptions.

**GENWORTH LIFE AND ANNUITY INSURANCE COMPANY
 MEDICARE STANDARD UNI-AGE PREMIUMS
 ARKANSAS RATES EFFECTIVE 6/1/08
 FOR USE IN ZIP CODES: 719-722
 UNISEX RATES**

ANNUAL RATES

Attained Age	Non-Tobacco User								Attained Age	Standard							
	Plan A	Plan B	Plan C	Plan D	Plan E	Plan F	PLAN HDF	Plan G		Plan A	Plan B	Plan C	Plan D	Plan E	Plan F	PLAN HDF	Plan G
All	1,800	2,195	2,592	2,206	2,217	2,672	1,051	2,262	All	2,002	2,439	2,880	2,451	2,466	2,968	1,167	2,514

SEMI-ANNUAL RATES

Attained Age	Non-Tobacco User								Attained Age	Standard							
	Plan A	Plan B	Plan C	Plan D	Plan E	Plan F	PLAN HDF	Plan G		Plan A	Plan B	Plan C	Plan D	Plan E	Plan F	PLAN HDF	Plan G
All	936.00	1,141.40	1,347.84	1,147.12	1,152.84	1,389.44	546.52	1,176.24	All	1,041.04	1,268.28	1,497.60	1,274.52	1,282.32	1,543.36	606.84	1,307.28

QUARTERLY RATES

Attained Age	Non-Tobacco User								Attained Age	Standard							
	Plan A	Plan B	Plan C	Plan D	Plan E	Plan F	PLAN HDF	Plan G		Plan A	Plan B	Plan C	Plan D	Plan E	Plan F	PLAN HDF	Plan G
All	477.00	581.68	686.88	584.59	587.51	708.08	278.52	599.43	All	530.53	646.34	763.20	649.52	653.49	786.52	309.26	666.21

MONTHLY RATES

Attained Age	Non-Tobacco User								Attained Age	Standard							
	Plan A	Plan B	Plan C	Plan D	Plan E	Plan F	PLAN HDF	Plan G		Plan A	Plan B	Plan C	Plan D	Plan E	Plan F	PLAN HDF	Plan G
All	156.06	190.31	224.73	191.26	192.21	231.66	91.12	196.12	All	173.57	211.46	249.70	212.50	213.80	257.33	101.18	217.96

GENWORTH LIFE AND ANNUITY INSURANCE COMPANY
MEDICARE STANDARD UNI-AGE PREMIUMS
ARKANSAS RATES EFFECTIVE 6/1/08
FOR USE IN ZIP CODES: 718, 727-729
UNISEX RATES

ANNUAL RATES

Attained Age	Non-Tobacco User								Attained Age	Standard							
	Plan A	Plan B	Plan C	Plan D	Plan E	Plan F	PLAN HDF	Plan G		Plan A	Plan B	Plan C	Plan D	Plan E	Plan F	PLAN HDF	Plan G
All	1,620	1,976	2,333	1,985	1,995	2,405	946	2,036	All	1,802	2,195	2,592	2,206	2,219	2,671	1,050	2,263

SEMI-ANNUAL RATES

Attained Age	Non-Tobacco User								Attained Age	Standard							
	Plan A	Plan B	Plan C	Plan D	Plan E	Plan F	PLAN HDF	Plan G		Plan A	Plan B	Plan C	Plan D	Plan E	Plan F	PLAN HDF	Plan G
All	842.40	1,027.52	1,213.16	1,032.20	1,037.40	1,250.60	491.92	1,058.72	All	937.04	1,141.40	1,347.84	1,147.12	1,153.88	1,388.92	546.00	1,176.76

QUARTERLY RATES

Attained Age	Non-Tobacco User								Attained Age	Standard							
	Plan A	Plan B	Plan C	Plan D	Plan E	Plan F	PLAN HDF	Plan G		Plan A	Plan B	Plan C	Plan D	Plan E	Plan F	PLAN HDF	Plan G
All	429.30	523.64	618.25	526.03	528.68	637.33	250.69	539.54	All	477.53	581.68	686.88	584.59	588.04	707.82	278.25	599.70

MONTHLY RATES

Attained Age	Non-Tobacco User								Attained Age	Standard							
	Plan A	Plan B	Plan C	Plan D	Plan E	Plan F	PLAN HDF	Plan G		Plan A	Plan B	Plan C	Plan D	Plan E	Plan F	PLAN HDF	Plan G
All	140.45	171.32	202.27	172.10	172.97	208.51	82.02	176.52	All	156.23	190.31	224.73	191.26	192.39	231.58	91.04	196.20

GENWORTH LIFE AND ANNUITY INSURANCE COMPANY
MEDICARE STANDARD UNI-AGE PREMIUMS
ARKANSAS RATES EFFECTIVE 6/1/08
FOR USE IN ZIP CODES: ALL EXCEPT 718-722, 727-729
UNISEX RATES

ANNUAL RATES

Attained Age	Non-Tobacco User								Attained Age	Standard							
	Plan A	Plan B	Plan C	Plan D	Plan E	Plan F	PLAN HDF	Plan G		Plan A	Plan B	Plan C	Plan D	Plan E	Plan F	PLAN HDF	Plan G
All	1,440	1,756	2,074	1,765	1,774	2,138	841	1,810	All	1,602	1,951	2,304	1,961	1,973	2,374	934	2,011

SEMI-ANNUAL RATES

Attained Age	Non-Tobacco User								Attained Age	Standard							
	Plan A	Plan B	Plan C	Plan D	Plan E	Plan F	PLAN HDF	Plan G		Plan A	Plan B	Plan C	Plan D	Plan E	Plan F	PLAN HDF	Plan G
All	748.80	913.12	1,078.48	917.80	922.48	1,111.76	437.32	941.20	All	833.04	1,014.52	1,198.08	1,019.72	1,025.96	1,234.48	485.68	1,045.72

QUARTERLY RATES

Attained Age	Non-Tobacco User								Attained Age	Standard							
	Plan A	Plan B	Plan C	Plan D	Plan E	Plan F	PLAN HDF	Plan G		Plan A	Plan B	Plan C	Plan D	Plan E	Plan F	PLAN HDF	Plan G
All	381.60	465.34	549.61	467.73	470.11	566.57	222.87	479.65	All	424.53	517.02	610.56	519.67	522.85	629.11	247.51	532.92

QUARTERLY RATES

Attained Age	Non-Tobacco User								Attained Age	Standard							
	Plan A	Plan B	Plan C	Plan D	Plan E	Plan F	PLAN HDF	Plan G		Plan A	Plan B	Plan C	Plan D	Plan E	Plan F	PLAN HDF	Plan G
All	124.85	152.25	179.82	153.03	153.81	185.36	72.91	156.93	All	138.89	169.15	199.76	170.02	171.06	205.83	80.98	174.35

PREMIUM INFORMATION

Genworth Life and Annuity Insurance Company can only raise your premium if we raise the premium for all policies like yours in this state.

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

Semi-annual: 0.5200 Quarterly: 0.2650 Monthly EFT: 0.0867

DISCLOSURES

Use this outline to compare benefits and premium among policies.

READ YOUR POLICY VERY CAREFULLY

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to Genworth Life and Annuity Insurance Company, P.O. Box 10824, Clearwater, FL 33757-8824. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

POLICY REPLACEMENT

If you are replacing another health insurance policy, do **NOT** cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE

The policy may not cover all of your medical costs.

Neither Genworth Life and Annuity 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 & 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 any 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.

THE FOLLOWING CHARTS DESCRIBE PLANS A, B, C, D, E, F, G AND HIGH DEDUCTIBLE F OFFERED BY GENWORTH LIFE AND ANNUITY INSURANCE COMPANY.

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
<p>HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days</p> <p>61st thru 90th day 91st day and after</p> <ul style="list-style-type: none"> •While using 60 lifetime reserve days •Once lifetime reserve days are used: <ul style="list-style-type: none"> •Additional 365 days •Beyond the Additional 365 days 	<p>All but \$1068</p> <p>All but \$267 a day</p> <p>All but \$534 a day</p> <p>\$0</p> <p>\$0</p>	<p>\$0</p> <p>\$267 a day</p> <p>\$534 a day</p> <p>100% of Medicare Eligible Expenses</p> <p>\$0</p>	<p>\$1068 (Part A Deductible)</p> <p>\$0</p> <p>\$0</p> <p>\$0**</p> <p>All costs</p>
<p>SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital</p> <p>First 20 days</p> <p>21st thru 100th day</p> <p>101st day and after</p>	<p>All approved amounts</p> <p>All but \$133.50 a day</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>\$0</p>	<p>\$0</p> <p>Up to \$133.50 a day</p> <p>All costs</p>
<p>BLOOD First 3 pints Additional amounts</p>	<p>\$0</p> <p>100%</p>	<p>3 pints</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p>
<p>HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services</p>	<p>All but very limited coinsurance for outpatient drugs and inpatient respite care</p>	<p>\$0</p>	<p>Balance</p>

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

PLAN A

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

*Once you have been billed \$135 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic test, durable medical equipment First \$135 of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0 Generally 80%	\$0 Generally 20%	\$135 (Part B Deductible) \$0
Part B Excess Charges (Above Medicare-Approved amounts)	\$0	\$0	All costs
BLOOD First 3 pints Next \$135 of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$135 (Part B Deductible) \$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES •Medically necessary skilled care services and medical supplies	100%	\$0	\$0
•Durable medical equipment •First \$135 of Medicare Approved amounts*	\$0	\$0	\$135 (Part B Deductible)
•Remainder of Medicare Approved amounts	80%	20%	\$0

PLAN B

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<p>HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days</p> <p>61st thru 90th day 91st day and after</p> <ul style="list-style-type: none"> •While using 60 lifetime reserve days •Once lifetime reserve days are used: <ul style="list-style-type: none"> •Additional 365 days •Beyond the Additional 365 days 	<p>All but \$1068</p> <p>All but \$267 a day</p> <p>All but \$534 a day</p> <p>\$0</p> <p>\$0</p>	<p>\$1068 (Part A Deductible)</p> <p>\$267 a day</p> <p>\$534 a day</p> <p>100% of Medicare Eligible Expenses</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>\$0</p> <p>\$0**</p> <p>All costs</p>
<p>SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital</p> <p>First 20 days</p> <p>21st thru 100th day</p> <p>101st day and after</p>	<p>All approved amounts</p> <p>All but \$133.50 a day</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>\$0</p>	<p>\$0</p> <p>Up to \$133.50 a day</p> <p>All costs</p>
<p>BLOOD First 3 pints Additional amounts</p>	<p>\$0</p> <p>100%</p>	<p>3 pints</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p>
<p>HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services</p>	<p>All but very limited coinsurance for outpatient drugs and inpatient respite care</p>	<p>\$0</p>	<p>Balance</p>

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

PLAN B

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

* Once you have been billed \$135 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic test, durable medical equipment First \$135 of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0 Generally 80%	\$0 Generally 20%	\$135 (Part B Deductible) \$0
Part B Excess Charges (Above Medicare-Approved amounts)	\$0	\$0	All costs
BLOOD First 3 pints Next \$135 of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$135 (Part B Deductible) \$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES •Medically necessary skilled care services and medical supplies	100%	\$0	\$0
•Durable medical equipment •First \$135 of Medicare Approved amounts*	\$0	\$0	\$135 (Part B Deductible)
•Remainder of Medicare Approved amounts	80%	20%	\$0

PLAN C

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<p>HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days</p> <p>61st thru 90th day 91st day and after</p> <ul style="list-style-type: none"> •While using 60 lifetime reserve days •Once lifetime reserve days are used: <ul style="list-style-type: none"> •Additional 365 days •Beyond the Additional 365 days 	<p>All but \$1068</p> <p>All but \$267 a day</p> <p>All but \$534 a day</p> <p>\$0</p> <p>\$0</p>	<p>\$1068 (Part A Deductible)</p> <p>\$267 a day</p> <p>\$534 a day</p> <p>100% of Medicare Eligible Expenses</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>\$0</p> <p>\$0**</p> <p>All costs</p>
<p>SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital</p> <p>First 20 days</p> <p>21st thru 100th day</p> <p>101st day and after</p>	<p>All approved amounts</p> <p>All but \$133.50 a day</p> <p>\$0</p>	<p>\$0</p> <p>Up to \$133.50 a day</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>All costs</p>
<p>BLOOD First 3 pints Additional amounts</p>	<p>\$0</p> <p>100%</p>	<p>3 pints</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p>
<p>HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services</p>	<p>All but very limited coinsurance for outpatient drugs and inpatient respite care</p>	<p>\$0</p>	<p>Balance</p>

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

PLAN C

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

*Once you have been billed \$135 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic test, durable medical equipment First \$135 of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0 Generally 80%	\$135 (Part B Deductible) Generally 20%	\$0 \$0
Part B Excess Charges (Above Medicare-Approved amounts)	\$0	\$0	All costs
BLOOD First 3 pints Next \$135 of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0 \$0 80%	All costs \$135 (Part B Deductible) 20%	\$0 \$0 \$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES •Medically necessary skilled care services and medical supplies	100%	\$0	\$0
•Durable medical equipment •First \$135 of Medicare Approved amounts*	\$0	\$135 (Part B Deductible)	\$0
•Remainder of Medicare Approved amounts	80%	20%	\$0

PLAN C

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

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
<p>HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days</p> <p>61st thru 90th day 91st day and after</p> <ul style="list-style-type: none"> •While using 60 lifetime reserve days •Once lifetime reserve days are used: <ul style="list-style-type: none"> •Additional 365 days •Beyond the Additional 365 days 	<p>All but \$1068</p> <p>All but \$267 a day</p> <p>All but \$534 a day</p> <p>\$0</p> <p>\$0</p>	<p>\$1068 (Part A Deductible)</p> <p>\$267 a day</p> <p>\$534 a day</p> <p>100% of Medicare Eligible Expenses</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>\$0</p> <p>\$0**</p> <p>All costs</p>
<p>SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital</p> <p>First 20 days</p> <p>21st thru 100th day</p> <p>101st day and after</p>	<p>All approved amounts</p> <p>All but \$133.50 a day</p> <p>\$0</p>	<p>\$0</p> <p>Up to \$133.50 a day</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>All costs</p>
<p>BLOOD First 3 pints Additional amounts</p>	<p>\$0</p> <p>100%</p>	<p>3 pints</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p>
<p>HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services</p>	<p>All but very limited coinsurance for outpatient drugs and inpatient respite care</p>	<p>\$0</p>	<p>Balance</p>

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

PLAN D

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

*Once you have been billed \$135 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic test, durable medical equipment First \$135 of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0 Generally 80%	\$0 Generally 20%	\$135 (Part B Deductible) \$0
Part B Excess Charges (Above Medicare-Approved amounts)	\$0	\$0	All costs
BLOOD First 3 pints Next \$135 of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$135 (Part B Deductible) \$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES •Medically necessary skilled care services and medical supplies •Durable medical equipment •First \$135 of Medicare Approved amounts* •Remainder of Medicare Approved amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$135 (Part B Deductible) \$0

**PLAN D
PARTS A & B**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE (cont'd) AT-HOME RECOVERY SERVICES – NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care beginning during recovery from an Injury or sickness for which Medicare approved a Home Care Treatment Plan •Benefit for each visit •Number of visits covered (must be received within 8 weeks of last Medicare-Approved visit) •Calendar year maximum	\$0 \$0 \$0	Actual Charges to \$40 a visit Up to the number of Medicare-Approved visits, not to exceed 7 each week \$1,600	Balance

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year 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

PLAN E

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<p>HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days</p> <p>61st thru 90th day 91st day and after</p> <ul style="list-style-type: none"> •While using 60 lifetime reserve days •Once lifetime reserve days are used: <ul style="list-style-type: none"> •Additional 365 days •Beyond the Additional 365 days 	<p>All but \$1068</p> <p>All but \$267 a day</p> <p>All but \$534 a day</p> <p>\$0</p> <p>\$0</p>	<p>\$1068 (Part A Deductible)</p> <p>\$267 a day</p> <p>\$534 a day</p> <p>100% of Medicare Eligible Expenses</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>\$0</p> <p>\$0**</p> <p>All costs</p>
<p>SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital</p> <p>First 20 days</p> <p>21st thru 100th day</p> <p>101st day and after</p>	<p>All approved amounts</p> <p>All but \$133.50 a day</p> <p>\$0</p>	<p>\$0</p> <p>Up to \$133.50 a day</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>All costs</p>
<p>BLOOD First 3 pints Additional amounts</p>	<p>\$0</p> <p>100%</p>	<p>3 pints</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p>
<p>HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services</p>	<p>All but very limited coinsurance for outpatient drugs and inpatient respite care</p>	<p>\$0</p>	<p>Balance</p>

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

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

*Once you have been billed \$135 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic test, durable medical equipment First \$135 of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0 Generally 80%	\$0 Generally 20%	\$135 (Part B Deductible) \$0
Part B Excess Charges (Above Medicare-Approved amounts)	\$0	\$0	All costs
BLOOD First 3 pints Next \$135 of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$135 (Part B Deductible) \$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES <ul style="list-style-type: none"> •Medically necessary skilled care services and medical supplies •Durable medical equipment •First \$135 of Medicare Approved amounts* •Remainder of Medicare Approved amounts 	100% \$0 80%	\$0 \$0 20%	\$0 \$135 (Part B Deductible) \$0

(continued)

PLAN E

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year 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
*PREVENTIVE MEDICAL CARE BENEFIT – NOT COVERED BY MEDICARE Some annual physical and preventive tests and services administered or ordered by your doctor when not covered by Medicare First \$120 each calendar year Additional charges	\$0 \$0	\$120 \$0	\$0 All costs

*Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

PLAN F

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<p>HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days</p> <p>61st thru 90th day 91st day and after</p> <ul style="list-style-type: none"> •While using 60 lifetime reserve days •Once lifetime reserve days are used: <ul style="list-style-type: none"> •Additional 365 days •Beyond the Additional 365 days 	<p>All but \$1068</p> <p>All but \$267 a day</p> <p>All but \$534 a day</p> <p>\$0</p> <p>\$0</p>	<p>\$1068 (Part A Deductible)</p> <p>\$267 a day</p> <p>\$534 a day</p> <p>100% of Medicare Eligible Expenses</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>\$0</p> <p>\$0**</p> <p>All costs</p>
<p>SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital</p> <p>First 20 days</p> <p>21st thru 100th day</p> <p>101st day and after</p>	<p>All approved amounts</p> <p>All but \$133.50 a day</p> <p>\$0</p>	<p>\$0</p> <p>Up to \$133.50 a day</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>All costs</p>
<p>BLOOD First 3 pints Additional amounts</p>	<p>\$0</p> <p>100%</p>	<p>3 pints</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p>
<p>HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services</p>	<p>All but very limited coinsurance for outpatient drugs and inpatient respite care</p>	<p>\$0</p>	<p>Balance</p>

(continued)

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

PLAN F

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

*Once you have been billed \$135 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic test, durable medical equipment First \$135 of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0 Generally 80%	\$135 (Part B Deductible) Generally 20%	\$0 \$0
Part B Excess Charges (Above Medicare-Approved amounts)	\$0	100%	\$0
BLOOD First 3 pints Next \$135 of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0 \$0 80%	All costs \$135 (Part B Deductible) 20%	\$0 \$0 \$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES •Medically necessary skilled care services and medical supplies	100%	\$0	\$0
•Durable medical equipment •First \$135 of Medicare Approved amounts* •Remainder of Medicare Approved amounts	\$0 80%	\$135 (Part B Deductible) 20%	\$0 \$0

PLAN F

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

**HIGH DEDUCTIBLE 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.

**This high deductible plan pays the same benefits as Plan F after you have paid a calendar year \$2000 deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are \$2000. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's foreign emergency travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$2000 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO \$2000 DEDUCTIBLE** YOU PAY
<p>HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days</p> <p>61st thru 90th day 91st day and after</p> <ul style="list-style-type: none"> •While using 60 lifetime reserve days •Once lifetime reserve days are used: <ul style="list-style-type: none"> •Additional 365 days •Beyond the Additional 365 days 	<p>All but \$1068</p> <p>All but \$267 a day</p> <p>All but \$534 a day</p> <p>\$0</p> <p>\$0</p>	<p>\$1068 (Part A Deductible)</p> <p>\$267 a day</p> <p>\$534 a day</p> <p>100% of Medicare Eligible Expenses</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>\$0</p> <p>\$0***</p> <p>All costs</p>
<p>SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital</p> <p>First 20 days</p> <p>21st thru 100th day</p> <p>101st day and after</p>	<p>All approved amounts</p> <p>All but \$133.50 a day</p> <p>\$0</p>	<p>\$0</p> <p>Up to \$133.50 a day</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>All costs</p>
<p>BLOOD First 3 pints Additional amounts</p>	<p>\$0</p> <p>100%</p>	<p>3 pints</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p>

HIGH DEDUCTIBLE PLAN F
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$2000 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO \$2000 DEDUCTIBLE** YOU PAY
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

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

HIGH DEDUCTIBLE PLAN F

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

*Once you have been billed \$135 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

**This high deductible plan pays the same benefits as Plan F after you have paid a calendar year \$2000 deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are \$2000. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's foreign emergency travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$2000 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO \$2000 DEDUCTIBLE** 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 test, durable medical equipment First \$135 of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0 Generally 80%	\$135 (Part B Deductible) Generally 20%	\$0 \$0
Part B Excess Charges (Above Medicare-Approved amounts)	\$0	100%	\$0
BLOOD First 3 pints Next \$135 of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0 \$0 80%	All costs \$135 (Part B Deductible) 20%	\$0 \$0 \$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

(continued)

HIGH DEDUCTIBLE PLAN F

PARTS A & B

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$2000 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO \$2000 DEDUCTIBLE** YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES <ul style="list-style-type: none"> • Medically necessary skilled care services and medical supplies • Durable medical equipment <ul style="list-style-type: none"> • First \$135 of Medicare Approved amounts* • Remainder of Medicare Approved amounts 	100% \$0 80%	\$0 \$135 (Part B Deductible) 20%	\$0 \$0 \$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$2000 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO \$2000 DEDUCTIBLE** YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year 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

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 61st thru 90th day 91st day and after •While using 60 lifetime reserve days •Once lifetime reserve days are used: •Additional 365 days •Beyond the Additional 365 days	All but \$1068 All but \$267 a day All but \$534 a day \$0 \$0	\$1068 (Part A Deductible) \$267 a day \$534 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 21st thru 100th day 101st day and after	All approved amounts All but \$133.50 a day \$0	\$0 Up to \$133.50 a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

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

PLAN G

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

*Once you have been billed \$135 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic test, durable medical equipment First \$135 of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0 Generally 80%	\$0 Generally 20%	\$135 (Part B Deductible) \$0
Part B Excess Charges (Above Medicare-Approved amounts)	\$0	80%	20%
BLOOD First 3 pints Next \$135 of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$135 (Part B Deductible) \$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES •Medically necessary skilled care services and medical supplies •Durable medical equipment • First \$135 of Medicare Approved amounts* •Remainder of Medicare Approved amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$135 (Part B Deductible) \$0

PLAN G
PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE (cont'd) AT-HOME RECOVERY SERVICES – NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care beginning during recovery from an Injury or sickness for which Medicare approved a Home Care Treatment Plan •Benefit for each visit •Number of visits covered (must be received within 8 weeks of last Medicare-Approved visit) •Calendar year maximum	\$0 \$0 \$0	Actual Charges to \$40 a visit Up to the number of Medicare-Approved visits, not to exceed 7 each week \$1,600	Balance

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year 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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Supporting Document Schedules

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Bypassed -Name: Certification/Notice 10/10/2008
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Comments:

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Bypassed -Name: Application 10/10/2008
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Comments:

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Comments:
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Satisfied -Name: Third Party Authorization Letter 10/10/2008
Comments:
Attachment:
 2008 03 GLAIC Filing Auth Ltr.pdf

MEDICARE SUPPLEMENT OUTLINE OF COVERAGE

ARKANSAS

**Benefit Plans A, B, C, D, E, F, G
& High Deductible F**

Genworth Life and Annuity Insurance Company

P.O. Box 10824
Clearwater, Florida 33757-8824
Telephone Number: (877) 825-9337

GENWORTH LIFE AND ANNUITY INSURANCE COMPANY
OUTLINE OF MEDICARE SUPPLEMENT COVERAGE COVER PAGE: Page 1 of 2
BENEFIT PLANS AVAILABLE: A, B, C, D, E, F, G AND HIGH DEDUCTIBLE F

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

See Outlines of Coverage sections for details about ALL Plans

Basic Benefits: Included in All Plans:

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

Medical Expenses: Part B coinsurance (generally 20% of Medicare-Approved expenses) or, copayments for hospital outpatient services

Blood: First three pints of blood each year.

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

*Plans F and J also have an option called a high deductible plan F and a high deductible plan J. These high deductible plans pay the same benefits as Plans F and J after one has paid a calendar year \$2000 deductible. Benefits from high deductible plans F and J will not begin until out-of-pocket expenses exceed \$2000. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

GENWORTH LIFE AND ANNUITY INSURANCE COMPANY
Outline of Medicare Supplement Coverage-Cover Page: Page 2

Basic Benefits for Plans K and L include similar services as Plans A-J, but cost sharing for the basic benefits is at different levels.

J	K**	L**
Basic Benefits	100% of Part A Hospitalization Coinsurance plus coverage for 365 Days after Medicare Benefits end. 50% Hospice cost-sharing 50% of Medicare-eligible expenses for the first three pints of blood. 50% Part B Coinsurance, except 100% Coinsurance for Part B Preventive Services.	100% of Part A Hospitalization Coinsurance plus coverage for 365 Days after Medicare Benefits end. 75% Hospice cost-sharing 75% of Medicare-eligible expenses for the first three pints of blood. 75% Part B Coinsurance, except 100% Coinsurance for Part B Preventive Services.
Skilled Nursing Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance
Part A Deductible	50% Part A Deductible	75% Part A Deductible
Part B Deductible		
Part B Excess		
Foreign Travel Emergency		
At-Home Recovery		
Preventive Care NOT covered by Medicare		
	\$4620 Out of Pocket Annual Limit***	\$2310 Out of Pocket Annual Limit***

** Plans K and L provide for different cost-sharing for items and services than Plans A-J. Once you reach the annual limit, the plan pays 100% of the Medicare copayments, coinsurance, and deductibles for the rest of the calendar year. The out-of-pocket annual limit does NOT include charges from your provider that exceed Medicare-approved amounts, called "Excess Charges". You will be responsible for paying excess charges.

*** The out-of-pocket annual limit will increase each year for inflation.

See Outlines of Coverage for details and exceptions.

**GENWORTH LIFE AND ANNUITY INSURANCE COMPANY
 MEDICARE STANDARD UNI-AGE PREMIUMS
 ARKANSAS RATES EFFECTIVE 6/1/08
 FOR USE IN ZIP CODES: 719-722
 UNISEX RATES**

ANNUAL RATES

Attained Age	Non-Tobacco User								Attained Age	Standard							
	Plan A	Plan B	Plan C	Plan D	Plan E	Plan F	PLAN HDF	Plan G		Plan A	Plan B	Plan C	Plan D	Plan E	Plan F	PLAN HDF	Plan G
All	1,800	2,195	2,592	2,206	2,217	2,672	1,051	2,262	All	2,002	2,439	2,880	2,451	2,466	2,968	1,167	2,514

SEMI-ANNUAL RATES

Attained Age	Non-Tobacco User								Attained Age	Standard							
	Plan A	Plan B	Plan C	Plan D	Plan E	Plan F	PLAN HDF	Plan G		Plan A	Plan B	Plan C	Plan D	Plan E	Plan F	PLAN HDF	Plan G
All	936.00	1,141.40	1,347.84	1,147.12	1,152.84	1,389.44	546.52	1,176.24	All	1,041.04	1,268.28	1,497.60	1,274.52	1,282.32	1,543.36	606.84	1,307.28

QUARTERLY RATES

Attained Age	Non-Tobacco User								Attained Age	Standard							
	Plan A	Plan B	Plan C	Plan D	Plan E	Plan F	PLAN HDF	Plan G		Plan A	Plan B	Plan C	Plan D	Plan E	Plan F	PLAN HDF	Plan G
All	477.00	581.68	686.88	584.59	587.51	708.08	278.52	599.43	All	530.53	646.34	763.20	649.52	653.49	786.52	309.26	666.21

MONTHLY RATES

Attained Age	Non-Tobacco User								Attained Age	Standard							
	Plan A	Plan B	Plan C	Plan D	Plan E	Plan F	PLAN HDF	Plan G		Plan A	Plan B	Plan C	Plan D	Plan E	Plan F	PLAN HDF	Plan G
All	156.06	190.31	224.73	191.26	192.21	231.66	91.12	196.12	All	173.57	211.46	249.70	212.50	213.80	257.33	101.18	217.96

GENWORTH LIFE AND ANNUITY INSURANCE COMPANY
MEDICARE STANDARD UNI-AGE PREMIUMS
ARKANSAS RATES EFFECTIVE 6/1/08
FOR USE IN ZIP CODES: 718, 727-729
UNISEX RATES

ANNUAL RATES

Attained Age	Non-Tobacco User								Attained Age	Standard							
	Plan A	Plan B	Plan C	Plan D	Plan E	Plan F	PLAN HDF	Plan G		Plan A	Plan B	Plan C	Plan D	Plan E	Plan F	PLAN HDF	Plan G
All	1,620	1,976	2,333	1,985	1,995	2,405	946	2,036	All	1,802	2,195	2,592	2,206	2,219	2,671	1,050	2,263

SEMI-ANNUAL RATES

Attained Age	Non-Tobacco User								Attained Age	Standard							
	Plan A	Plan B	Plan C	Plan D	Plan E	Plan F	PLAN HDF	Plan G		Plan A	Plan B	Plan C	Plan D	Plan E	Plan F	PLAN HDF	Plan G
All	842.40	1,027.52	1,213.16	1,032.20	1,037.40	1,250.60	491.92	1,058.72	All	937.04	1,141.40	1,347.84	1,147.12	1,153.88	1,388.92	546.00	1,176.76

QUARTERLY RATES

Attained Age	Non-Tobacco User								Attained Age	Standard							
	Plan A	Plan B	Plan C	Plan D	Plan E	Plan F	PLAN HDF	Plan G		Plan A	Plan B	Plan C	Plan D	Plan E	Plan F	PLAN HDF	Plan G
All	429.30	523.64	618.25	526.03	528.68	637.33	250.69	539.54	All	477.53	581.68	686.88	584.59	588.04	707.82	278.25	599.70

MONTHLY RATES

Attained Age	Non-Tobacco User								Attained Age	Standard							
	Plan A	Plan B	Plan C	Plan D	Plan E	Plan F	PLAN HDF	Plan G		Plan A	Plan B	Plan C	Plan D	Plan E	Plan F	PLAN HDF	Plan G
All	140.45	171.32	202.27	172.10	172.97	208.51	82.02	176.52	All	156.23	190.31	224.73	191.26	192.39	231.58	91.04	196.20

**GENWORTH LIFE AND ANNUITY INSURANCE COMPANY
 MEDICARE STANDARD UNI-AGE PREMIUMS
 ARKANSAS RATES EFFECTIVE 6/1/08
 FOR USE IN ZIP CODES: ALL EXCEPT 718-722, 727-729
 UNISEX RATES**

ANNUAL RATES

Attained Age	Non-Tobacco User								Attained Age	Standard							
	Plan A	Plan B	Plan C	Plan D	Plan E	Plan F	PLAN HDF	Plan G		Plan A	Plan B	Plan C	Plan D	Plan E	Plan F	PLAN HDF	Plan G
All	1,440	1,756	2,074	1,765	1,774	2,138	841	1,810	All	1,602	1,951	2,304	1,961	1,973	2,374	934	2,011

SEMI-ANNUAL RATES

Attained Age	Non-Tobacco User								Attained Age	Standard							
	Plan A	Plan B	Plan C	Plan D	Plan E	Plan F	PLAN HDF	Plan G		Plan A	Plan B	Plan C	Plan D	Plan E	Plan F	PLAN HDF	Plan G
All	748.80	913.12	1,078.48	917.80	922.48	1,111.76	437.32	941.20	All	833.04	1,014.52	1,198.08	1,019.72	1,025.96	1,234.48	485.68	1,045.72

QUARTERLY RATES

Attained Age	Non-Tobacco User								Attained Age	Standard							
	Plan A	Plan B	Plan C	Plan D	Plan E	Plan F	PLAN HDF	Plan G		Plan A	Plan B	Plan C	Plan D	Plan E	Plan F	PLAN HDF	Plan G
All	381.60	465.34	549.61	467.73	470.11	566.57	222.87	479.65	All	424.53	517.02	610.56	519.67	522.85	629.11	247.51	532.92

QUARTERLY RATES

Attained Age	Non-Tobacco User								Attained Age	Standard							
	Plan A	Plan B	Plan C	Plan D	Plan E	Plan F	PLAN HDF	Plan G		Plan A	Plan B	Plan C	Plan D	Plan E	Plan F	PLAN HDF	Plan G
All	124.85	152.25	179.82	153.03	153.81	185.36	72.91	156.93	All	138.89	169.15	199.76	170.02	171.06	205.83	80.98	174.35

PREMIUM INFORMATION

Genworth Life and Annuity Insurance Company can only raise your premium if we raise the premium for all policies like yours in this state.

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

Semi-annual: 0.5200 Quarterly: 0.2650 Monthly EFT: 0.0867

DISCLOSURES

Use this outline to compare benefits and premium among policies.

READ YOUR POLICY VERY CAREFULLY

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to Genworth Life and Annuity Insurance Company, P.O. Box 10824, Clearwater, FL 33757-8824. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

POLICY REPLACEMENT

If you are replacing another health insurance policy, do **NOT** cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE

The policy may not cover all of your medical costs.

Neither Genworth Life and Annuity 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 & 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 any 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.

THE FOLLOWING CHARTS DESCRIBE PLANS A, B, C, D, E, F, G AND HIGH DEDUCTIBLE F OFFERED BY GENWORTH LIFE AND ANNUITY INSURANCE COMPANY.

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
<p>HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days</p> <p>61st thru 90th day 91st day and after</p> <ul style="list-style-type: none"> •While using 60 lifetime reserve days •Once lifetime reserve days are used: <ul style="list-style-type: none"> •Additional 365 days •Beyond the Additional 365 days 	<p>All but \$1068</p> <p>All but \$267 a day</p> <p>All but \$534 a day</p> <p>\$0</p> <p>\$0</p>	<p>\$0</p> <p>\$267 a day</p> <p>\$534 a day</p> <p>100% of Medicare Eligible Expenses</p> <p>\$0</p>	<p>\$1068 (Part A Deductible)</p> <p>\$0</p> <p>\$0</p> <p>\$0**</p> <p>All costs</p>
<p>SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital</p> <p>First 20 days</p> <p>21st thru 100th day</p> <p>101st day and after</p>	<p>All approved amounts</p> <p>All but \$133.50 a day</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>\$0</p>	<p>\$0</p> <p>Up to \$133.50 a day</p> <p>All costs</p>
<p>BLOOD First 3 pints Additional amounts</p>	<p>\$0</p> <p>100%</p>	<p>3 pints</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p>
<p>HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services</p>	<p>All but very limited coinsurance for outpatient drugs and inpatient respite care</p>	<p>\$0</p>	<p>Balance</p>

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

PLAN A

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

*Once you have been billed \$135 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic test, durable medical equipment First \$135 of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0 Generally 80%	\$0 Generally 20%	\$135 (Part B Deductible) \$0
Part B Excess Charges (Above Medicare-Approved amounts)	\$0	\$0	All costs
BLOOD First 3 pints Next \$135 of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$135 (Part B Deductible) \$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES •Medically necessary skilled care services and medical supplies	100%	\$0	\$0
•Durable medical equipment •First \$135 of Medicare Approved amounts*	\$0	\$0	\$135 (Part B Deductible)
•Remainder of Medicare Approved amounts	80%	20%	\$0

PLAN B

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<p>HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days</p> <p>61st thru 90th day 91st day and after</p> <ul style="list-style-type: none"> •While using 60 lifetime reserve days •Once lifetime reserve days are used: <ul style="list-style-type: none"> •Additional 365 days •Beyond the Additional 365 days 	<p>All but \$1068</p> <p>All but \$267 a day</p> <p>All but \$534 a day</p> <p>\$0</p> <p>\$0</p>	<p>\$1068 (Part A Deductible)</p> <p>\$267 a day</p> <p>\$534 a day</p> <p>100% of Medicare Eligible Expenses</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>\$0</p> <p>\$0**</p> <p>All costs</p>
<p>SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital</p> <p>First 20 days</p> <p>21st thru 100th day</p> <p>101st day and after</p>	<p>All approved amounts</p> <p>All but \$133.50 a day</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>\$0</p>	<p>\$0</p> <p>Up to \$133.50 a day</p> <p>All costs</p>
<p>BLOOD First 3 pints Additional amounts</p>	<p>\$0</p> <p>100%</p>	<p>3 pints</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p>
<p>HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services</p>	<p>All but very limited coinsurance for outpatient drugs and inpatient respite care</p>	<p>\$0</p>	<p>Balance</p>

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

PLAN B

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

* Once you have been billed \$135 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic test, durable medical equipment First \$135 of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0 Generally 80%	\$0 Generally 20%	\$135 (Part B Deductible) \$0
Part B Excess Charges (Above Medicare-Approved amounts)	\$0	\$0	All costs
BLOOD First 3 pints Next \$135 of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$135 (Part B Deductible) \$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES •Medically necessary skilled care services and medical supplies	100%	\$0	\$0
•Durable medical equipment •First \$135 of Medicare Approved amounts*	\$0	\$0	\$135 (Part B Deductible)
•Remainder of Medicare Approved amounts	80%	20%	\$0

PLAN C

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<p>HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days</p> <p>61st thru 90th day 91st day and after</p> <ul style="list-style-type: none"> •While using 60 lifetime reserve days •Once lifetime reserve days are used: <ul style="list-style-type: none"> •Additional 365 days •Beyond the Additional 365 days 	<p>All but \$1068</p> <p>All but \$267 a day</p> <p>All but \$534 a day</p> <p>\$0</p> <p>\$0</p>	<p>\$1068 (Part A Deductible)</p> <p>\$267 a day</p> <p>\$534 a day</p> <p>100% of Medicare Eligible Expenses</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>\$0</p> <p>\$0**</p> <p>All costs</p>
<p>SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital</p> <p>First 20 days</p> <p>21st thru 100th day</p> <p>101st day and after</p>	<p>All approved amounts</p> <p>All but \$133.50 a day</p> <p>\$0</p>	<p>\$0</p> <p>Up to \$133.50 a day</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>All costs</p>
<p>BLOOD First 3 pints Additional amounts</p>	<p>\$0</p> <p>100%</p>	<p>3 pints</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p>
<p>HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services</p>	<p>All but very limited coinsurance for outpatient drugs and inpatient respite care</p>	<p>\$0</p>	<p>Balance</p>

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

PLAN C

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

*Once you have been billed \$135 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic test, durable medical equipment First \$135 of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0 Generally 80%	\$135 (Part B Deductible) Generally 20%	\$0 \$0
Part B Excess Charges (Above Medicare-Approved amounts)	\$0	\$0	All costs
BLOOD First 3 pints Next \$135 of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0 \$0 80%	All costs \$135 (Part B Deductible) 20%	\$0 \$0 \$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES •Medically necessary skilled care services and medical supplies	100%	\$0	\$0
•Durable medical equipment •First \$135 of Medicare Approved amounts*	\$0	\$135 (Part B Deductible)	\$0
•Remainder of Medicare Approved amounts	80%	20%	\$0

PLAN C

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

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
<p>HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days</p> <p>61st thru 90th day 91st day and after</p> <ul style="list-style-type: none"> •While using 60 lifetime reserve days •Once lifetime reserve days are used: •Additional 365 days •Beyond the Additional 365 days 	<p>All but \$1068</p> <p>All but \$267 a day</p> <p>All but \$534 a day</p> <p>\$0</p> <p>\$0</p>	<p>\$1068 (Part A Deductible)</p> <p>\$267 a day</p> <p>\$534 a day</p> <p>100% of Medicare Eligible Expenses</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>\$0</p> <p>\$0**</p> <p>All costs</p>
<p>SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital</p> <p>First 20 days</p> <p>21st thru 100th day</p> <p>101st day and after</p>	<p>All approved amounts</p> <p>All but \$133.50 a day</p> <p>\$0</p>	<p>\$0</p> <p>Up to \$133.50 a day</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>All costs</p>
<p>BLOOD First 3 pints Additional amounts</p>	<p>\$0</p> <p>100%</p>	<p>3 pints</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p>
<p>HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services</p>	<p>All but very limited coinsurance for outpatient drugs and inpatient respite care</p>	<p>\$0</p>	<p>Balance</p>

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

PLAN D

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

*Once you have been billed \$135 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic test, durable medical equipment First \$135 of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0 Generally 80%	\$0 Generally 20%	\$135 (Part B Deductible) \$0
Part B Excess Charges (Above Medicare-Approved amounts)	\$0	\$0	All costs
BLOOD First 3 pints Next \$135 of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$135 (Part B Deductible) \$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES •Medically necessary skilled care services and medical supplies •Durable medical equipment •First \$135 of Medicare Approved amounts* •Remainder of Medicare Approved amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$135 (Part B Deductible) \$0

PLAN D
PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE (cont'd) AT-HOME RECOVERY SERVICES – NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care beginning during recovery from an Injury or sickness for which Medicare approved a Home Care Treatment Plan •Benefit for each visit •Number of visits covered (must be received within 8 weeks of last Medicare-Approved visit) •Calendar year maximum	\$0 \$0 \$0	Actual Charges to \$40 a visit Up to the number of Medicare-Approved visits, not to exceed 7 each week \$1,600	Balance

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year 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

PLAN E

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<p>HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days</p> <p>61st thru 90th day 91st day and after</p> <ul style="list-style-type: none"> •While using 60 lifetime reserve days •Once lifetime reserve days are used: <ul style="list-style-type: none"> •Additional 365 days •Beyond the Additional 365 days 	<p>All but \$1068</p> <p>All but \$267 a day</p> <p>All but \$534 a day</p> <p>\$0</p> <p>\$0</p>	<p>\$1068 (Part A Deductible)</p> <p>\$267 a day</p> <p>\$534 a day</p> <p>100% of Medicare Eligible Expenses</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>\$0</p> <p>\$0**</p> <p>All costs</p>
<p>SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital</p> <p>First 20 days</p> <p>21st thru 100th day</p> <p>101st day and after</p>	<p>All approved amounts</p> <p>All but \$133.50 a day</p> <p>\$0</p>	<p>\$0</p> <p>Up to \$133.50 a day</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>All costs</p>
<p>BLOOD First 3 pints Additional amounts</p>	<p>\$0</p> <p>100%</p>	<p>3 pints</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p>
<p>HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services</p>	<p>All but very limited coinsurance for outpatient drugs and inpatient respite care</p>	<p>\$0</p>	<p>Balance</p>

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

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

*Once you have been billed \$135 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic test, durable medical equipment First \$135 of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0 Generally 80%	\$0 Generally 20%	\$135 (Part B Deductible) \$0
Part B Excess Charges (Above Medicare-Approved amounts)	\$0	\$0	All costs
BLOOD First 3 pints Next \$135 of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$135 (Part B Deductible) \$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES <ul style="list-style-type: none"> •Medically necessary skilled care services and medical supplies •Durable medical equipment •First \$135 of Medicare Approved amounts* •Remainder of Medicare Approved amounts 	100% \$0 80%	\$0 \$0 20%	\$0 \$135 (Part B Deductible) \$0

(continued)

PLAN E

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<p>FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of charges</p>	<p>\$0 \$0</p>	<p>\$0 80% to a lifetime maximum benefit of \$50,000</p>	<p>\$250 20% and amounts over the \$50,000 lifetime maximum</p>
<p>*PREVENTIVE MEDICAL CARE BENEFIT – NOT COVERED BY MEDICARE Some annual physical and preventive tests and services administered or ordered by your doctor when not covered by Medicare First \$120 each calendar year Additional charges</p>	<p>\$0 \$0</p>	<p>\$120 \$0</p>	<p>\$0 All costs</p>

*Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

PLAN F

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<p>HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days</p> <p>61st thru 90th day 91st day and after</p> <ul style="list-style-type: none"> •While using 60 lifetime reserve days •Once lifetime reserve days are used: <ul style="list-style-type: none"> •Additional 365 days •Beyond the Additional 365 days 	<p>All but \$1068</p> <p>All but \$267 a day</p> <p>All but \$534 a day</p> <p>\$0</p> <p>\$0</p>	<p>\$1068 (Part A Deductible)</p> <p>\$267 a day</p> <p>\$534 a day</p> <p>100% of Medicare Eligible Expenses</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>\$0</p> <p>\$0**</p> <p>All costs</p>
<p>SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital</p> <p>First 20 days</p> <p>21st thru 100th day</p> <p>101st day and after</p>	<p>All approved amounts</p> <p>All but \$133.50 a day</p> <p>\$0</p>	<p>\$0</p> <p>Up to \$133.50 a day</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>All costs</p>
<p>BLOOD First 3 pints Additional amounts</p>	<p>\$0</p> <p>100%</p>	<p>3 pints</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p>
<p>HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services</p>	<p>All but very limited coinsurance for outpatient drugs and inpatient respite care</p>	<p>\$0</p>	<p>Balance</p>

(continued)

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

PLAN F

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

*Once you have been billed \$135 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic test, durable medical equipment First \$135 of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0 Generally 80%	\$135 (Part B Deductible) Generally 20%	\$0 \$0
Part B Excess Charges (Above Medicare-Approved amounts)	\$0	100%	\$0
BLOOD First 3 pints Next \$135 of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0 \$0 80%	All costs \$135 (Part B Deductible) 20%	\$0 \$0 \$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES •Medically necessary skilled care services and medical supplies	100%	\$0	\$0
•Durable medical equipment •First \$135 of Medicare Approved amounts* •Remainder of Medicare Approved amounts	\$0 80%	\$135 (Part B Deductible) 20%	\$0 \$0

PLAN F

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

**HIGH DEDUCTIBLE 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.

**This high deductible plan pays the same benefits as Plan F after you have paid a calendar year \$2000 deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are \$2000. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's foreign emergency travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$2000 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO \$2000 DEDUCTIBLE** YOU PAY
<p>HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days</p> <p>61st thru 90th day 91st day and after</p> <ul style="list-style-type: none"> •While using 60 lifetime reserve days •Once lifetime reserve days are used: <ul style="list-style-type: none"> •Additional 365 days •Beyond the Additional 365 days 	<p>All but \$1068</p> <p>All but \$267 a day</p> <p>All but \$534 a day</p> <p>\$0</p> <p>\$0</p>	<p>\$1068 (Part A Deductible)</p> <p>\$267 a day</p> <p>\$534 a day</p> <p>100% of Medicare Eligible Expenses</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>\$0</p> <p>\$0***</p> <p>All costs</p>
<p>SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital</p> <p>First 20 days</p> <p>21st thru 100th day</p> <p>101st day and after</p>	<p>All approved amounts</p> <p>All but \$133.50 a day</p> <p>\$0</p>	<p>\$0</p> <p>Up to \$133.50 a day</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>All costs</p>
<p>BLOOD First 3 pints Additional amounts</p>	<p>\$0</p> <p>100%</p>	<p>3 pints</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p>

HIGH DEDUCTIBLE PLAN F
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$2000 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO \$2000 DEDUCTIBLE** YOU PAY
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

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

HIGH DEDUCTIBLE PLAN F

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

*Once you have been billed \$135 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

**This high deductible plan pays the same benefits as Plan F after you have paid a calendar year \$2000 deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are \$2000. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's foreign emergency travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$2000 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO \$2000 DEDUCTIBLE** 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 test, durable medical equipment First \$135 of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0 Generally 80%	\$135 (Part B Deductible) Generally 20%	\$0 \$0
Part B Excess Charges (Above Medicare-Approved amounts)	\$0	100%	\$0
BLOOD First 3 pints Next \$135 of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0 \$0 80%	All costs \$135 (Part B Deductible) 20%	\$0 \$0 \$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

(continued)

HIGH DEDUCTIBLE PLAN F

PARTS A & B

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$2000 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO \$2000 DEDUCTIBLE** YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES <ul style="list-style-type: none"> • Medically necessary skilled care services and medical supplies • Durable medical equipment <ul style="list-style-type: none"> • First \$135 of Medicare Approved amounts* • Remainder of Medicare Approved amounts 	100% \$0 80%	\$0 \$135 (Part B Deductible) 20%	\$0 \$0 \$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$2000 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO \$2000 DEDUCTIBLE** YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year 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

PLAN G

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<p>HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days</p> <p>61st thru 90th day 91st day and after</p> <ul style="list-style-type: none"> •While using 60 lifetime reserve days •Once lifetime reserve days are used: •Additional 365 days •Beyond the Additional 365 days 	<p>All but \$1068</p> <p>All but \$267 a day</p> <p>All but \$534 a day</p> <p>\$0</p> <p>\$0</p>	<p>\$1068 (Part A Deductible)</p> <p>\$267 a day</p> <p>\$534 a day</p> <p>100% of Medicare Eligible Expenses</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>\$0</p> <p>\$0**</p> <p>All costs</p>
<p>SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital</p> <p>First 20 days</p> <p>21st thru 100th day</p> <p>101st day and after</p>	<p>All approved amounts</p> <p>All but \$133.50 a day</p> <p>\$0</p>	<p>\$0</p> <p>Up to \$133.50 a day</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>All costs</p>
<p>BLOOD First 3 pints Additional amounts</p>	<p>\$0</p> <p>100%</p>	<p>3 pints</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p>
<p>HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services</p>	<p>All but very limited coinsurance for outpatient drugs and inpatient respite care</p>	<p>\$0</p>	<p>Balance</p>

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

PLAN G

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

*Once you have been billed \$135 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic test, durable medical equipment First \$135 of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0 Generally 80%	\$0 Generally 20%	\$135 (Part B Deductible) \$0
Part B Excess Charges (Above Medicare-Approved amounts)	\$0	80%	20%
BLOOD First 3 pints Next \$135 of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$135 (Part B Deductible) \$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES •Medically necessary skilled care services and medical supplies •Durable medical equipment • First \$135 of Medicare Approved amounts* •Remainder of Medicare Approved amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$135 (Part B Deductible) \$0

**PLAN G
PARTS A & B**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE (cont'd) AT-HOME RECOVERY SERVICES – NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care beginning during recovery from an Injury or sickness for which Medicare approved a Home Care Treatment Plan •Benefit for each visit •Number of visits covered (must be received within 8 weeks of last Medicare-Approved visit) •Calendar year maximum	\$0 \$0 \$0	Actual Charges to \$40 a visit Up to the number of Medicare-Approved visits, not to exceed 7 each week \$1,600	Balance

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year 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



6620 W. Broad Street Bldg 4
Richmond, VA 23230
804 484.3996
804 281.6285 fax

March 3, 2008

Ms. Darcey Shaffer, ACS, FLMI
Compliance Manager
Wakely and Associates, Inc.
8545 126th Avenue North, Suite 200
Largo, Florida 33773-1502

Re: Filing/Reporting Requirements for Medicare Supplement Insurance
Certificates

Dear Ms. Shaffer:

This letter authorizes Wakely and Associates, Inc. to file on behalf of Genworth Life and Annuity Insurance Company Medicare Supplement forms and rates with the State Departments of Insurance. Also, Wakely and Associates, Inc. may correspond with the State Departments of Insurance regarding any questions they may have concerning the filings.

A copy of this letter is as valid as the original. This authorization will be valid for twelve months from the date of this letter.

Sincerely,
Genworth Life and Annuity Insurance Company

By: 
Aaron Ball
Vice President