Sentinel Security Life Insurance Company Administrative Office P.O. Box 16960, Clearwater, FL 33766-6960 (888) 510-0668

Outline of Medicare Supplement Coverage – Cover Page

Benefit Plans A, B, C#, D# and F# - See Outlines of Coverage sections for details about ALL plans

This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plan "A" available. Some plans may not be available in your state. Plans E, H, I and J are no longer available for sale.

Basic Benefits:

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

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

Blood: First three pints of blood each year.

Hospice: Part A coinsurance.

A	B	C	D	F	F*	G
Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance		Basic, including 100% Part B coinsurance
		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 B Deductible		Part B Deductible		
				Part B Excess (100%)		Part B Excess (100%)
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency		Foreign Travel Emergency

K	L	M	N
Basic, Including 100% Part B coinsurance; other basic benefits paid at 50%	Basic, Including 100% Part B coinsurance; other basic benefits paid at 75%	Basic, Including 100% Part B coinsurance	Basic, including 100% Part B coinsurance, except up to $20 copayment for office visit, and up to $50 copayment for ER
50% Skilled Nursing Facility coinsurance	75% Skilled Nursing Facility coinsurance	Skilled Nursing Facility coinsurance	Skilled Nursing Facility coinsurance
50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Foreign Travel Emergency	Foreign Travel Emergency
Out-of-Pocket limit $4620; paid at 100% after limit reached	Out-of-Pocket limit $2310; paid at 100% after limit reached		

Plans C, D and F are also offered as Medicare Supplement Select Plans. If you choose a Medicare Select plan, when medical care is provided in a Participating Hospital, the Initial Part A Deductible is waived. If medical care is not provided in a Participating Hospital, you are responsible for payment of the Initial Part A Deductible. Medicare Supplement Select Plans are not available in all states.

* Plan F also has an option called a high deductible Plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2,000 deductible. Benefits from high deductible Plan F will not begin until out-of-pocket expenses exceed $2,000. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

PREMIUM INFORMATION
We, Sentinel Security Life Insurance Company, can only raise Your premium if (a) We change the premium rates which apply to all policies of this form issued by Us and in-force in Your state; (b) coverage under Medicare changes; or (c) You move to a different ZIP code location. We will send You the advance written notice required by your state when We change the premium rates for all policies of this form issued by Us and in-force in Your state.

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

DISCLOSURES
Use this Outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY
This is only an Outline, describing Your Policy's most important features. The Policy is Your insurance contract. You must read the Policy itself to understand all of the rights and duties of both You and Your insurance company.

30-DAY RIGHT TO RETURN POLICY
If You find that You are not satisfied with your policy, You may return it to Sentinel Security Life Insurance Company, P.O. Box 16960, Clearwater, FL 33766-6960. If You send the policy back to Us within 30 days after You receive it, We will treat the policy as if it had never been issued and return all of Your premiums.

POLICY REPLACEMENT
If You are replacing another health insurance Policy, do NOT cancel it until You have actually received Your new Policy and are sure You want to keep it.

NOTICE
This Policy may not fully cover all of Your medical costs. Neither Sentinel Security Life Insurance Company nor its agents are connected with Medicare. This Outline of Coverage does not give all the details of Medicare coverage. Contact Your local Social Security Office or consult *Medicare and You* for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT
When You fill out the application for the new Policy, be sure to answer truthfully and completely all questions about Your medical and health history. The Company may cancel Your Policy and refuse to pay any claims if You leave out or falsify important medical information.

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

RENEWABILITY
This Policy is guaranteed renewable for life.

SENTINEL SECURITY LIFE INSURANCE COMPANY - MONTHLY RATES*
ZIP CODES: All ZIP's
STANDARD PLANS - NON-TOBACCO

Female						Male				
Std. Plan A SSLA10ST-UT	Std. Plan B SSLB10ST-UT	Std. Plan C SSLC10ST-UT	Std. Plan D SSLD10ST-UT	Std. Plan F SSLF10ST-UT	Attained Age	Std. Plan A SSLA10ST-UT	Std. Plan B SSLB10ST-UT	Std. Plan C SSLC10ST-UT	Std. Plan D SSLD10ST-UT	Std. Plan F SSLF10ST-UT
$66.74	$73.99	$90.68	$76.40	$92.87	65	$76.75	$85.09	$104.28	$87.86	$106.80
69.03	76.38	93.66	78.88	95.92	66	79.39	87.84	107.71	90.71	110.30
72.10	79.61	97.68	82.24	100.03	67	82.92	91.56	112.33	94.57	115.04
74.47	82.19	100.90	84.95	103.33	68	85.64	94.51	116.04	97.69	118.83
76.76	84.83	104.23	87.78	106.75	69	88.28	97.56	119.87	100.95	122.76
78.95	87.40	107.48	90.55	110.07	70	90.79	100.51	123.60	104.13	126.58
81.02	89.86	110.60	93.22	113.27	71	93.17	103.34	127.20	107.20	130.26
82.97	92.22	113.62	95.80	116.35	72	95.41	106.05	130.66	110.17	133.81
84.72	94.37	116.38	98.18	119.19	73	97.43	108.52	133.84	112.91	137.06
86.25	96.35	118.95	100.41	121.82	74	99.19	110.80	136.80	115.47	140.09
88.42	99.09	122.49	103.45	125.43	75	101.68	113.95	140.86	118.97	144.24
91.43	102.81	127.24	107.54	130.30	76	105.14	118.23	146.33	123.68	149.84
92.61	104.47	129.47	109.50	132.58	77	106.50	120.14	148.89	125.92	152.46
94.62	107.06	132.85	112.42	136.03	78	108.81	123.12	152.78	129.29	156.44
95.66	108.56	134.90	114.23	138.13	79	110.00	124.85	155.14	131.37	158.85
96.70	110.08	136.97	116.05	140.25	80	111.20	126.59	157.51	133.46	161.29
97.67	111.53	138.98	117.83	142.30	81	112.32	128.26	159.83	135.51	163.65
99.51	114.01	142.29	120.72	145.69	82	114.44	131.11	163.63	138.82	167.54
100.33	115.31	144.14	122.36	147.58	83	115.38	132.61	165.76	140.72	169.72
101.07	116.57	145.96	123.99	149.44	84	116.24	134.06	167.85	142.59	171.86
102.75	118.90	149.13	126.77	152.68	85	118.16	136.74	171.50	145.78	175.58
103.44	120.11	150.90	128.37	154.50	86	118.95	138.13	173.54	147.62	177.67
104.14	121.36	152.75	130.03	156.38	87	119.76	139.56	175.66	149.53	179.84
104.84	122.57	154.54	131.65	158.21	88	120.57	140.95	177.72	151.40	181.94
105.55	123.81	156.34	133.32	160.06	89	121.38	142.38	179.80	153.32	184.07
107.28	126.27	159.72	136.33	163.51	90	123.37	145.21	183.68	156.78	188.04
108.02	127.58	161.65	138.11	165.49	91	124.23	146.72	185.90	158.83	190.31
108.79	128.93	163.66	139.96	167.54	92	125.11	148.27	188.21	160.96	192.67
109.59	130.32	165.72	141.86	169.64	93	126.03	149.86	190.58	163.14	195.09
110.40	131.76	167.89	143.86	171.86	94	126.97	151.53	193.07	165.43	197.64
112.25	134.45	171.65	147.22	175.71	95	129.09	154.62	197.40	169.31	202.06
113.03	135.88	173.84	149.24	177.94	96	129.99	156.26	199.91	171.63	204.63
113.74	137.21	175.92	151.17	180.07	97	130.81	157.80	202.31	173.85	207.08
114.44	138.56	178.05	153.14	182.24	98	131.60	159.34	204.75	176.12	209.58
115.14	139.93	180.23	155.17	184.47	99	132.41	160.92	207.26	178.45	212.14

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

SENTINEL SECURITY LIFE INSURANCE COMPANY - MONTHLY RATES*
ZIP CODES: All ZIP's
STANDARD PLANS - TOBACCO

Female						Male				
Std. Plan A SSLA10ST-UT	Std. Plan B SSLB10ST-UT	Std. Plan C SSLC10ST-UT	Std. Plan D SSLD10ST-UT	Std. Plan F SSLF10ST-UT	Attained Age	Std. Plan A SSLA10ST-UT	Std. Plan B SSLB10ST-UT	Std. Plan C SSLC10ST-UT	Std. Plan D SSLD10ST-UT	Std. Plan F SSLF10ST-UT
$76.75	$85.09	$104.28	$87.86	$106.80	65	$88.27	$97.85	$119.92	$101.04	$122.82
79.39	87.84	107.71	90.71	110.30	66	91.30	101.01	123.86	104.32	126.85
82.92	91.56	112.33	94.57	115.04	67	95.36	105.29	129.18	108.76	132.30
85.64	94.51	116.04	97.69	118.83	68	98.48	108.69	133.44	112.35	136.66
88.28	97.56	119.87	100.95	122.76	69	101.52	112.19	137.85	116.09	141.18
90.79	100.51	123.60	104.13	126.58	70	104.40	115.58	142.14	119.75	145.56
93.17	103.34	127.20	107.20	130.26	71	107.14	118.84	146.28	123.29	149.80
95.41	106.05	130.66	110.17	133.81	72	109.73	121.96	150.26	126.70	153.88
97.43	108.52	133.84	112.91	137.06	73	112.05	124.80	153.92	129.84	157.62
99.19	110.80	136.80	115.47	140.09	74	114.07	127.42	157.32	132.79	161.10
101.68	113.95	140.86	118.97	144.24	75	116.93	131.04	161.99	136.82	165.88
105.14	118.23	146.33	123.68	149.84	76	120.92	135.96	168.28	142.23	172.32
106.50	120.14	148.89	125.92	152.46	77	122.48	138.16	171.22	144.81	175.33
108.81	123.12	152.78	129.29	156.44	78	125.13	141.59	175.69	148.68	179.91
110.00	124.85	155.14	131.37	158.85	79	126.50	143.58	178.41	151.07	182.68
111.20	126.59	157.51	133.46	161.29	80	127.88	145.57	181.14	153.48	185.48
112.32	128.26	159.83	135.51	163.65	81	129.17	147.50	183.80	155.83	188.20
114.44	131.11	163.63	138.82	167.54	82	131.61	150.78	188.18	159.65	192.68
115.38	132.61	165.76	140.72	169.72	83	132.68	152.50	190.62	161.82	195.17
116.24	134.06	167.85	142.59	171.86	84	133.67	154.17	193.03	163.98	197.63
118.16	136.74	171.50	145.78	175.58	85	135.89	157.25	197.22	167.65	201.92
118.95	138.13	173.54	147.62	177.67	86	136.80	158.85	199.57	169.76	204.32
119.76	139.56	175.66	149.53	179.84	87	137.72	160.50	202.01	171.96	206.82
120.57	140.95	177.72	151.40	181.94	88	138.65	162.10	204.37	174.11	209.23
121.38	142.38	179.80	153.32	184.07	89	139.59	163.73	206.76	176.31	211.68
123.37	145.21	183.68	156.78	188.04	90	141.87	166.99	211.23	180.30	216.25
124.23	146.72	185.90	158.83	190.31	91	142.86	168.72	213.79	182.66	218.85
125.11	148.27	188.21	160.96	192.67	92	143.88	170.51	216.44	185.10	221.57
126.03	149.86	190.58	163.14	195.09	93	144.93	172.34	219.17	187.61	224.35
126.97	151.53	193.07	165.43	197.64	94	146.01	174.26	222.03	190.25	227.28
129.09	154.62	197.40	169.31	202.06	95	148.45	177.81	227.01	194.70	232.37
129.99	156.26	199.91	171.63	204.63	96	149.48	179.70	229.90	197.37	235.32
130.81	157.80	202.31	173.85	207.08	97	150.43	181.47	232.66	199.93	238.15
131.60	159.34	204.75	176.12	209.58	98	151.34	183.25	235.47	202.53	241.01
132.41	160.92	207.26	178.45	212.14	99	152.27	185.06	238.35	205.21	243.96

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

PLAN A

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1100	$0	$1100 (Part A Deductible)
61st thru 90th day	All but $275 a day	$275 a day	$0
91st day and after:			
• While using 60 lifetime reserve days	All but $550 a day	$550 a day	$0
• Once lifetime reserve days are used:			
- Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
- Beyond the additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $137.50 a day	$0	Up to $137.50 a day
101st day and after	$0	$0	All Costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as Your doctor certifies You are terminally ill and You elect to receive these services.	All but very limited coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

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

* Once You have been billed $155 of Medicare-approved amounts for covered services (which are noted with an asterisk), Your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment. First $155 of Medicare-approved amounts* (the Part B Deductible) Remainder of Medicare-approved amounts	 $0 Generally 80%	 $0 Generally 20%	 $155 (Part B Deductible) $0
Part B Excess Charges (Above Medicare-approved amounts)	$0	$0	All costs
BLOOD First 3 pints Next $155 of Medicare-approved amounts* Remainder of Medicare-approved amounts	 $0 $0 80%	 All Costs $0 20%	 $0 $155 (Part B Deductible) $0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE MEDICARE-APPROVED SERVICES • Medically necessary skilled care services and medical supplies • Durable medical equipment First $155 of Medicare-approved amounts* Remainder of Medicare-approved amounts	 100% $0 80%	 $0 $0 20%	 $0 $155 (Part B Deductible) $0

PLAN B

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1100	$1100 (Part A Deductible)	$0
61st thru 90th day	All but $275 a day	$275 a day	$0
91st day and after:			
• While using 60 lifetime reserve days	All but $550 a day	$550 a day	$0
• Once lifetime reserve days are used:			
- Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
- Beyond the additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $137.50 a day	$0	Up to $137.50 a day
101st day and after	$0	$0	All Costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as Your doctor certifies You are terminally ill and You elect to receive these services.	All but very limited coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

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

* Once You have been billed $155 of Medicare-approved amounts for covered services (which are noted with an asterisk), Your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.			
First $155 of Medicare-approved amounts* (the Part B Deductible)	$0	$0	$155 (Part B Deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-approved amounts)	$0	$0	All Costs
BLOOD			
First 3 pints	$0	All Costs	$0
Next $155 of Medicare-approved amounts*	$0	$0	$155 (Part B Deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
• Medically necessary skilled care services and medical supplies	100%	$0	$0
• Durable medical equipment			
First $155 of Medicare-approved amounts*	$0	$0	$155 (Part B Deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

PLAN C

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1100	$1100 (Part A Deductible)	$0
61st thru 90th day	All but $275 a day	$275 a day	$0
91st day and after:			
• While using 60 lifetime reserve days	All but $550 a day	$550 a day	$0
• Once lifetime reserve days are used:			
- Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
- Beyond the additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $137.50 a day	Up to $137.50 a day	$0
101st day and after	$0	$0	All Costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as Your doctor certifies You are terminally ill and You elect to receive these services.	All but very limited coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

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

* Once You have been billed $155 of Medicare-approved amounts for covered services (which are noted with an asterisk), Your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.			
First $155 of Medicare-approved amounts* (the Part B Deductible)	$0	$155 (Part B Deductible)	$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-approved amounts)	$0	$0	All Costs
BLOOD			
First 3 pints	$0	All Costs	$0
Next $155 of Medicare-approved amounts*	$0	$155 (Part B Deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
• Medically necessary skilled care services and medical supplies	100%	$0	$0
• Durable medical equipment			
First $155 of Medicare-approved amounts*	$0	$155 (Part B Deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

PLAN D

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1100	$1100 (Part A Deductible)	$0
61st thru 90th day	All but $275 a day	$275 a day	$0
91st day and after:			
• While using 60 lifetime reserve days	All but $550 a day	$550 a day	$0
• Once lifetime reserve days are used:			
- Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
- Beyond the additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $137.50 a day	Up to $137.50 a day	$0
101st day and after	$0	$0	All Costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as Your doctor certifies You are terminally ill and You elect to receive these services.	All but very limited coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

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

* Once You have been billed $155 of Medicare-approved amounts for covered services (which are noted with an asterisk), Your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment. First $155 of Medicare-approved amounts* (the Part B Deductible) Remainder of Medicare-approved amounts	 $0 Generally 80%	 $0 Generally 20%	 $155 (Part B Deductible) $0
Part B Excess Charges (Above Medicare-approved amounts)	$0	$0	All Costs
BLOOD First 3 pints Next $155 of Medicare-approved amounts* Remainder of Medicare-approved amounts	 $0 $0 80%	 All Costs $0 20%	 $0 $155 (Part B Deductible) $0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE MEDICARE-APPROVED SERVICES • Medically necessary skilled care services and medical supplies • Durable medical equipment First $155 of Medicare-approved amounts* Remainder of Medicare-approved amounts	 100% $0 80%	 $0 $0 20%	 $0 $155 (Part B Deductible) $0

PLAN D

OTHER BENEFITS – NOT COVERED BY MEDICARE

FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services during the first 60 days of each trip outside the USA First $250 each calendar year 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 F

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1100	$1100 (Part A Deductible)	$0
61st thru 90th day	All but $275 a day	$275 a day	$0
91st day and after:			
• While using 60 lifetime reserve days	All but $550 a day	$550 a day	$0
• Once lifetime reserve days are used:			
- Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
- Beyond the additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $137.50 a day	Up to $137.50 a day	$0
101st day and after	$0	$0	All Costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as Your doctor certifies You are terminally ill and You elect to receive these services.	All but very limited coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

PLAN F

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

* Once You have been billed $155 of Medicare-approved amounts for covered services (which are noted with an asterisk), Your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.			
First $155 of Medicare-approved amounts* (the Part B Deductible)	$0	$155 (Part B Deductible)	$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-approved amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All Costs	$0
Next $155 of Medicare-approved amounts*	$0	$155 (Part B Deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
• Medically necessary skilled care services and medical supplies	100%	$0	$0
• Durable medical equipment			
First $155 of Medicare-approved amounts*	$0	$155 (Part B Deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

GRIEVANCE PROCEDURE (MEDICARE SELECT POLICIES ONLY)

GRIEVANCE PROCEDURE

We have a customer service program which can provide information to you, handle your complaints, and help satisfy your concerns. This grievance procedure is intended to provide an opportunity for you and us to achieve mutual agreement for the settlement of disputes that have not been settled through our customer service program or your desire to have settled by means of a written grievance. The following procedures are aimed at achieving mutual agreement for the settlement of a dispute.

1) All grievances must be presented to us in written form. Any written grievance between you and us or between you and a hospital must be dealt with through this grievance procedure.
2) Any written grievance must contain the words "THIS IS A GRIEVANCE" or other words that clearly state that the intention of the written communication is to serve as a written grievance to be handled according to this procedure.
3) A grievance must be filed by submitting the complete details in writing to Sentinel Security Life Insurance Company, c/o Grievance Review, P.O. Box 16960, Clearwater, FL 33766-6960.
4) Each grievance is processed within a maximum of 60 days after it is received by us. Each level of the grievance process is handled by a person with problem-solving authority. A Physician, other than your primary care physician, must be involved in reviewing any medically related grievances.
5) If a grievance is found to be valid, corrective action will be taken promptly.
6) All concerned parties are to be notified about the result of a grievance.
7) You have the right to appeal to the Department of Insurance after first completing our grievance process.
8) Any meeting with you must be scheduled at a location or in a manner which is convenient and will not necessitate excessive travel or undue hardship.
9) The time for filing a grievance is limited to a period of not more than one year from the date of occurrence.

Sentinel Security Life Insurance Company
Administrative Office
P.O. Box 16960
Clearwater, FL 33766-6960

Toll-free 888-510-0668
Fax 800-719-1264

www.sentinellife.org