800 Crescent Centre Dr.
Suite 200
Franklin, TN 37067
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aetnaseniorproducts.com

Outline of Coverage

Medicare Supplement Insurance

BENEFIT PLANS A, B, F, HIGH DEDUCTIBLE F, G, N

Underwritten by

An Aetna Company **Continental Life Insurance Company of Brentwood, Tennessee**

Oregon

CLIMS01097OR

Rates Effective: 06/2017 A

CONTINENTAL LIFE INSURANCE COMPANY OF BRENTWOOD, TENNESSEE
OUTLINE OF MEDICARE SUPPLEMENT COVERAGE COVER PAGE: Page 1 of 2
BENEFIT PLANS AVAILABLE: A, B, F, HIGH DEDUCTIBLE F, G, N

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.

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, copayments for hospital outpatient services. Plans K, L, and N require insureds to pay a portion of coinsurance or copayments.
Blood: First three pints of blood each year.
Hospice: Part A coinsurance

A	B	C	D	F/F*	G	K	L	M	N
Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance, except up to $20 copayment for office visit, and up to $50 copayment for ER
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Part B Deductible		Part B Deductible					
				Part B Excess (100%)	Part B Excess (100%)				
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency			Foreign Travel Emergency	Foreign Travel Emergency
						Out-of-pocket limit $5120; paid at 100% after limit reached	Out-of-pocket limit $2560; paid at 100% after limit reached		

*Plan F also has an option called a high deductible plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2200 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed $2200. 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.

Continental Life Insurance Company of Brentwood, Tennessee

Annual Attained Age Premiums

For Use in ZIP Codes: 970-972

Female Rates

Rates Effective 6/1/2017

Attained Age	Preferred					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
0 - 64	1,554	1,960	2,339	894	1,891	1,580
65	1,554	1,960	2,339	894	1,891	1,580
66	1,554	1,960	2,339	894	1,891	1,580
67	1,554	1,960	2,339	894	1,891	1,580
68	1,621	2,041	2,435	933	1,969	1,648
69	1,694	2,134	2,530	969	2,044	1,723
70	1,760	2,220	2,623	1,005	2,119	1,790
71	1,829	2,301	2,714	1,038	2,194	1,859
72	1,893	2,383	2,799	1,071	2,261	1,924
73	1,950	2,459	2,874	1,100	2,324	1,986
74	2,009	2,531	2,949	1,131	2,385	2,041
75	2,060	2,595	3,014	1,154	2,439	2,095
76	2,108	2,653	3,075	1,178	2,484	2,144
77	2,151	2,708	3,129	1,198	2,530	2,190
78	2,190	2,761	3,175	1,216	2,565	2,233
79	2,230	2,811	3,223	1,234	2,603	2,271
80	2,268	2,856	3,260	1,249	2,636	2,309
81	2,299	2,893	3,304	1,265	2,670	2,340
82	2,329	2,935	3,345	1,283	2,704	2,370
83	2,361	2,975	3,385	1,296	2,735	2,403
84	2,390	3,008	3,423	1,311	2,768	2,435
85	2,416	3,046	3,464	1,328	2,799	2,460
86	2,443	3,079	3,495	1,339	2,826	2,486
87	2,470	3,113	3,534	1,354	2,858	2,513
88	2,494	3,145	3,565	1,368	2,880	2,540
89	2,518	3,174	3,595	1,376	2,906	2,564
90	2,540	3,199	3,626	1,389	2,930	2,586
91	2,560	3,229	3,655	1,399	2,953	2,605
92	2,581	3,254	3,678	1,409	2,971	2,626
93	2,599	3,276	3,704	1,421	2,994	2,645
94	2,618	3,295	3,718	1,425	3,006	2,663
95	2,630	3,314	3,739	1,433	3,023	2,679
96	2,648	3,334	3,760	1,440	3,040	2,694
97	2,663	3,355	3,779	1,449	3,054	2,708
98	2,676	3,374	3,800	1,456	3,071	2,723
99	2,694	3,395	3,816	1,461	3,085	2,743

Attained Age	Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
0 - 64	1,729	2,180	2,599	994	2,101	1,760
65	1,729	2,180	2,599	994	2,101	1,760
66	1,729	2,180	2,599	994	2,101	1,760
67	1,729	2,180	2,599	994	2,101	1,760
68	1,801	2,271	2,705	1,035	2,185	1,833
69	1,880	2,369	2,813	1,080	2,274	1,916
70	1,955	2,464	2,914	1,116	2,355	1,991
71	2,030	2,560	3,014	1,154	2,439	2,065
72	2,101	2,650	3,108	1,191	2,511	2,138
73	2,168	2,730	3,195	1,225	2,583	2,206
74	2,230	2,811	3,278	1,258	2,648	2,273
75	2,285	2,880	3,353	1,284	2,708	2,326
76	2,338	2,949	3,414	1,308	2,760	2,381
77	2,390	3,010	3,473	1,331	2,809	2,435
78	2,436	3,069	3,528	1,354	2,851	2,480
79	2,480	3,124	3,579	1,369	2,890	2,523
80	2,518	3,174	3,621	1,388	2,928	2,564
81	2,553	3,218	3,670	1,405	2,965	2,601
82	2,588	3,264	3,716	1,425	3,005	2,635
83	2,623	3,304	3,763	1,440	3,041	2,670
84	2,655	3,346	3,805	1,456	3,075	2,700
85	2,683	3,383	3,848	1,474	3,110	2,733
86	2,716	3,421	3,886	1,490	3,141	2,765
87	2,745	3,455	3,925	1,503	3,171	2,795
88	2,770	3,491	3,960	1,518	3,201	2,820
89	2,798	3,524	3,996	1,530	3,230	2,850
90	2,823	3,558	4,028	1,543	3,255	2,874
91	2,845	3,584	4,060	1,554	3,279	2,895
92	2,868	3,613	4,089	1,568	3,305	2,921
93	2,886	3,638	4,114	1,574	3,324	2,939
94	2,906	3,663	4,136	1,585	3,344	2,961
95	2,925	3,685	4,156	1,591	3,359	2,978
96	2,939	3,706	4,175	1,598	3,375	2,994
97	2,959	3,726	4,196	1,609	3,394	3,010
98	2,976	3,748	4,220	1,618	3,410	3,026
99	2,995	3,773	4,244	1,624	3,429	3,048

Modal Factors: Semi-Annual: 0.5200 Quarterly: 0.2650 Monthly: 0.0833

The above rates do not include the $20 application fee.

To calculate a Household discount:

Annual premium x modal factor = modal premium (round to nearest whole cent)

Modal premium x .95 = discounted premium

If applying during Open Enrollment or Guaranteed Issue Period, use Preferred rates.

Continental Life Insurance Company of Brentwood, Tennessee

Annual Attained Age Premiums

For Use in ZIP Codes: 970-972

Male Rates

Rates Effective 6/1/2017

Attained Age	Preferred					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
0 - 64	1,789	2,253	2,690	1,030	2,174	1,820
65	1,789	2,253	2,690	1,030	2,174	1,820
66	1,789	2,253	2,690	1,030	2,174	1,820
67	1,789	2,253	2,690	1,030	2,174	1,820
68	1,864	2,349	2,799	1,071	2,261	1,898
69	1,948	2,455	2,911	1,116	2,353	1,984
70	2,025	2,551	3,019	1,155	2,439	2,063
71	2,103	2,650	3,123	1,198	2,524	2,138
72	2,174	2,741	3,223	1,234	2,603	2,213
73	2,244	2,826	3,306	1,265	2,674	2,284
74	2,309	2,909	3,393	1,299	2,743	2,349
75	2,368	2,980	3,469	1,330	2,804	2,408
76	2,419	3,049	3,534	1,354	2,858	2,464
77	2,471	3,115	3,595	1,376	2,906	2,515
78	2,523	3,175	3,654	1,399	2,953	2,566
79	2,564	3,231	3,705	1,421	2,995	2,611
80	2,605	3,283	3,750	1,435	3,031	2,653
81	2,641	3,330	3,800	1,456	3,071	2,691
82	2,679	3,375	3,848	1,474	3,110	2,726
83	2,715	3,420	3,893	1,493	3,146	2,761
84	2,745	3,458	3,939	1,506	3,184	2,796
85	2,780	3,501	3,981	1,525	3,218	2,831
86	2,811	3,540	4,023	1,541	3,253	2,860
87	2,839	3,580	4,064	1,555	3,285	2,890
88	2,870	3,615	4,100	1,571	3,314	2,924
89	2,893	3,650	4,136	1,585	3,344	2,950
90	2,925	3,683	4,170	1,596	3,370	2,975
91	2,945	3,710	4,198	1,609	3,395	2,998
92	2,968	3,738	4,228	1,620	3,416	3,020
93	2,990	3,769	4,256	1,631	3,440	3,043
94	3,006	3,791	4,283	1,641	3,463	3,061
95	3,024	3,814	4,303	1,648	3,476	3,079
96	3,044	3,836	4,323	1,658	3,493	3,096
97	3,060	3,855	4,344	1,664	3,511	3,115
98	3,079	3,880	4,365	1,673	3,528	3,135
99	3,096	3,901	4,388	1,681	3,546	3,151

Attained Age	Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
0 - 64	1,988	2,505	2,986	1,145	2,415	2,023
65	1,988	2,505	2,986	1,145	2,415	2,023
66	1,988	2,505	2,986	1,145	2,415	2,023
67	1,988	2,505	2,986	1,145	2,415	2,023
68	2,073	2,609	3,111	1,191	2,513	2,109
69	2,161	2,726	3,233	1,238	2,611	2,204
70	2,249	2,835	3,353	1,284	2,708	2,291
71	2,336	2,941	3,469	1,330	2,804	2,376
72	2,416	3,046	3,579	1,369	2,890	2,460
73	2,494	3,140	3,671	1,408	2,968	2,536
74	2,564	3,231	3,766	1,445	3,044	2,611
75	2,628	3,311	3,855	1,478	3,115	2,676
76	2,691	3,386	3,928	1,504	3,174	2,740
77	2,746	3,465	3,996	1,530	3,230	2,796
78	2,799	3,526	4,055	1,553	3,279	2,851
79	2,850	3,591	4,114	1,574	3,324	2,900
80	2,893	3,649	4,165	1,596	3,369	2,949
81	2,936	3,701	4,221	1,618	3,414	2,990
82	2,976	3,749	4,273	1,638	3,453	3,030
83	3,018	3,799	4,326	1,658	3,495	3,070
84	3,053	3,845	4,376	1,676	3,538	3,110
85	3,089	3,890	4,425	1,694	3,579	3,141
86	3,124	3,936	4,471	1,713	3,615	3,176
87	3,151	3,976	4,511	1,729	3,649	3,213
88	3,188	4,014	4,554	1,746	3,683	3,245
89	3,218	4,053	4,598	1,760	3,713	3,276
90	3,243	4,088	4,633	1,775	3,745	3,305
91	3,275	4,125	4,670	1,788	3,775	3,333
92	3,301	4,155	4,699	1,800	3,799	3,359
93	3,323	4,181	4,729	1,811	3,820	3,381
94	3,344	4,211	4,754	1,821	3,843	3,400
95	3,360	4,236	4,776	1,830	3,863	3,420
96	3,383	4,261	4,804	1,840	3,884	3,441
97	3,400	4,286	4,826	1,848	3,901	3,464
98	3,421	4,313	4,851	1,858	3,921	3,485
99	3,441	4,338	4,876	1,868	3,941	3,503

Modal Factors: Semi-Annual: 0.5200 Quarterly: 0.2650 Monthly: 0.0833

The above rates do not include the $20 application fee.

To calculate a Household discount:

Annual premium x modal factor = modal premium (round to nearest whole cent)

Modal premium x .95 = discounted premium

If applying during Open Enrollment or Guaranteed Issue Period, use Preferred rates.

Continental Life Insurance Company of Brentwood, Tennessee

Annual Attained Age Premiums

For Use in ZIP Codes: Rest of state

Female Rates

Rates Effective 6/1/2017

Attained Age	Preferred					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
0 - 64	1,429	1,803	2,152	822	1,740	1,454
65	1,429	1,803	2,152	822	1,740	1,454
66	1,429	1,803	2,152	822	1,740	1,454
67	1,429	1,803	2,152	822	1,740	1,454
68	1,492	1,878	2,240	858	1,811	1,516
69	1,558	1,963	2,328	891	1,880	1,585
70	1,619	2,042	2,413	925	1,949	1,647
71	1,682	2,117	2,497	955	2,018	1,710
72	1,741	2,192	2,575	986	2,080	1,770
73	1,794	2,262	2,644	1,012	2,138	1,827
74	1,848	2,329	2,713	1,041	2,194	1,878
75	1,895	2,387	2,773	1,061	2,244	1,927
76	1,939	2,440	2,829	1,083	2,285	1,972
77	1,979	2,491	2,878	1,102	2,328	2,015
78	2,015	2,540	2,921	1,119	2,360	2,054
79	2,052	2,586	2,965	1,135	2,394	2,090
80	2,086	2,628	2,999	1,149	2,425	2,124
81	2,115	2,661	3,039	1,164	2,456	2,153
82	2,142	2,700	3,077	1,180	2,487	2,180
83	2,172	2,737	3,114	1,193	2,516	2,210
84	2,199	2,767	3,149	1,206	2,546	2,240
85	2,223	2,803	3,187	1,221	2,575	2,263
86	2,247	2,832	3,215	1,232	2,600	2,287
87	2,272	2,864	3,251	1,245	2,629	2,312
88	2,294	2,893	3,280	1,258	2,650	2,337
89	2,316	2,920	3,307	1,266	2,674	2,359
90	2,337	2,943	3,336	1,278	2,696	2,379
91	2,355	2,970	3,363	1,287	2,716	2,397
92	2,375	2,993	3,383	1,296	2,734	2,416
93	2,391	3,014	3,407	1,308	2,754	2,433
94	2,408	3,031	3,420	1,311	2,766	2,450
95	2,420	3,049	3,440	1,318	2,781	2,464
96	2,436	3,067	3,459	1,325	2,797	2,478
97	2,450	3,087	3,476	1,333	2,809	2,491
98	2,462	3,104	3,496	1,340	2,826	2,505
99	2,478	3,123	3,511	1,344	2,838	2,523

Attained Age	Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
0 - 64	1,590	2,006	2,391	914	1,933	1,619
65	1,590	2,006	2,391	914	1,933	1,619
66	1,590	2,006	2,391	914	1,933	1,619
67	1,590	2,006	2,391	914	1,933	1,619
68	1,657	2,090	2,489	952	2,010	1,686
69	1,730	2,179	2,588	994	2,092	1,763
70	1,799	2,267	2,681	1,027	2,167	1,832
71	1,868	2,355	2,773	1,061	2,244	1,900
72	1,933	2,438	2,859	1,096	2,310	1,967
73	1,994	2,512	2,939	1,127	2,376	2,030
74	2,052	2,586	3,015	1,157	2,436	2,091
75	2,102	2,650	3,084	1,181	2,491	2,140
76	2,151	2,713	3,141	1,203	2,539	2,191
77	2,199	2,769	3,195	1,225	2,584	2,240
78	2,241	2,823	3,245	1,245	2,623	2,282
79	2,282	2,874	3,292	1,259	2,659	2,321
80	2,316	2,920	3,332	1,277	2,693	2,359
81	2,348	2,960	3,376	1,293	2,728	2,393
82	2,381	3,003	3,419	1,311	2,765	2,424
83	2,413	3,039	3,462	1,325	2,798	2,456
84	2,443	3,079	3,501	1,340	2,829	2,484
85	2,468	3,112	3,540	1,356	2,861	2,514
86	2,499	3,148	3,575	1,371	2,890	2,544
87	2,525	3,179	3,611	1,382	2,918	2,571
88	2,548	3,212	3,643	1,396	2,945	2,594
89	2,574	3,242	3,677	1,408	2,972	2,622
90	2,597	3,273	3,705	1,419	2,995	2,644
91	2,617	3,297	3,735	1,429	3,016	2,663
92	2,638	3,324	3,762	1,442	3,041	2,688
93	2,655	3,347	3,785	1,448	3,058	2,704
94	2,674	3,370	3,805	1,458	3,076	2,724
95	2,691	3,390	3,824	1,464	3,090	2,739
96	2,704	3,410	3,841	1,470	3,105	2,754
97	2,722	3,428	3,861	1,480	3,122	2,769
98	2,738	3,448	3,882	1,488	3,137	2,784
99	2,755	3,471	3,904	1,494	3,154	2,804

Modal Factors: Semi-Annual: 0.5200 Quarterly: 0.2650 Monthly: 0.0833

The above rates do not include the $20 application fee.

To calculate a Household discount:

Annual premium x modal factor = modal premium (round to nearest whole cent)

Modal premium x .95 = discounted premium

If applying during Open Enrollment or Guaranteed Issue Period, use Preferred rates.

Continental Life Insurance Company of Brentwood, Tennessee

Annual Attained Age Premiums

For Use in ZIP Codes: Rest of state

Male Rates

Rates Effective 6/1/2017

Attained Age	Preferred					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
0 - 64	1,646	2,072	2,475	948	2,000	1,674
65	1,646	2,072	2,475	948	2,000	1,674
66	1,646	2,072	2,475	948	2,000	1,674
67	1,646	2,072	2,475	948	2,000	1,674
68	1,715	2,161	2,575	986	2,080	1,746
69	1,792	2,259	2,678	1,027	2,164	1,825
70	1,863	2,347	2,777	1,063	2,244	1,898
71	1,934	2,438	2,873	1,102	2,322	1,967
72	2,000	2,522	2,965	1,135	2,394	2,036
73	2,064	2,600	3,042	1,164	2,460	2,101
74	2,124	2,676	3,121	1,195	2,523	2,161
75	2,178	2,742	3,191	1,224	2,579	2,215
76	2,225	2,805	3,251	1,245	2,629	2,267
77	2,274	2,866	3,307	1,266	2,674	2,314
78	2,321	2,921	3,361	1,287	2,716	2,361
79	2,359	2,973	3,409	1,308	2,755	2,402
80	2,397	3,020	3,450	1,320	2,789	2,440
81	2,430	3,064	3,496	1,340	2,826	2,476
82	2,464	3,105	3,540	1,356	2,861	2,508
83	2,498	3,146	3,581	1,373	2,895	2,540
84	2,525	3,181	3,624	1,386	2,929	2,573
85	2,558	3,221	3,663	1,403	2,960	2,605
86	2,586	3,257	3,701	1,418	2,992	2,631
87	2,612	3,294	3,739	1,431	3,022	2,659
88	2,640	3,326	3,772	1,446	3,049	2,690
89	2,661	3,358	3,805	1,458	3,076	2,714
90	2,691	3,388	3,836	1,469	3,100	2,737
91	2,709	3,413	3,862	1,480	3,123	2,758
92	2,730	3,439	3,889	1,490	3,143	2,778
93	2,751	3,467	3,916	1,501	3,165	2,799
94	2,766	3,488	3,940	1,510	3,186	2,816
95	2,782	3,509	3,958	1,516	3,198	2,832
96	2,800	3,529	3,977	1,525	3,213	2,849
97	2,815	3,547	3,996	1,531	3,230	2,866
98	2,832	3,570	4,016	1,539	3,245	2,884
99	2,849	3,589	4,037	1,547	3,263	2,899

Attained Age	Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
0 - 64	1,829	2,305	2,747	1,053	2,222	1,861
65	1,829	2,305	2,747	1,053	2,222	1,861
66	1,829	2,305	2,747	1,053	2,222	1,861
67	1,829	2,305	2,747	1,053	2,222	1,861
68	1,907	2,400	2,862	1,096	2,312	1,940
69	1,988	2,508	2,974	1,139	2,402	2,027
70	2,069	2,608	3,084	1,181	2,491	2,108
71	2,149	2,706	3,191	1,224	2,579	2,186
72	2,223	2,803	3,292	1,259	2,659	2,263
73	2,294	2,889	3,378	1,295	2,730	2,333
74	2,359	2,973	3,465	1,329	2,800	2,402
75	2,417	3,046	3,547	1,359	2,866	2,462
76	2,476	3,115	3,613	1,383	2,920	2,521
77	2,527	3,188	3,677	1,408	2,972	2,573
78	2,575	3,244	3,731	1,428	3,016	2,623
79	2,622	3,304	3,785	1,448	3,058	2,668
80	2,661	3,357	3,832	1,469	3,099	2,713
81	2,701	3,405	3,884	1,488	3,141	2,751
82	2,738	3,449	3,931	1,507	3,176	2,788
83	2,776	3,495	3,980	1,525	3,215	2,824
84	2,808	3,537	4,026	1,542	3,255	2,861
85	2,842	3,579	4,071	1,558	3,292	2,890
86	2,874	3,621	4,114	1,576	3,326	2,922
87	2,899	3,658	4,150	1,590	3,357	2,956
88	2,933	3,693	4,189	1,607	3,388	2,985
89	2,960	3,728	4,230	1,619	3,416	3,014
90	2,983	3,761	4,262	1,633	3,445	3,041
91	3,013	3,795	4,296	1,645	3,473	3,066
92	3,037	3,823	4,323	1,656	3,495	3,090
93	3,057	3,847	4,350	1,666	3,514	3,111
94	3,076	3,874	4,373	1,676	3,535	3,128
95	3,091	3,897	4,394	1,684	3,554	3,146
96	3,112	3,920	4,419	1,693	3,573	3,166
97	3,128	3,943	4,440	1,700	3,589	3,187
98	3,148	3,968	4,463	1,709	3,608	3,206
99	3,166	3,991	4,486	1,718	3,626	3,222

Modal Factors: Semi-Annual: 0.5200 Quarterly: 0.2650 Monthly: 0.0833

The above rates do not include the $20 application fee.

To calculate a Household discount:

Annual premium x modal factor = modal premium (round to nearest whole cent)

Modal premium x .95 = discounted premium

If applying during Open Enrollment or Guaranteed Issue Period, use Preferred rates.

PREMIUM INFORMATION

Continental Life Insurance Company of Brentwood, Tennessee can only raise your premium if we raise the premium for all policies like yours in this state. Premiums for this policy will increase due to the increase in your age. Upon attainment of an age requiring a rate increase, the renewal premium for the policy will be the renewal premium then in effect for your attained age. Other policies may be provided with Issue Age rating and do not increase with age. You should compare Issue Age with Attained Age policies.

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

Semi-annual: 0.5200 Quarterly: 0.2650 Monthly EFT: 0.0833.

HOUSEHOLD DISCOUNT

In order to be eligible for the Household discount under a Continental Life Insurance Company of Brentwood, Tennessee Medicare supplement plan, you must apply for a Medicare supplement plan at the same time as another Medicare eligible adult or the other Medicare eligible adult must currently be covered by a Continental Life Insurance Company of Brentwood, Tennessee Medicare supplement policy. The Medicare eligible adult must be either (a) your spouse; (b) be someone with whom you are in a civil union partnership; or (c) be a permanent resident in your home. The household discount will only be applicable if a policy for each applicant is issued. The discounted rate will be 5 percent lower than the individual rates and will apply as long as both policies remain in force.

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 Continental Life Insurance Company of Brentwood, Tennessee, P.O. Box 14770, Lexington, KY 40512-4770. 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 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 Continental Life Insurance Company of Brentwood, Tennessee 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, F, HIGH DEDUCTIBLE F, G and N OFFERED BY CONTINENTAL LIFE INSURANCE COMPANY OF BRENTWOOD, TENNESSEE.

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 $1316	$0	$1316 (Part A Deductible)
61st thru 90th day	All but $329 a day	$329 a day	$0
91st day and after			
While using 60 lifetime reserve days	All but $658 a day	$658 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 $164.50 a day	$0	Up to $164.50 a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

PLAN A

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

*Once you have been billed $183 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic test, durable medical equipment			
First $183 of Medicare-Approved amounts*	$0	$0	$183 (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 $183 of Medicare-Approved amounts*	$0	$0	$183 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	$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 $183 of Medicare Approved amounts*	$0	$0	$183 (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
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1316	$1316 (Part A Deductible)	$0
61st thru 90th day	All but $329 a day	$329 a day	$0
91st day and after			
□While using 60 lifetime reserve days	All but $658 a day	$658 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 $164.50 a day	$0	Up to $164.50 a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in 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 $183 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic test, durable medical equipment			
First $183 of Medicare-Approved amounts*	$0	$0	$183 (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 $183 of Medicare-Approved amounts*	$0	$0	$183 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	$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 $183 of Medicare Approved amounts*	$0	$0	$183 (Part B Deductible)
Remainder of Medicare Approved amounts	80%	20%	$0

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 $1316	$1316 (Part A Deductible)	$0
61st thru 90th day	All but $329 a day	$329 a day	$0
91st day and after			
□While using 60 lifetime reserve days	All but $658 a day	$658 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 $164.50 a day	Up to $164.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in 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 $183 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic test, durable medical equipment			
First $183 of Medicare-Approved amounts*	$0	$183 (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 $183 of Medicare-Approved amounts*	$0	$183 (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

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 $183 of Medicare Approved amounts*	$0	$183 (Part B Deductible)	$0
Remainder of Medicare Approved amounts	80%	20%	$0

PLAN F

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	$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

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 one has paid a calendar year $2200 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses are $2200. 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.**

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2200 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2200 DEDUCTIBLE*** YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1316	$1316 (Part A Deductible)	$0
61st thru 90th day	All but $329 a day	$329 a day	$0
91st day and after			
While using 60 lifetime reserve days	All but $658 a day	$658 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 $164.50 a day	Up to $164.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0

HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in 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 $183 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

*****This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2200 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses are $2200. 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.**

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2200 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2200 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 $183 of Medicare-Approved amounts*	$0	$183 (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 $183 of Medicare-Approved amounts*	$0	$183 (Part B Deductible)	$0
Remainder of Medicare-Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

HIGH DEDUCTIBLE PLAN F

PARTS A & B

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2200 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2200 DEDUCTIBLE*** YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
First $183 of Medicare Approved amounts*	$0	$183 (Part B Deductible)	$0
Remainder of Medicare Approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2200 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2200 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	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN G

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1316	$1316 (Part A Deductible)	$0
61st thru 90th day	All but $329 a day	$329 a day	$0
91st day and after			
□While using 60 lifetime reserve days	All but $658 a day	$658 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 $164.50 a day	Up to $164.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness services	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in 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 $183 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic test, durable medical equipment			
First $183 of Medicare-Approved amounts*	$0	$0	$183 (Part B Deductible)
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 $183 of Medicare-Approved amounts*	$0	$0	$183 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	$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 $183 of Medicare Approved amounts*	$0	$0	$183 (Part B Deductible)
Remainder of Medicare Approved amounts	80%	20%	$0

PLAN G

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	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN N

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1316	$1316 (Part A Deductible)	$0
61st thru 90th day	All but $329 a day	$329 a day	$0
91st day and after			
□While using 60 lifetime reserve days	All but $658 a day	$658 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 $164.50 a day	Up to $164.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness services	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in 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 N

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

*Once you have been billed $183 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic test, durable medical equipment			
First $183 of Medicare-Approved amounts*	$0	$0	$183 (Part B Deductible)
Remainder of Medicare-Approved amounts	Generally 80%	Balance, other than up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
Part B Excess Charges (Above Medicare-Approved amounts)	$0	0%	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $183 of Medicare-Approved amounts*	$0	$0	$183 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN N

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 $183 of Medicare Approved amounts*	$0	$0	$183 (Part B Deductible)
Remainder of Medicare Approved amounts	80%	20%	$0

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	$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