800 Crescent Centre Dr.
Suite 200
Franklin, TN 37067
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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**

New Hampshire

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, co-payments 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
Basic, including 100% Part B co-insurance	Basic, including 100% Part B co-insurance	Basic, including 100% Part B co-insurance	Basic, including 100% Part B co-insurance	Basic, including 100% Part B co-insurance	Basic, including 100% Part B co-insurance	Basic, including 100% Part B co-insurance	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%
		Skilled Nursing Facility Co-insurance	Skilled Nursing Facility Co-insurance	Skilled Nursing Facility Co-insurance	Skilled Nursing Facility Co-insurance	Skilled Nursing Facility Co-insurance	50% Skilled Nursing Facility Co-insurance	75% Skilled Nursing Facility Co-insurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	50% Part A Deductible	75% Part A Deductible
		Part B Deductible		Part B Deductible	Part B Deductible			
				Part B Excess (100%)	Part B Excess (100%)	Part B Excess (100%)		
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency		
							Out-of-pocket limit $4960; paid at 100% after limit reached	Out-of-pocket limit $2480; 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 $2180 deductible. Benefits from high deductible Plan F will not begin until out-of-pocket expenses exceed $2180. 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
OUTLINE OF MEDICARE SUPPLEMENT COVERAGE COVER PAGE: Page 2 of 2
BENEFIT PLANS AVAILABLE: A, B, F, HIGH DEDUCTIBLE F, G, N

M	N
Basic, including 100% Part B co-insurance	Basic, including 100% Part B coinsurance, except up to $20 co-payment for office visit, and up to $50 copayment for ER
Skilled Nursing Facility Co-insurance	Skilled Nursing Facility Coinsurance
50% Part A Deductible	Part A Deductible
Foreign Travel Emergency	Foreign Travel Emergency

Continental Life Insurance Company of Brentwood, Tennessee

Annual Issue Age Premiums

For Use in ZIP Codes: Entire State

Female Rates

Issue Age	Preferred						Issue Age	Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N		Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	2,016	2,539	2,780	1,094	2,308	2,051	Under 65	2,240	2,822	3,090	1,215	2,565	2,280
65	1,397	1,761	2,015	805	1,672	1,421	65	1,552	1,957	2,239	894	1,857	1,580
66	1,397	1,761	2,015	805	1,672	1,421	66	1,552	1,957	2,239	894	1,857	1,580
67	1,397	1,761	2,015	805	1,672	1,421	67	1,552	1,957	2,239	894	1,857	1,580
68	1,438	1,809	2,069	827	1,718	1,463	68	1,597	2,011	2,296	918	1,907	1,625
69	1,481	1,867	2,120	848	1,759	1,508	69	1,644	2,074	2,358	942	1,957	1,676
70	1,521	1,917	2,171	868	1,801	1,548	70	1,688	2,128	2,412	964	2,002	1,720
71	1,559	1,963	2,216	885	1,839	1,586	71	1,731	2,182	2,461	984	2,044	1,760
72	1,593	2,007	2,256	903	1,872	1,621	72	1,770	2,230	2,507	1,004	2,081	1,802
73	1,623	2,046	2,287	916	1,897	1,653	73	1,803	2,273	2,542	1,018	2,110	1,836
74	1,651	2,081	2,317	928	1,923	1,678	74	1,834	2,310	2,575	1,033	2,138	1,867
75	1,674	2,109	2,342	940	1,944	1,704	75	1,858	2,343	2,603	1,043	2,160	1,891
76	1,693	2,132	2,363	948	1,961	1,722	76	1,881	2,371	2,625	1,051	2,179	1,914
77	1,710	2,153	2,384	952	1,979	1,741	77	1,902	2,393	2,648	1,059	2,196	1,936
78	1,726	2,176	2,405	960	1,995	1,759	78	1,920	2,418	2,672	1,066	2,217	1,954
79	1,743	2,196	2,424	965	2,013	1,774	79	1,937	2,442	2,693	1,072	2,236	1,971
80	1,760	2,216	2,441	971	2,024	1,792	80	1,954	2,463	2,711	1,076	2,251	1,990
81	1,774	2,235	2,459	977	2,042	1,806	81	1,970	2,483	2,731	1,084	2,266	2,007
82	1,787	2,252	2,480	984	2,058	1,820	82	1,986	2,505	2,753	1,094	2,286	2,024
83	1,804	2,272	2,498	990	2,074	1,835	83	2,004	2,523	2,775	1,101	2,304	2,040
84	1,816	2,287	2,518	998	2,090	1,851	84	2,018	2,543	2,800	1,108	2,324	2,053
85	1,827	2,305	2,540	1,004	2,109	1,860	85	2,029	2,558	2,823	1,114	2,344	2,066
86	1,839	2,318	2,557	1,008	2,123	1,872	86	2,043	2,575	2,842	1,120	2,359	2,081
87	1,850	2,329	2,576	1,013	2,138	1,883	87	2,055	2,587	2,861	1,127	2,375	2,092
88	1,867	2,352	2,598	1,021	2,157	1,902	88	2,075	2,613	2,887	1,137	2,395	2,111
89	1,884	2,374	2,618	1,031	2,174	1,918	89	2,093	2,636	2,911	1,145	2,416	2,130
90	1,900	2,393	2,642	1,039	2,192	1,935	90	2,113	2,661	2,934	1,153	2,435	2,150
91	1,916	2,415	2,662	1,046	2,210	1,950	91	2,128	2,682	2,956	1,164	2,453	2,165
92	1,929	2,434	2,679	1,053	2,223	1,964	92	2,146	2,703	2,978	1,172	2,473	2,184
93	1,944	2,450	2,696	1,062	2,238	1,980	93	2,159	2,722	2,995	1,178	2,486	2,197
94	1,958	2,465	2,709	1,066	2,249	1,991	94	2,175	2,740	3,012	1,185	2,500	2,214
95	1,968	2,480	2,725	1,072	2,260	2,004	95	2,187	2,757	3,027	1,189	2,512	2,227
96	1,981	2,494	2,739	1,077	2,273	2,016	96	2,197	2,772	3,042	1,197	2,524	2,239
97	1,991	2,509	2,752	1,083	2,285	2,026	97	2,214	2,789	3,058	1,204	2,538	2,252
98	2,003	2,523	2,767	1,088	2,296	2,038	98	2,225	2,803	3,074	1,209	2,552	2,264
99	2,016	2,539	2,780	1,094	2,308	2,051	99	2,240	2,822	3,090	1,215	2,565	2,280

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 Issue Age Premiums

For Use in ZIP Codes: Entire State

Male Rates

Issue Age	Preferred						Issue Age	Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N		Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	2,317	2,918	3,197	1,257	2,653	2,359	Under 65	2,575	3,244	3,552	1,397	2,948	2,620
65	1,606	2,024	2,317	926	1,923	1,636	65	1,785	2,249	2,575	1,029	2,138	1,817
66	1,606	2,024	2,317	926	1,923	1,636	66	1,785	2,249	2,575	1,029	2,138	1,817
67	1,606	2,024	2,317	926	1,923	1,636	67	1,785	2,249	2,575	1,029	2,138	1,817
68	1,652	2,082	2,377	950	1,972	1,682	68	1,836	2,313	2,643	1,055	2,193	1,869
69	1,704	2,148	2,441	976	2,024	1,736	69	1,892	2,385	2,711	1,083	2,251	1,927
70	1,749	2,204	2,497	999	2,073	1,781	70	1,944	2,449	2,773	1,109	2,301	1,980
71	1,793	2,257	2,550	1,019	2,117	1,822	71	1,991	2,508	2,833	1,132	2,351	2,026
72	1,833	2,309	2,596	1,039	2,155	1,865	72	2,035	2,565	2,883	1,152	2,393	2,073
73	1,867	2,351	2,630	1,053	2,182	1,900	73	2,075	2,613	2,923	1,171	2,425	2,111
74	1,896	2,391	2,667	1,069	2,214	1,930	74	2,108	2,656	2,961	1,186	2,458	2,147
75	1,925	2,423	2,694	1,079	2,237	1,958	75	2,138	2,693	2,993	1,201	2,484	2,176
76	1,947	2,452	2,717	1,087	2,255	1,982	76	2,162	2,725	3,019	1,209	2,506	2,203
77	1,964	2,479	2,740	1,096	2,274	2,002	77	2,185	2,753	3,045	1,217	2,526	2,223
78	1,986	2,504	2,766	1,104	2,295	2,024	78	2,207	2,780	3,071	1,224	2,550	2,248
79	2,005	2,525	2,790	1,109	2,315	2,042	79	2,227	2,807	3,097	1,232	2,572	2,265
80	2,024	2,549	2,806	1,115	2,328	2,060	80	2,248	2,831	3,118	1,240	2,587	2,288
81	2,040	2,571	2,828	1,122	2,347	2,076	81	2,265	2,857	3,145	1,247	2,611	2,308
82	2,057	2,592	2,850	1,131	2,366	2,093	82	2,285	2,879	3,166	1,257	2,629	2,326
83	2,074	2,613	2,873	1,139	2,385	2,110	83	2,305	2,902	3,193	1,266	2,650	2,346
84	2,087	2,630	2,897	1,146	2,404	2,125	84	2,319	2,923	3,220	1,274	2,672	2,362
85	2,102	2,648	2,920	1,152	2,423	2,140	85	2,337	2,942	3,246	1,282	2,694	2,377
86	2,115	2,664	2,941	1,161	2,442	2,153	86	2,350	2,962	3,268	1,287	2,713	2,391
87	2,126	2,680	2,962	1,166	2,458	2,163	87	2,361	2,977	3,291	1,295	2,731	2,405
88	2,148	2,706	2,989	1,176	2,480	2,186	88	2,385	3,004	3,319	1,306	2,754	2,428
89	2,164	2,730	3,013	1,185	2,501	2,207	89	2,407	3,032	3,349	1,317	2,779	2,450
90	2,186	2,753	3,036	1,195	2,520	2,224	90	2,426	3,059	3,373	1,328	2,801	2,473
91	2,205	2,776	3,059	1,204	2,539	2,243	91	2,449	3,086	3,400	1,338	2,822	2,493
92	2,219	2,797	3,080	1,211	2,556	2,259	92	2,468	3,108	3,423	1,345	2,841	2,513
93	2,237	2,818	3,100	1,219	2,574	2,276	93	2,484	3,129	3,445	1,355	2,859	2,529
94	2,250	2,836	3,118	1,227	2,587	2,290	94	2,500	3,150	3,463	1,363	2,875	2,545
95	2,262	2,851	3,133	1,233	2,600	2,305	95	2,515	3,169	3,481	1,370	2,889	2,558
96	2,277	2,868	3,149	1,239	2,613	2,317	96	2,530	3,188	3,499	1,376	2,904	2,575
97	2,290	2,884	3,164	1,245	2,625	2,330	97	2,545	3,205	3,516	1,382	2,917	2,590
98	2,305	2,901	3,182	1,251	2,640	2,346	98	2,559	3,225	3,534	1,390	2,934	2,606
99	2,317	2,918	3,197	1,257	2,653	2,359	99	2,575	3,244	3,552	1,397	2,948	2,620

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 payable other than annual 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 1188, Brentwood, Tennessee 37024. 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) – MEDICAL SERVICES – PER CALENDAR YEAR

*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 $1288	$0	$1288 (Part A Deductible)
61st thru 90th day	All but $322 a day	$322 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $644 a day	$644 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 $161.00 a day	$0	Up to $161.00 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 $166 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 $166 of Medicare-Approved amounts*	$0	$0	$166 (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 $166 of Medicare-Approved amounts*	$0	$0	$166 (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 $166 of Medicare Approved amounts*	$0	$0	$166 (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 $1288	$1288 (Part A Deductible)	$0
61st thru 90th day	All but $322 a day	$322 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $644 a day	$644 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 $161.00 a day	$0	Up to $161.00 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 $166 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 $166 of Medicare-Approved amounts*	$0	$0	$166 (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 $166 of Medicare-Approved amounts*	$0	$0	$166 (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 $166 of Medicare Approved amounts*	$0	$0	$166 (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 $1288	$1288 (Part A Deductible)	$0
61st thru 90th day	All but $322 a day	$322 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $644 a day	$644 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 $161.00 a day	Up to $161.00 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 $166 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 $166 of Medicare-Approved amounts*	$0	$166 (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 $166 of Medicare-Approved amounts*	$0	$166 (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 $166 of Medicare Approved amounts*	$0	$166 (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 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 $2180 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses are $2180. 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 $2180 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2180 DEDUCTIBLE** YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1288	$1288 (Part A Deductible)	$0
61st thru 90th day	All but $322 a day	$322 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $644 a day	$644 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 $161.00 a day	Up to $161.00 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 $166 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 $2180 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses are $2180. 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 $2180 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2180 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 $166 of Medicare-Approved amounts*	$0	$166 (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 $166 of Medicare-Approved amounts*	$0	$166 (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 $2180 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2180 DEDUCTIBLE** YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
•Medically necessary skilled care services and medical supplies	100%	$0	$0
•Durable medical equipment			
•First $166 of Medicare Approved amounts*	$0	$166 (Part B Deductible)	$0
•Remainder of Medicare Approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2180 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2180 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 $1288	$1288 (Part A Deductible)	$0
61st thru 90th day	All but $322 a day	$322 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $644 a day	$644 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 $161.00 a day	Up to $161.00 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 $166 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 $166 of Medicare-Approved amounts*	$0	$0	$166 (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 $166 of Medicare-Approved amounts*	$0	$0	$166 (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 $166 of Medicare Approved amounts*	$0	$0	$166 (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 $1288	$1288 (Part A Deductible)	$0
61st thru 90th day	All but $322 a day	$322 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $644 a day	$644 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 $161.00 a day	Up to $161.00 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 co-payment/ 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 $166 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 $166 of Medicare-Approved amounts*	$0	$0	$166 (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 co-payment 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 $166 of Medicare-Approved amounts*	$0	$0	$166 (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 $166 of Medicare Approved amounts*	$0	$0	$166 (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