CONTINENTAL LIFE INSURANCE COMPANY OF BRENTWOOD, TENNESSEE
OUTLINE OF MEDICARE SUPPLEMENT COVERAGE COVER PAGE
BENEFIT PLANS AVAILABLE: BASIC MEDICARE SUPPLEMENT PLAN
EXTENDED MEDICARE SUPPLEMENT PLAN
HIGH DEDUCTIBLE PLAN
MEDICARE SUPPLEMENT COPAYMENT PLAN

THE COMMISSIONER OF COMMERCE OF THE STATE OF MINNESOTA HAS ESTABLISHED TWO CATEGORIES FOR MEDICARE SUPPLEMENTS. THE CATEGORIES ARE BASIC MEDICARE SUPPLEMENT AND EXTENDED BASIC MEDICARE SUPPLEMENTS WITH EXTENDED MEDICARE SUPPLEMENTS BEING THE MOST COMPREHENSIVE AND BASIC MEDICARE SUPPLEMENTS BEING THE LEAST COMPREHENSIVE.

THIS CHART SHOWS THE BENEFITS INCLUDED IN ALL PLANS.

BASIC BENEFITS included in all plans:

Inpatient Hospital Care: Covers the Medicare Part A coinsurance

Medical Costs: Covers the Medicare Part B coinsurance (generally 20% of the Medicare Approved payment amount), or in the case of hospital outpatient department services under a prospective payment system, applicable co-payments.

Blood: Covers the first 3 pints of blood each year.

BASIC	EXTENDED BASIC	HIGH DEDUCTIBLE PLAN**	COPAYMENT PLAN
Hospitalization: Part A Coinsurance	Hospitalization: Part A Coinsurance	Hospitalization: Part A Coinsurance	Hospitalization: Part A Coinsurance
Medical Expenses: Part B Coinsurance	Medical Expenses: Part B Coinsurance	Medical Expenses: Part B Coinsurance	Medical Expenses: Part B Coinsurance except up to $20 copayment for office visits and up to $50 copayment for ER
Blood: First 3 Pints of blood each year	Blood: First 3 Pints of blood each year	Blood: First 3 Pints of blood each year	Blood: First 3 Pints of blood each year
Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance
*Part A Deductible Rider	Part A Deductible	Part A Deductible	Part A Deductible
*Part B Deductible Rider	Part B Deductible		
*Part B Excess Charges Rider	Part B Excess (100%)		
Foreign Travel Emergency	Foreign Travel Medical Care	Foreign Travel Emergency	Foreign Travel Emergency
*Preventive Health Rider	Preventive Care		

**This plan will pay coverage upon payment of the annual deductible. For 2019 the deductible amount is $2,300. This amount will be adjusted annually to reflect the changes in Medicare.

*Optional Riders are available for the Part A deductible, Part B deductible, Part B excess and Preventive Health Services.

Annual Issue Age Premiums

CONTINENTAL LIFE INSURANCE COMPANY OF BRENTWOOD, TENNESSEE

2010 Medicare Supplement Policy

Rates Effective 5/1/2019

Plan Description	Issue Age	Preferred - Unisex	Standard - Unisex
Basic Benefit Plan	All	1,970	2,226
Rider A - Part A Deductible	All	469	530
Rider B - Part B Deductible**	All	185	185
Rider C - Preventive Care	All	72	80
Rider D - Part B Excess (100%)	All	97	108
High Deductible Plan	All	973	1,100
Copayment Plan	All	1,983	2,239
Extended Basic	All	2,274	2,569

Modal Factors: Ann:1.0000 Semi: 0.5200 Qtrly: 0.2650 Mthly: 0.0833

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

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

**Rider B is not subject to area rating.
***Our premium for the Part B deductible will be equal to and not more than the Part B deductible amount as determined annually by CMS.

MEDICARE SUPPLEMENT POLICY FORMS

REQUIRED OUTLINE OF COVERAGE

POLICY FORM CLIMSP10BP IS A BASIC MEDICARE SUPPLEMENT POLICY
POLICY FORM CLIMSP10EB IS AN EXTENDED MEDICARE SUPPLEMENT POLICY
POLICY FORM CLIMSP10HD IS A HIGH DEDUCTIBLE MEDICARE SUPPLEMENT POLICY
POLICY FORM CLIMSP10CP IS A CO-PAY MEDICARE SUPPLEMENT POLICY

DISCLOSURES: Use this outline to compare benefits and premiums among policies.

1. **READ YOUR POLICY CAREFULLY-**This Outline of Coverage provides a brief description of the important features of your policy. It does not give all the details of Medicare coverage. Contact your local social security office or consult the Medicare handbook for more details. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and the Company. It is important that you **READ YOUR POLICY CAREFULLY!**

2. **MEDICARE SUPPLEMENTAL COVERAGE-**Policies of this category are designed to Supplement Medicare by covering some hospital, medical and surgical services which are partially covered by Medicare. Coverage is provided for hospital inpatient expenses and some physician expenses, subject to any deductibles and co-payments provisions which may be in addition to those provided by Medicare and subject to other limitations which may be set forth in the policy. The policy does not provide benefits for custodial care such as help in walking, getting in and out of bed, eating, dressing, bathing and taking medicine.

3. **GUARANTEED RENEWABLE-**You have the right to renew the policy, for consecutive terms, by payment of the required premium before the end of each grace period. You have the right to renew the policy regardless of changes in your physical, mental or health conditions.

4. **EFFECTIVE DATE OF COVERAGE-**Coverage commences on the effective date for all covered injuries occurring after the effective date. The policy covers sickness first manifesting itself after the effective date.

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

6. **RIGHT TO RETURN POLICY-**If you find you are not satisfied with your policy for any reason 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 of your payments within 10 days.

7. **PREMIUM AGREEMENT-**The company may change the premium for your policy only if the premium for all other policies issued with the same form number to persons in your state are also changed. Any premium increase will become effective on the next policy anniversary date. At least 30 days advance notice in writing will be given before any premium increase.

8. **NOTICE-**The policy may not fully cover all of your medical costs.

9. Neither Continental Life Insurance Company of Brentwood, Tennessee nor its agents are connected with Medicare.

10. **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 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.

11. **ANTICIPATED LOSS RATIO-**The policy provides an anticipated loss ratio of 65%. This means that, on the average, you may expect that $65.00 of every $100.00 in premium will be returned as benefits to you over the life of the contract.

THE POLICY DOES NOT COVER ALL MEDICAL EXPENSES BEYOND THOSE COVERED BY MEDICARE. THE POLICY DOES NOT COVER ALL SKILLED NURSING HOME CARE EXPENSES AND DOES NOT COVER CUSTODIAL OR RESIDENTIAL NURSING CARE. READ YOUR POLICY CAREFULLY TO DETERMINE WHICH NURSING HOME FACILITIES AND EXPENSES ARE COVERED BY YOUR POLICY.

THE FOLLOWING CHARTS DESCRIBE THE MEDICARE SUPPLEMENT PLANS OFFERED BY CONTINENTAL LIFE INSURANCE COMPANY OF BRENTWOOD, TENNESSEE.

Basic Plan-CLIMSP10BP

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	BASIC PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,364	$0 or Optional Part A Deductible Rider +	$1,364 or $0
61st thru 90th day	All but $341 a day	$341 a day	$0
91st through 150th day	All but $682 a day	$682 a day	$0
Beyond 150 days	$0	100% of Medicare eligible Expenses	$0
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	100% of approved amounts	$0	$0
21st thru 100th day	All but $170.50 a day	Up to $170.50 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	Balance

+This is an optional Rider. You purchased this benefit if the box is checked and you paid the premium

Basic Plan-CLIMSP10BP

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

*Once you have been billed $185 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 $185 of Medicare Approved Amounts*	$0	$0 or Optional Part B Deductible Rider+	$185 or $0
Remainder of Medicare-Approved amounts	80%	20%	$0
Part B Excess Charges (Above Medicare-Approved amounts)	$0	$0 or Optional Part B Excess Charges Deductible Rider+	All costs or $0
BLOOD			
First 3 pints	$0	All costs	$0
Next $185 of Medicare-Approved Amounts	$0	$0 or Optional Part B Deductible Rider+	$0
Remainder of Medicare-Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

+This is an optional Rider. You purchased this benefit if the box is checked and you paid the premium

Basic Plan-CLIMSP10BP

MEDICARE (PARTS A & B) — PER CALENDAR YEAR

*Once you have been billed $185 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
HOME HEALTH CARE- MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
First $185 of Medicare Approved amounts*	$0	$0 or Optional Part B Deductible Rider+	$185 (Part B Deductible) or $0
Remainder of Medicare Approved Amounts	80%	20%	$0
FOREIGN TRAVEL-NOT COVERED BY MEDICARE			
Medically necessary emergency care services incurred during travel outside the USA (hospital, medical expense and supplies)	$0	80% of covered expenses	20% of covered expenses
PREVENTIVE MEDICAL CARE BENEFIT-NOT COVERED BY MEDICARE			
Some annual physical and preventive tests and services administered or ordered by your doctor when not covered by Medicare.			
First $120 each calendar year	$0	$0 or $120 Optional Rider+	$120 $0
Additional Charges	$0	$0	All Costs

*This is an Optional Rider. You purchased this benefit if the box is checked and you paid the premium.

Extended Basic Plan-CLIMSP10EB

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,364	$1,364 (Part A Deductible)	$0
61st thru 90th day	All but $341 a day	$341 a day	$0
91st through 150th day	All but $682 a day	$682 a day	$0
Beyond 150th Day	$0	100% of Medicare Eligible Expenses	$0
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 $170.50 a day	Up to $170.50 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	Balance

Extended Basic Plan-CLIMSP10EB

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

*Once you have been billed $185 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 $185 of Medicare-Approved Amounts	$0	$185 Part B Deductible	$0
Remainder of Medicare-Approved Amounts	80%	20%	$0
Part B Excess Charges (Above Medicare-Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $185 of Medicare-Approved amounts*	$0	$185 (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 $185 of Medicare Approved amounts*	$0	$185	$0
• Remainder of Medicare Approved amounts	80%	20%	$0

Extended Basic Plan-CLIMSP10EB

Other Benefits Not Covered by Medicare

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL-NOT COVERED BY MEDICARE Medically necessary care and services incurred during travel outside the USA (hospital, medical expense and supplies)	$0	80% of covered expenses	20% of covered expenses
PREVENTIVE MEDICAL CARE BENEFIT-NOT COVERED BY MEDICARE Some annual physical and preventive tests and services administered or ordered by your doctor when not covered by Medicare			
First $120 each calendar year	$0	$120	$0
Additional Charges	$0	$0	All Costs

High Deductible Plan-CLIMSP10HD

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 Medicare supplement plan will pay upon payment of the annual high deductible. The annual deductible shall consist of out-of-pocket expenses, other than premiums, for services covered. The basis for the deductible shall be $2,300 and shall be adjusted annually to reflect the changes in the Consumer Price Index for all consumers for the 12 month period ending with August of the previous year.**

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,300 DEDUCTIBLE PLAN PAYS	IN ADDITION TO THE $2,300 DEDUCTIBLE YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,364	$1,364 (Part A Deductible)	$0
61st thru 90th day	All but $341 a day	$341 a day	$0
91st through 150th day	All but $682 a day	$682 a day	$0
Beyond 150th Day	$0	100% of Medicare Eligible Expenses	$0
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 $170.50 a day	Up to $170.50 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	Balance

High Deductible Plan-CLIMSP10HD

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

*Once you have been billed $185 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 Medicare supplement plan will pay upon payment of the annual high deductible. The annual deductible shall consist of out-of-pocket expenses, other than premiums, for services covered. The basis for the deductible shall be $2,300 and shall be adjusted annually to reflect the changes in the Consumer Price Index for all consumers for the 12 month period ending with August of the previous year.**

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,300 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2,300 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 tests, durable medical equipment			
First $185 of Medicare-Approved amounts*	$0	$185	$0
Remainder of Medicare-Approved amounts	80%	20%	$0
Part B Excess Charges (Above Medicare-Approved amounts)	$0	$0	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $185 of Medicare-Approved amounts*	$0	$185 (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-CLIMSP10HD

PARTS A & B

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,300 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2,300 DEDUCTIBLE** YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
• Medically necessary skilled care services and medical supplies	100%	$0	$0
• Durable medical equipment			
• First $185 of Medicare Approved amounts*	$0	$185 (Part B Deductible)	$0
• Remainder of Medicare Approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,300 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2,300 DEDUCTIBLE** YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services incurred during travel outside the USA	$0	100% of covered expenses	$0

Co-Payment Plan CLIMSP10CP

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,364	$1,364 (Part A Deductible)	$0
61st thru 90th day	All but $341 a day	$341 a day	$0
91st through 150th day	All but $682 a day	$682 a day	$0
Beyond 150th day	$0	100% of Medicare Eligible Expenses	$0
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 $170.50 a day	Up to $170.50 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 co-payment/ coinsurance	Balance

Co-Payment Plan CLIMSP10CP

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

*Once you have been billed $185 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 $185 of Medicare-Approved amounts*	$0	$0	$185 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	100% of the cost sharing except for the lesser of $20 or the Medicare Part B coinsurance or copayment per office visit and the lesser of $50 or the Medicare Part B coinsurance or copayment for each covered emergency room visit, payment is waived if the insured is admitted to the hospital and the emergency visit is covered as a 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 $185 of Medicare-Approved amounts*	$0	$0	$185 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

Co-Payment Plan-CLIMSP10CP

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 $185 of Medicare Approved amounts*	$0	$0	$185 (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 incurred during travel outside the USA	$0	80% of covered expenses	20% of covered expenses

12. In addition, the policies offer the following state-mandated benefits:

(a) **IMMUNIZATION BENEFIT -** We will pay the expense incurred for an immunization received by you. Benefits are not payable for that portion of expense for which benefits were paid by Medicare Part D or under any other portion of the policy.

(b) ALCOHOLISM, CHEMICAL DEPENDENCY AND DRUG ADDICTION BENEFIT - We will pay benefits on the same basis as coverage for any other condition. We will pay the cost sharing amount as determined by Medicare. Benefits are not payable for that portion of expense that is paid by Medicare.

(c) **SCALP HAIR PROSTHESES BENEFIT -** We will pay the expenses incurred for any Scalp hair prostheses worn for hair loss suffered as a result of alopecia areata. This benefit is subject to the Policy's Part B coinsurance allowance and is limited to a maximum of one prosthesis per calendar year, exclusive of the Part B deductible. Amounts in excess of the usual and customary charges in a geographical area involved (as determined by us) are considered expense. Benefits are not payable for that portion of expense that is paid by Medicare.

(d) **TMJ and CMD BENEFIT -** We will pay the expenses incurred for any surgical or nonsurgical treatment by a Physician or dentist of tempomandibular joint disorder and craniomandibular disorder on the same basis as that for treatment to any other joint in the body. Such treatment must be administered or prescribed by a physician or dentist. Benefits are not payable for any portion of expense for which benefits were paid by Medicare.

(e) **CANCER SCREENING BENEFIT -** We will pay the expenses incurred for routine Screening procedures for cancer, including mammograms and pap smears, surveillance tests for ovarian cancer and colorectal screenings, when ordered or provided by Physician in accordance with the standard practice of medicine. Benefits are not payable for that portion of expense that is paid by Medicare.

(f) **RECONSTRUCTIVE SURGERY BENEFIT -** We will pay benefits for reconstructive surgery when such service is incidental to or follows surgery resulting from injury, sickness, or other diseases of the involved part. Benefits are not payable under this policy for an expense payable under Medicare.

(g) **PROSTATE CANCER SCREENING BENEFIT -** We will pay the expenses incurred for a prostate-specific antigen blood test and a digital rectal examination, for symptomatic or high-risk category men age 40 or older, and for all men age 50 and older. If such expenses are eligible expenses under Part B, we will pay 20% of the amount in excess of the Part B Calendar Year Deductible.

(h) **LYME DISEASE BENEFIT -** We will pay the expenses incurred for treatment of Lyme disease. If such expenses are Eligible Expenses under Part B, we will pay 20% of the amount in excess of the Part B Calendar Year Deductible.

(i) **PHENYLKETONURIA TREATMENT -**Benefits are payable for special dietary treatment for phenylketonuria when recommended by a physician.

(j) **VENTILATOR DEPENDENCY-**We will pay coverage for up to 120 hours of services provided by a private duty nurse or personal care assistant to a ventilator dependent person during the time the ventilator dependent person is in a licensed hospital. The personal care assistant or private duty nurse shall perform only the services of communicator or interpreter for the ventilator dependent patient during a transition period to assure adequate training of the hospital staff to communicate with the patient and to understand the comfort, safety and personal care needs of the ventilator dependent person. Benefits are not payable under this part of your policy for any expense payable under Medicare.

(k) **DIABETES EQUIPMENT AND SUPPLIES BENEFIT -**We will pay for all expenses incurred for 1) physician prescribed medically appropriate and necessary equipment and supplies used in the management and treatment of diabetes; and 2) diabetes outpatient self-management training and education, including medical nutrition therapy, that is provided by a certified, registered, or licensed health care professional working in a program consistent with the national standards of diabetes self-management education as established by the American Diabetes Association. Coverage includes insured persons with gestational, type I or type II diabetes. Coverage is subject to the same deductibles and coinsurance provisions applicable under this plan.

13. The chart summarizing Medicare benefits only briefly describes the benefits. The Health Care Financing Administration or its Medicare publications should be consulted for further details and limitations. The chart contains a description of benefits in effect on the date you receive this Outline of Coverage. When Medicare changes, your benefits will change automatically.

THE POLICY DOES NOT COVER ALL MEDICARE EXPENSES BEYOND THOSE COVERED BY MEDICARE. THE POLICY DOES NOT COVER ALL SKILLED NURSING FACILITY CARE EXPENSES AND DOES NOT COVER CUSTODIALOR RESIDENTIAL NURSING CARE. READ YOUR POLICY CAREFULLY TO DETERMINE WHICH NURSING HOME FACILITIES AND EXPENSES ARE COVERED BY YOUR POLICY.

14. The policy does not cover the following:
    (a) private duty nursing;
    (b) skilled nursing facility care costs beyond what is covered by Medicare;
    (c) custodial nursing home care costs;
    (d) intermediate nursing home care costs;
    (e) home health care above the number of visits covered by Medicare;
    (f) Physician's charges above Medicare's reasonable charge (unless EBR10) is purchased;
    (g) Drugs other than prescription drugs furnished during Hospital or skilled nursing facility stay; nor
    (h) dental care or dentures (except for surgical or nonsurgical treatment of tempomandibular joint disorder and craniomandibular disorder by a Physician or dentist), check-ups (except for routine screening procedures for cancer, including mammograms and pap smears, when ordered or provided by a Physician in accordance with the standard practice of medicine), cosmetic surgery, routine foot care, examinations for eyeglasses or hearing aids.

15. **EXCEPTIONS-** The policy does not cover:
    (a) charges deemed unreasonable or unnecessary by Medicare (except as provided under the terms of the Policy);
    (b) charges which Medicare does not deem to be usual and customary (except as provided under the terms of the policy);
    (c) expenses which are not deemed to be Medicare Eligible Expenses (except as provided under the terms of the policy);
    (d) expenses for which you are compensated by Medicare.

OPTIONAL COVERAGE AVAILABLE FOR BASIC PLAN-FORM CLIMSP10BP
(CHECK IF APPLIED FOR)

[ ] Form PADR10-Medicare Part A Deductible Rider
When you are hospital confined for a covered condition, we will pay the Medicare Part A Deductible that you incur.

[ ] Form PBDR10-Medicare Part B Calendar Year Deductible Rider
When you incur expense that is applied to the Medicare Part B deductible and Medicare does not pay the deductible, we will pay the entire Medicare Part B annual deductible.

[ ] Form PBECR-Part B Excess Charges Rider
If you incur services or supplies, that are eligible under Medic are Part B, we will pay that portion of the usual and customary charges which: (a) is in excess of the Medicare Part B approved charge; and (b) you are required to pay.

[ ] Form PHSR10-Preventive Health Services Rider
We will pay the Medicare-approved amount for each of the following preventive health services, as if Medicare were to cover the service, as identified in the American Medical Association's current procedural terminology (AMA CPT) codes, to a maximum of $120 annually under this benefit.
    (a) an annual clinical preventive medical history and physical exam that may include tests and services from (b) and patient education to address preventive health care measures;
    (b) preventive screening tests or preventive services, the selection and frequency of which is determined to be medically appropriate by the attending physician.

    Benefits for Preventive Health Services will not duplicate any payment for a procedure that is already covered by Medicare.