aetna®

Outline of coverage

Medicare Supplement Insurance

Benefit plan: Basic Plan

Underwritten by

Continental Life Insurance Company of Brentwood, Tennessee

An Aetna Company

Minnesota

aetnaseniorproducts.com

CLIMS04544MN

08/2019 B

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
$20 and $50 CO-PAYMENT MEDICARE SUPPLEMENT PLAN

THE COMMISSIONER OF COMMERCE OF THE STATE OF MINNESOTA HAS ESTABLISHED TWO CATEGORIES FOR MEDICARE SUPPLEMENTS. THE CATEGORIES ARE BASIC MEDICARE SUPPLEMENTS 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 PLAN	EXTENDED BASIC PLAN	HIGH DEDUCTIBLE PLAN**	$20 and $50 CO-PAYMENT 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 co-payment for office visits and up to $50 co-payment 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 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.

CONTINENTAL LIFE INSURANCE COMPANY
OF BRENTWOOD, TENNESSEE

2010 Medicare Supplement Policy

Rates Effective 8/1/2019

Plan Description	Issue Age	Preferred - Unisex	Standard - Unisex
Basic Benefit Plan	All	2,147	2,426
Rider A - Part A Deductible	All	511	578
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	827	935
Copayment Plan	All	1,686	1,903
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
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. **Your policy will not be canceled or non-renewed based on the deterioration of your health.**

4. **EFFECTIVE DATE OF COVERAGE-**Coverage commences on the effective date for injuries occurring after the effective date. The policy covers sickness 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 plan to persons in your state are also changed. Any premium increase will become effective on the next policy anniversary date and only after filing and approval by the state of Minnesota. At least 30 days advance notice in writing will be given before any premium change.

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. When applying for underwritten coverage, the company may cancel your policy and refuse any claims if you 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.

12. **POLICY FEE-** When the policy is issued you will be charged a $20.00 one-time administrative processing fee.

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 through 90th day	All but $341 a day	$341 a day	$0
91st through 150th day	All but $[670] a day	$[670] a day	$0
150st through 515th day	$0	100% of Medicare eligible Expenses	$0
Beyond 515th day	$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	100% of approved amounts	$0	$0
21st through 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 co-payment/ coinsurance for outpatient drugs and inpatient respite care	Medicare co-payment/ 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 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 or $185 $0
Remainder of Medicare-Approved Amounts	80%	20%	
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

PARTS A & B

*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

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

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 (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.

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

(a) **IMMUNIZATION BENEFIT -** We will pay 100 percent of the cost of immunizations not otherwise covered under Part D of the Medicare program.

(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) **TMJ and CMD BENEFIT -** We will pay the expenses incurred for any surgical or nonsurgical treatment 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.

(d) **SCALP HAIR PROSTHESES BENEFIT -** When you incur expense for a scalp hair prosthesis needed because of hair loss suffered as a result of alopecia areata, We will pay the expense incurred that is not paid by Medicare or paid under any other part of the policy. This benefit is limited to one prosthesis per Calendar Year.

(e) **CANCER SCREENING BENEFIT -** We will pay the expenses incurred for routine screening procedures for cancer and the office or facility visit, including mammograms and pap smears, surveillance tests for ovarian cancer for women who are at risk for ovarian cancer and colorectal screening tests for both men and women 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 on the same basis as that for any other surgery when such service is incidental to or follows surgery resulting from injury, sickness, or other diseases of the involved part.

Reconstructive surgery benefits include all stages of reconstruction of the breast on which the mastectomy was performed, surgery of the other breast to produce a symmetrical appearance and prosthesis and physical complications at all stages of the mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician. Benefits are not payable for that portion of expense for which benefits were paid by Medicare or under any other part of the policy.

(g) **PROSTATE CANCER SCREENING BENEFIT -** We will pay for prostate cancer screening, consisting of a prostate-specific antigen blood test and a digital rectal examination. Such screening will be provided for men 40 years or older who are symptomatic or in a high-risk category and for all men 50 years of age or older.

(h) **LYME DISEASE BENEFIT -** We will pay for expenses incurred for treatment of diagnosed Lyme disease as any other medical service. Benefits will not be payable for that portion of expense that is paid by Medicare or under any other part of this policy.

(i) **PHENYLKETONURIA TREATMENT -** Benefits are payable for special dietary treatment for phenylketonuria when recommended by a physician. Benefits are not payable under this part of your policy for any expense payable under Medicare.

(j) **DIABETES EQUIPMENT AND SUPPLIES -** 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. Benefits are not payable under this part of your policy for any expense payable under Medicare.

(k) **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.

(l) **HOSPICE CARE AND RESPITE CARE -** We will provide coverage for the cost sharing portion for all Medicare Part A eligible hospice care and Respite Care expenses.

(m) **MENTAL HEALTH BENEFIT -** When you receive outpatient or inpatient hospital mental health services, we will pay benefits on the same basis as coverage for outpatient and inpatient hospital services, respectively. Benefits are not payable for that portion of expense for which benefits were paid by Medicare or paid under any other part of this policy.

Coverage for court-ordered mental health services. We will pay for mental health services ordered by a court of competent jurisdiction under a court order that is issued on the basis of a behavioral care evaluation performed by a licensed psychiatrist or a doctoral level licensed psychologist, which includes a diagnosis and an individual treatment plan for care in the most appropriate, least restrictive environment. You may be required to send us a copy of the court order and the behavioral care evaluation.

(n) **OUTPATIENT MEDICAL AND SURGICAL SERVICES BENEFIT -** We will pay for health care treatment or surgery on an outpatient basis at an Outpatient Medical and Surgical Services Center equipped to perform these services, whether or not the facility is part of a Hospital. Coverage shall be on the same basis as coverage provided for the same health care treatment or service in a Hospital. Benefits are not payable for that portion of expense for which benefits were paid by Medicare or under any other part of this policy.

14. 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.

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

[ ] Form PADR10 - Medicare Part A Deductible Rider
We will pay the Medicare Part A
Deductible that you incur during any benefit period.

[ ] Form PBDR10 - Medicare Part B Calendar Year Deductible Rider
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 Medicare Part B, we will pay 100 percent of the Medicare Part B excess charges coverage for all of the difference between the actual Medicare Part B charges as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

[ ] 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.

EXCLUSIONS

We will not pay for:

1. Loss incurred while your policy is not in force, except as provided in the Extension of Benefits section of your policy;
2. That portion of any Loss incurred which is paid for by Medicare;
3. Services for non-Medicare Eligible Expenses except as otherwise covered by this policy, including, but not limited to, routine exams not mandated by state law, take-home drugs and eye refractions; or
4. Services for which a charge is not normally made in the absence of insurance.

aetna®

Outline of coverage

Medicare Supplement Insurance

Benefit plans: Extended Basic Plan

Underwritten by

Continental Life Insurance Company of Brentwood, Tennessee

An Aetna Company

Minnesota

aetnaseniorproducts.com

CLIMS04545MN

08/2019 B

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
$20 and $50 CO-PAYMENT MEDICARE SUPPLEMENT PLAN

THE COMMISSIONER OF COMMERCE OF THE STATE OF MINNESOTA HAS ESTABLISHED TWO CATEGORIES FOR MEDICARE SUPPLEMENTS. THE CATEGORIES ARE BASIC MEDICARE SUPPLEMENTS 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 PLAN	EXTENDED BASIC PLAN	HIGH DEDUCTIBLE PLAN**	$20 and $50 CO-PAYMENT 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 co-payment for office visits and up to $50 co-payment 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 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.

CONTINENTAL LIFE INSURANCE COMPANY
OF BRENTWOOD, TENNESSEE

2010 Medicare Supplement Policy

Rates Effective 8/1/2019

Plan Description	Issue Age	Preferred - Unisex	Standard - Unisex
Basic Benefit Plan	All	2,147	2,426
Rider A - Part A Deductible	All	511	578
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	827	935
Copayment Plan	All	1,686	1,903
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 CLIMSP10EB IS AN EXTENDED BASIC 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 injuries occurring after the effective date. The policy covers sickness 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 plan to persons in your state are also changed. Any premium increase will become effective on the next policy anniversary date and only after filing and approval by the state of Minnesota. At least 30 days advance notice in writing will be given before any premium change.

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. When applying for underwritten

coverage, the company may cancel your policy and refuse any claims if you 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.

12. **POLICY FEE-**When the policy is issued you will be charged a $20.00 one-time administrative processing fee.

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.

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 through 90th day	All but $341 a day	$341 a day	$0
91st through 150th day	All but $682 a day	$682 a day	$0
151st through 515th day	$0	100% of Medicare Eligible Expenses	$0
Beyond 515th day	$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 through 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 co-payment/ coinsurance for outpatient drugs and inpatient respite care	Medicare co-payment/ 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 (Part B Deductible)	$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

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

(a) **IMMUNIZATION BENEFIT -** We will pay 100 percent of the cost of immunizations not otherwise covered under Part D of the Medicare program.

(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) **TMJ and CMD BENEFIT -** We will pay the expenses incurred for the surgical or non-surgical treatment 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.

(d) **SCALP HAIR PROSTHESES BENEFIT -** When you incur expense for a scalp hair prosthesis needed because of hair loss suffered as a result of alopecia areata, We will pay the expense incurred that is not paid by Medicare or paid under any other part of the policy. This benefit is limited to one prosthesis per Calendar Year.

(e) **CANCER SCREENING BENEFIT -** We will pay the expenses incurred for routine screening procedures for cancer and the office or facility visit, including mammograms and pap smears, surveillance tests for ovarian cancer for women who are at risk for ovarian cancer and colorectal screening tests for both men and women 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 on the same basis as that for any other surgery when such service is incidental to or follows surgery resulting from injury, sickness, or other diseases of the involved part.

Reconstructive surgery benefits include all stages of reconstruction of the breast on which the mastectomy was performed, surgery of the other breast to produce a symmetrical appearance and prosthesis and physical complications at all stages of the mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician. Benefits are not payable for that portion of expense for which benefits were paid by Medicare or under any other part of the policy.

(g) **PROSTATE CANCER SCREENING BENEFIT -** We will pay for prostate cancer screening, consisting of a prostate-specific antigen blood test and a digital rectal examination. Such screening will be provided for men 40 years or older who are symptomatic or in a high-risk category and for all men 50 years of age or older.

(h) **LYME DISEASE BENEFIT -** We will pay for expenses incurred for treatment of diagnosed Lyme disease as any other medical service. Benefits will not be payable for that portion of expense that is paid by Medicare or under any other part of this policy.

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

(j) **DIABETES EQUIPMENT AND SUPPLIES -** 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. Benefits are not payable under this part of your policy for any expense payable under Medicare.

(k) **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.

(l) **HOSPICE CARE AND RESPITE CARE -** We will provide coverage for the cost sharing portion for all Medicare Part A eligible hospice care and Respite Care expenses.

(m) **MENTAL HEALTH BENEFIT -** When you receive outpatient or inpatient hospital mental health services, we will pay benefits on the same basis as coverage for outpatient and inpatient hospital services, respectively. Benefits are not payable for that portion of expense for which benefits were paid by Medicare or paid under any other part of this policy.

Coverage for court-ordered mental health services. We will pay for mental health services ordered by a court of competent jurisdiction under a court order that is issued on the basis of a behavioral care evaluation performed by a licensed psychiatrist or a doctoral level licensed psychologist, which includes a diagnosis and an individual treatment plan for care in the most appropriate, least restrictive environment. You may be required to send us a copy of the court order and the behavioral care evaluation.

(n) **OUTPATIENT MEDICAL AND SURGICAL SERVICES BENEFIT -** We will pay for health care treatment or surgery on an outpatient basis at an Outpatient Medical and Surgical Services Center equipped to perform these services, whether or not the facility is part of a Hospital. Coverage shall be on the same basis as coverage provided for the same health care treatment or service in a Hospital. Benefits are not payable for that portion of expense for which benefits were paid by Medicare or under any other part of this policy.

14. 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.

ADDITIONAL BENEFITS EXTENDED BASIC PLAN-FORM CLIMSP10EB

Additional Benefits Not Covered By Medicare

We will pay 80% of the usual and customary charges, not to exceed any charge limitation established by the Medicare program or state law, for the following articles and services prescribed by a physician which are not paid by Medicare or payable under any other provision of Your policy. When Your out-of-pocket expenses equal $1,000 in a Calendar Year, We will pay 100% of the covered articles and services during the remainder of such Calendar Year.

1. Hospital Services;
2. Professional services for the diagnosis or treatment of Injuries, illnesses or conditions when such services are given by a Physician or at the Physician's direction. Outpatient dental services are not covered;
3. Drugs requiring a Physician's prescription;
4. Services of a nursing home for not more than 120 days in a year if the services would qualify as reimbursable services under Medicare;
5. Services of a home health agency if the services would qualify as reimbursable services under Medicare;
6. Use of radium or other radioactive materials;
7. Oxygen;
8. Anesthetics;
9. Prosthetic devices other than dental;
10. Rental or purchase, as appropriate, of durable medical equipment other than eyeglasses and hearing aids;
11. Diagnostic X-rays and laboratory tests;
12. Oral surgery for: (a) partially or completely unerupted impacted teeth; (b) a tooth root without the extraction of the entire tooth; or (c) the gums or tissues of the mouth when not performed in connection with the extraction or repair of teeth;
13. Services of a physical therapist;
14. Transportation provided by a licensed ambulance service to the nearest facility qualified to treat the condition; or a reasonable mileage rate for transportation to a kidney dialysis center for treatment;
15. Services of an occupational therapist;
16. Well-baby care;
17. A second opinion from a Physician on all surgical procedures expected to cost a total of five hundred dollars ($500) or more in Physician, laboratory and Hospital fees. Coverage is not provided for the repetition of any diagnostic tests; and
18. Coverage for special dietary treatment for phenylketonuria when recommended by a Physician.

Benefits will be considered under this part of your policy for charges incurred within or outside of the United States.

EXCLUSIONS Applicable to Additional Benefits Section Only

We will not pay for:

1. Any charge for treatment for cosmetic purposes other than for reconstructive surgery, as listed in section 13(f), when such service is incidental to or follows surgery resulting from Injury, sickness, or other diseases of the involved part;
2. Care which is primarily for custodial or domiciliary purposes which would not qualify as eligible services under Medicare;
3. Any charge for confinement in a private room to the extent it is in excess of the institution's charge for its most common semiprivate room, unless a private room is prescribed as Medically Necessary by a Physician, provided, however, that if the institution does not have semiprivate rooms, its most common semiprivate room charge shall be considered to be ninety percent (90%) of its lowest private room charge;
4. That part of any charge for services or articles rendered or prescribed by a Physician, dentist, or other health care personnel which exceeds the prevailing charge in the locality where the service is provided unless covered as a Medicare Part B excess charge under this policy; or
5. Any charge for services or articles the provision of which is not within the scope of authorized practice of the institution or individual rendering the services or articles.

EXCLUSIONS Applicable to Policy

We will not pay for:

1. Loss incurred while your policy is not in force, except as provided in the Extension of Benefits section of your policy;
2. That portion of any Loss incurred which is paid for by Medicare;
3. Services for non-Medicare Eligible Expenses except as otherwise covered by this policy, including, but not limited to, routine exams not mandated by state law, take-home drugs and eye refractions; or
4. Services for which a charge is not normally made in the absence of insurance.

aetna®

Outline of coverage

Medicare Supplement Insurance

Benefit plan: Co-Payment Plan

Underwritten by

Continental Life Insurance Company of Brentwood, Tennessee

An Aetna Company

Minnesota

aetnaseniorproducts.com

CLIMS04546MN

08/2019 B

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
$20 and $50 CO-PAYMENT MEDICARE SUPPLEMENT PLAN

THE COMMISSIONER OF COMMERCE OF THE STATE OF MINNESOTA HAS ESTABLISHED TWO CATEGORIES FOR MEDICARE SUPPLEMENTS. THE CATEGORIES ARE BASIC MEDICARE SUPPLEMENTS 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 PLAN	EXTENDED BASIC PLAN	HIGH DEDUCTIBLE PLAN**	$20 and $50 CO-PAYMENT 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 co-payment for office visits and up to $50 co-payment 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 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.

CONTINENTAL LIFE INSURANCE COMPANY
OF BRENTWOOD, TENNESSEE

2010 Medicare Supplement Policy

Rates Effective 8/1/2019

Plan Description	Issue Age	Preferred - Unisex	Standard - Unisex
Basic Benefit Plan	All	2,147	2,426
Rider A - Part A Deductible	All	511	578
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	827	935
Copayment Plan	All	1,686	1,903
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 CLIMSP10CP IS A $20 and $50 CO-PAYMENT 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 injuries occurring after the effective date. The policy covers sickness 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 plan to persons in your state are also changed. Any premium increase will become effective on the next policy anniversary date and only after filing and approval by the state of Minnesota. At least 30 days advance notice in writing will be given before any premium change.

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. When applying for underwritten

coverage, the company may cancel your policy and refuse any claims if you 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.

12. **POLICY FEE-** When the policy is issued you will be charged a $20.00 one-time administrative processing fee.

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.

$20 and $50 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 through 90th day	All but $341 a day	$341 a day	$0
91st through 150th day	All but $682 a day	$682 a day	$0
151st through 515th day	$0	100% of Medicare Eligible Expenses	$0
Beyond 515th day	$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 through 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 co-payment/ coinsurance for outpatient drugs and inpatient respite care	Medicare co-payment/ coinsurance	Balance

$20 and $50 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 co-payment per office visit and the lesser of $50 or the Medicare Part B coinsurance or co-payment 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 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.
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

$20 and $50 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

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

(a) **IMMUNIZATION BENEFIT -** We will pay 100 percent of the cost of immunizations not otherwise covered under Part D of the Medicare program.

(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) **TMJ and CMD BENEFIT -** We will pay benefits for the surgical or non-surgical treatment 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.

(d) **SCALP HAIR PROSTHESES BENEFIT -** When you incur expense for a scalp hair prosthesis needed because of hair loss suffered as a result of alopecia areata, We will pay the expense incurred that is not paid by Medicare or paid under any other part of the policy. This benefit is limited to one prosthesis per Calendar Year.

(e) **CANCER SCREENING BENEFIT -** We will pay the expenses incurred for routine screening procedures for cancer and the office or facility visit, including mammograms and pap smears, surveillance tests for ovarian cancer for women who are at risk for ovarian cancer and colorectal screening tests for both men and women when ordered or provided by a 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 on the same basis as that for any other surgery when such service is incidental to or follows surgery resulting from injury, sickness, or other diseases of the involved part.

Reconstructive surgery benefits include all stages of reconstruction of the breast on which the mastectomy was performed, surgery of the other breast to produce a symmetrical appearance and prosthesis and physical complications at all stages of the mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician. Benefits are not payable for that portion of expense for which benefits were paid by Medicare or under any other part of the policy.

(g) **PROSTATE CANCER SCREENING BENEFIT -** We will pay for prostate cancer screening consisting of a prostate-specific antigen blood test and a digital rectal examination Such screening will be provided for men 40 years or older who are symptomatic or in a high-risk category and for all men 50 years of age or older.

(h) **LYME DISEASE BENEFIT -** We will pay for expenses incurred for treatment of diagnosed Lyme disease as any other medical service. Benefits will not be payable for that portion of expense that is paid by Medicare or under any other part of this policy.

(i) **PHENYLKETONURIA TREATMENT -** Benefits are payable for special dietary treatment for phenylketonuria when recommended by a physician. Benefits are not payable under this part of your policy for any expense payable under Medicare.

(j) **DIABETES EQUIPMENT AND SUPPLIES -** 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. Benefits are not payable under this part of your policy for any expense payable under Medicare.

(k) **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.

(l) **HOSPICE CARE AND RESPITE CARE -** We will provide coverage for the cost sharing portion for all Medicare Part A eligible hospice care and Respite Care expenses.

(m) **MENTAL HEALTH BENEFIT -** When you receive outpatient or inpatient hospital mental health services, we will pay benefits on the same basis as coverage for outpatient and inpatient hospital services, respectively. Benefits are not payable for that portion of expense for which benefits were paid by Medicare or paid under any other part of this policy.

Coverage for court-ordered mental health services. We will pay for mental health services ordered by a court of competent jurisdiction under a court order that is issued on the basis of a behavioral care evaluation performed by a licensed psychiatrist or a doctoral level licensed psychologist, which includes a diagnosis and an individual treatment plan for care in the most appropriate, least restrictive environment. You may be required to send us a copy of the court order and the behavioral care evaluation.

(n) **OUTPATIENT MEDICAL AND SURGICAL SERVICES BENEFIT -** We will pay for health care treatment or surgery on an outpatient basis at an Outpatient Medical and Surgical Services Center equipped to perform these services, whether or not the facility is part of a Hospital. Coverage shall be on the same basis as coverage provided for the same health care treatment or service in a Hospital. Benefits are not payable for that portion of expense for which benefits were paid by Medicare or under any other part of this policy.

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.

EXCLUSIONS

We will not pay for:

1. Loss incurred while your policy is not in force, except as provided in the Extension of Benefits section of your policy;
2. That portion of any Loss incurred which is paid for by Medicare;
3. Services for non-Medicare Eligible Expenses except as otherwise covered by this policy, including, but not limited to, routine exams not mandated by state law, take-home drugs and eye refractions; or
4. Services for which a charge is not normally made in the absence of insurance.

aetna®

Outline of coverage

Medicare Supplement Insurance

Benefit plan: High Deductible Plan

Underwritten by

Continental Life Insurance Company of Brentwood, Tennessee

An Aetna Company

Minnesota

aetnaseniorproducts.com

CLIMS04547MN

08/2019 B

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
$20 and $50 CO-PAYMENT MEDICARE SUPPLEMENT PLAN

THE COMMISSIONER OF COMMERCE OF THE STATE OF MINNESOTA HAS ESTABLISHED TWO CATEGORIES FOR MEDICARE SUPPLEMENTS. THE CATEGORIES ARE BASIC MEDICARE SUPPLEMENTS 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 PLAN	EXTENDED BASIC PLAN	HIGH DEDUCTIBLE PLAN**	$20 and $50 CO-PAYMENT 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 co-payment for office visits and up to $50 co-payment 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 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.

CONTINENTAL LIFE INSURANCE COMPANY
OF BRENTWOOD, TENNESSEE

2010 Medicare Supplement Policy

Rates Effective 8/1/2019

Plan Description	Issue Age	Preferred - Unisex	Standard - Unisex
Basic Benefit Plan	All	2,147	2,426
Rider A - Part A Deductible	All	511	578
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	827	935
Copayment Plan	All	1,686	1,903
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 CLIMSP10HD IS A HIGH DEDUCTIBLE 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 injuries occurring after the effective date. The policy covers sickness 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 plan to persons in your state are also changed. Any premium increase will become effective on the next policy anniversary date and only after filing and approval by the state of Minnesota. At least 30 days advance notice in writing will be given before any premium change.

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. When applying for underwritten

coverage, the company may cancel your policy and refuse any claims if you 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.

12. **POLICY FEE-** When the policy is issued you will be charged a $20.00 one-time administrative processing fee.

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.

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 through 90th day	All but $341 a day	$341 a day	$0
91st through 150th day	All but $682 a day	$682 a day	$0
151st through 515th day	$0	100% of Medicare Eligible Expenses	$0
Beyond 515th day	$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 through 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 co-payment/ coinsurance for outpatient drugs and inpatient respite care	Medicare co-payment/ coinsurance	$0

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

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

(a) **IMMUNIZATION BENEFIT -** We will pay 100 percent of the cost of immunizations not otherwise covered under Part D of the Medicare program.

(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) **TMJ and CMD BENEFIT -** We will pay the expenses incurred for the surgical or non-surgical treatment 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.

(d) **SCALP HAIR PROSTHESES BENEFIT -** When you incur expense for a scalp hair prosthesis needed because of hair loss suffered as a result of alopecia areata, We will pay the expense incurred that is not paid by Medicare or paid under any other part of the policy. This benefit is limited to one prosthesis per Calendar Year.

(e) **CANCER SCREENING BENEFIT -** We will pay the expenses incurred for routine screening procedures for cancer and the office or facility visit, including mammograms and pap smears, surveillance tests for ovarian cancer for women who are at risk for ovarian cancer and colorectal screening tests for both men and women 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 on the same basis as that for any other surgery when such service is incidental to or follows surgery resulting from injury, sickness, or other diseases of the involved part.

Reconstructive surgery benefits include all stages of reconstruction of the breast on which the mastectomy was performed, surgery of the other breast to produce a symmetrical appearance and prosthesis and physical complications at all stages of the mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician. Benefits are not payable for that portion of expense for which benefits were paid by Medicare or under any other part of the policy.

(g) **PROSTATE CANCER SCREENING BENEFIT -** We will pay for prostate cancer screening, consisting of a prostate-specific antigen blood test and a digital rectal examination. Such screening will be provided for men 40 years or older who are symptomatic or in a high-risk category and for all men 50 years of age or older.

(h) **LYME DISEASE BENEFIT -** We will pay for expenses incurred for treatment of diagnosed Lyme disease as any other medical service. Benefits will not be payable for that portion of expense that is paid by Medicare or under any other part of this policy.

(i) **PHENYLKETONURIA TREATMENT -** Benefits are payable for special dietary treatment for phenylketonuria when recommended by a physician. Benefits are not payable under this part of your policy for any expense payable under Medicare.

(j) **DIABETES EQUIPMENT AND SUPPLIES -** 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. Benefits are not payable under this part of your policy for any expense payable under Medicare.

(k) **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.

(l) **HOSPICE CARE AND RESPITE CARE -** We will provide coverage for the cost sharing portion for all Medicare Part A eligible hospice care and Respite Care expenses.

(m) **MENTAL HEALTH BENEFIT -** When you receive outpatient or inpatient hospital mental health services, we will pay benefits on the same basis as coverage for outpatient and inpatient hospital services, respectively. Benefits are not payable for that portion of expense for which benefits were paid by Medicare or paid under any other part of this policy.

Coverage for court-ordered mental health services. We will pay for mental health services ordered by a court of competent jurisdiction under a court order that is issued on the basis of a behavioral care evaluation performed by a licensed psychiatrist or a doctoral level licensed psychologist, which includes a diagnosis and an individual treatment plan for care in the most appropriate, least restrictive environment. You may be required to send us a copy of the court order and the behavioral care evaluation.

(n) **OUTPATIENT MEDICAL AND SURGICAL SERVICES BENEFIT -** We will pay for health care treatment or surgery on an outpatient basis at an Outpatient Medical and Surgical Services Center equipped to perform these services, whether or not the facility is part of a Hospital. Coverage shall be on the same basis as coverage provided for the same health care treatment or service in a Hospital. Benefits are not payable for that portion of expense for which benefits were paid by Medicare or under any other part of this policy.

14. 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.

EXCLUSIONS

We will not pay for:

1. Loss incurred while your policy is not in force, except as provided in the Extension of Benefits section of your policy;
2. That portion of any Loss incurred which is paid for by Medicare;
3. Services for non-Medicare Eligible Expenses except as otherwise covered by this policy, including, but not limited to, routine exams not mandated by state law, take-home drugs and eye refractions; or
4. Services for which a charge is not normally made in the absence of insurance.