Outline of coverage

Medicare Supplement Insurance

Benefit Plans A, B, F, High Deductible F, G, N

Oregon

Underwritten by

Continental Life Insurance Company of Brentwood, Tennessee

An Aetna Company

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CLIMS05023OR

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Rates effective: 05/2026 A

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

This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plan "A" available. Some plans may not be available. Only applicants **first** eligible for Medicare before 2020 may purchase Plans C, F, and High Deductible F.

Note: A ✓ means 100% of the benefit is paid.

Benefits	Plans Available to All Applicants								Medicare first eligible before 2020 only	
	A	B	D	G[1]	K	L	M	N	C	F[1]
Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Medicare Part B coinsurance or copayment	✓	✓	✓	✓	50%	75%	✓	✓ copays apply[3]	✓	✓
Blood (first three pints)	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Part A hospice care coinsurance or copayment	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Skilled nursing facility coinsurance			✓	✓	50%	75%	✓	✓	✓	✓
Medicare Part A deductible		✓	✓	✓	50%	75%	50%	✓	✓	✓
Medicare Part B deductible									✓	✓
Medicare Part B excess charges				✓						✓
Foreign travel emergency (up to plan limits)			✓	✓			✓	✓	✓	✓
Out-of-pocket limit in 2026[2]					**$8,000**[2]	**$4,000**[2]				

[1] Plans F and G also have a high deductible option, which require first paying a plan deductible of **$2,950** before the plan begins to pay. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High deductible plan G does not cover the Medicare Part B deductible. However, high deductible plans F and G count your payment of the Medicare Part B deductible toward meeting the plan deductible.

[2] Plans K and L pay 100% of covered services for the rest of the calendar year once you meet the out-of-pocket yearly limit.

[3] Plan N pays 100% of the Part B coinsurance, except for a copayment of up to $20 for some office visits and up to a $50 copayment for emergency room visits that do not result in an inpatient admission.

Continental Life Insurance Company of Brentwood, Tennessee

Annual Attained Age Premiums

For Use in ZIP Codes: 970-972

Female rates

Rates effective 5/1/2026

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
0 - 64	3,043	4,410	5,134	1,349	4,258	3,556
65	3,043	4,410	5,134	1,349	4,258	3,556
66	3,043	4,410	5,134	1,349	4,258	3,556
67	3,043	4,410	5,134	1,349	4,258	3,556
68	3,174	4,596	5,344	1,408	4,431	3,710
69	3,316	4,804	5,553	1,464	4,600	3,875
70	3,448	5,000	5,758	1,518	4,771	4,028
71	3,584	5,184	5,955	1,568	4,939	4,185
72	3,705	5,365	6,145	1,619	5,088	4,333
73	3,819	5,536	6,309	1,660	5,233	4,474
74	3,935	5,701	6,470	1,709	5,373	4,596
75	4,033	5,843	6,616	1,744	5,491	4,718
76	4,126	5,970	6,748	1,779	5,590	4,824
77	4,213	6,095	6,868	1,808	5,695	4,933
78	4,289	6,218	6,969	1,838	5,776	5,028
79	4,368	6,329	7,074	1,864	5,859	5,114
80	4,439	6,431	7,156	1,888	5,938	5,195
81	4,501	6,513	7,253	1,910	6,010	5,268
82	4,559	6,606	7,341	1,938	6,086	5,336
83	4,621	6,693	7,433	1,958	6,159	5,409
84	4,679	6,771	7,513	1,980	6,230	5,480
85	4,731	6,858	7,601	2,006	6,304	5,538
86	4,783	6,933	7,674	2,021	6,363	5,598
87	4,836	7,006	7,755	2,044	6,433	5,656
88	4,883	7,081	7,828	2,064	6,484	5,715
89	4,928	7,148	7,894	2,079	6,544	5,770
90	4,970	7,200	7,963	2,098	6,596	5,820
91	5,010	7,268	8,023	2,114	6,650	5,865
92	5,055	7,323	8,075	2,129	6,688	5,914
93	5,086	7,376	8,133	2,148	6,739	5,954
94	5,123	7,419	8,161	2,154	6,768	5,995
95	5,146	7,463	8,205	2,163	6,806	6,030
96	5,185	7,504	8,258	2,175	6,845	6,063
97	5,213	7,553	8,293	2,189	6,874	6,095
98	5,241	7,598	8,340	2,200	6,916	6,131
99	5,271	7,640	8,379	2,208	6,945	6,173

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
0 - 64	3,384	4,908	5,703	1,501	4,730	3,965
65	3,384	4,908	5,703	1,501	4,730	3,965
66	3,384	4,908	5,703	1,501	4,730	3,965
67	3,384	4,908	5,703	1,501	4,730	3,965
68	3,525	5,114	5,935	1,565	4,918	4,126
69	3,681	5,334	6,175	1,633	5,116	4,314
70	3,826	5,545	6,399	1,685	5,305	4,479
71	3,974	5,761	6,616	1,744	5,491	4,650
72	4,113	5,968	6,823	1,801	5,655	4,813
73	4,244	6,146	7,014	1,851	5,815	4,968
74	4,368	6,329	7,194	1,901	5,963	5,115
75	4,471	6,484	7,359	1,939	6,095	5,236
76	4,575	6,635	7,495	1,975	6,216	5,359
77	4,679	6,774	7,625	2,010	6,321	5,480
78	4,768	6,910	7,744	2,044	6,419	5,586
79	4,858	7,033	7,856	2,066	6,506	5,681
80	4,928	7,148	7,948	2,096	6,591	5,770
81	4,996	7,245	8,054	2,121	6,676	5,855
82	5,064	7,346	8,159	2,154	6,764	5,933
83	5,135	7,438	8,260	2,175	6,846	6,010
84	5,198	7,535	8,354	2,200	6,920	6,079
85	5,251	7,616	8,445	2,226	7,003	6,151
86	5,318	7,703	8,530	2,249	7,073	6,226
87	5,375	7,779	8,615	2,271	7,140	6,290
88	5,423	7,858	8,693	2,293	7,204	6,348
89	5,475	7,936	8,773	2,311	7,273	6,418
90	5,525	8,008	8,843	2,330	7,325	6,470
91	5,570	8,068	8,909	2,348	7,380	6,518
92	5,613	8,133	8,974	2,368	7,443	6,574
93	5,650	8,188	9,030	2,376	7,479	6,616
94	5,690	8,245	9,081	2,394	7,526	6,664
95	5,728	8,295	9,123	2,404	7,563	6,705
96	5,754	8,344	9,168	2,413	7,599	6,739
97	5,791	8,389	9,211	2,430	7,639	6,774
98	5,828	8,439	9,264	2,443	7,679	6,815
99	5,864	8,496	9,316	2,453	7,718	6,863

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

To calculate the 5% Household discount:

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

Modal premium **x** .95 **= discounted premium**

If applying during Open Enrollment or Guaranteed Issue periods, use preferred rates.

Modal factors

Semi-annual 0.5200

Quarterly 0.2650

Monthly 0.0833

Continental Life Insurance Company of Brentwood, Tennessee

Annual Attained Age Premiums

For Use in ZIP Codes: 970-972

Male rates

Rates effective 5/1/2026

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
0 - 64	3,501	5,073	5,905	1,555	4,896	4,099
65	3,501	5,073	5,905	1,555	4,896	4,099
66	3,501	5,073	5,905	1,555	4,896	4,099
67	3,501	5,073	5,905	1,555	4,896	4,099
68	3,646	5,288	6,145	1,619	5,088	4,271
69	3,811	5,529	6,393	1,685	5,296	4,468
70	3,965	5,743	6,625	1,745	5,491	4,644
71	4,115	5,968	6,855	1,808	5,683	4,813
72	4,258	6,169	7,074	1,864	5,859	4,980
73	4,394	6,363	7,258	1,910	6,021	5,139
74	4,518	6,546	7,446	1,963	6,173	5,288
75	4,635	6,710	7,616	2,009	6,313	5,423
76	4,734	6,865	7,755	2,044	6,433	5,545
77	4,838	7,011	7,894	2,079	6,544	5,660
78	4,940	7,149	8,021	2,114	6,650	5,779
79	5,018	7,274	8,134	2,148	6,744	5,876
80	5,100	7,390	8,233	2,168	6,823	5,970
81	5,169	7,496	8,340	2,200	6,916	6,058
82	5,244	7,599	8,445	2,226	7,003	6,139
83	5,313	7,699	8,541	2,255	7,084	6,218
84	5,375	7,785	8,646	2,275	7,168	6,294
85	5,443	7,881	8,739	2,305	7,245	6,374
86	5,504	7,970	8,830	2,329	7,321	6,438
87	5,556	8,059	8,923	2,349	7,398	6,506
88	5,620	8,140	9,000	2,373	7,463	6,584
89	5,663	8,216	9,081	2,394	7,526	6,639
90	5,728	8,290	9,153	2,411	7,589	6,693
91	5,766	8,350	9,213	2,430	7,640	6,746
92	5,811	8,415	9,279	2,448	7,691	6,796
93	5,855	8,481	9,341	2,464	7,745	6,849
94	5,885	8,533	9,399	2,479	7,795	6,891
95	5,920	8,585	9,446	2,490	7,824	6,933
96	5,956	8,635	9,488	2,503	7,864	6,970
97	5,991	8,683	9,536	2,514	7,904	7,011
98	6,029	8,734	9,581	2,526	7,943	7,059
99	6,061	8,781	9,630	2,539	7,981	7,095

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
0 - 64	3,891	5,639	6,553	1,729	5,440	4,555
65	3,891	5,639	6,553	1,729	5,440	4,555
66	3,891	5,639	6,553	1,729	5,440	4,555
67	3,891	5,639	6,553	1,729	5,440	4,555
68	4,058	5,874	6,829	1,801	5,656	4,750
69	4,233	6,139	7,098	1,870	5,876	4,963
70	4,400	6,381	7,359	1,939	6,095	5,159
71	4,574	6,623	7,616	2,009	6,313	5,349
72	4,731	6,858	7,856	2,066	6,506	5,538
73	4,883	7,070	8,058	2,125	6,683	5,710
74	5,018	7,274	8,268	2,183	6,850	5,876
75	5,144	7,453	8,465	2,230	7,011	6,028
76	5,268	7,625	8,624	2,273	7,148	6,168
77	5,379	7,799	8,773	2,311	7,273	6,294
78	5,481	7,941	8,901	2,346	7,380	6,419
79	5,580	8,088	9,030	2,376	7,479	6,529
80	5,663	8,214	9,143	2,411	7,584	6,635
81	5,746	8,331	9,266	2,443	7,686	6,734
82	5,828	8,441	9,376	2,475	7,773	6,821
83	5,908	8,554	9,491	2,503	7,869	6,911
84	5,976	8,658	9,605	2,533	7,966	7,003
85	6,044	8,756	9,715	2,559	8,058	7,073
86	6,115	8,859	9,815	2,585	8,140	7,150
87	6,170	8,951	9,903	2,611	8,214	7,234
88	6,240	9,036	9,995	2,638	8,290	7,309
89	6,300	9,125	10,091	2,660	8,358	7,376
90	6,345	9,203	10,170	2,681	8,430	7,443
91	6,411	9,288	10,248	2,700	8,499	7,503
92	6,464	9,353	10,313	2,719	8,554	7,563
93	6,503	9,413	10,378	2,735	8,600	7,610
94	6,545	9,479	10,436	2,751	8,654	7,656
95	6,578	9,534	10,486	2,766	8,694	7,699
96	6,623	9,593	10,544	2,778	8,746	7,746
97	6,658	9,650	10,595	2,790	8,781	7,798
98	6,698	9,709	10,648	2,806	8,826	7,848
99	6,736	9,763	10,703	2,821	8,874	7,886

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

To calculate the 5% Household discount:

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

Modal premium **x** .95 **= discounted premium**

If applying during Open Enrollment or Guaranteed Issue periods, use preferred rates.

Modal factors

Semi-annual 0.5200

Quarterly 0.2650

Monthly 0.0833

Continental Life Insurance Company of Brentwood, Tennessee

Annual Attained Age Premiums

For Use in ZIP Codes: Rest of state

Female rates

Rates effective 5/1/2026

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
0 - 64	2,799	4,057	4,723	1,241	3,917	3,272
65	2,799	4,057	4,723	1,241	3,917	3,272
66	2,799	4,057	4,723	1,241	3,917	3,272
67	2,799	4,057	4,723	1,241	3,917	3,272
68	2,920	4,229	4,916	1,295	4,077	3,413
69	3,051	4,419	5,108	1,347	4,232	3,565
70	3,172	4,600	5,297	1,396	4,390	3,705
71	3,297	4,769	5,479	1,442	4,544	3,850
72	3,409	4,936	5,653	1,489	4,681	3,986
73	3,513	5,093	5,804	1,527	4,814	4,116
74	3,620	5,245	5,952	1,572	4,943	4,229
75	3,710	5,375	6,087	1,604	5,052	4,340
76	3,796	5,492	6,208	1,636	5,143	4,438
77	3,876	5,607	6,318	1,663	5,239	4,538
78	3,946	5,720	6,411	1,691	5,314	4,625
79	4,018	5,822	6,508	1,715	5,390	4,705
80	4,084	5,917	6,584	1,737	5,463	4,779
81	4,141	5,992	6,672	1,757	5,529	4,846
82	4,194	6,078	6,754	1,783	5,599	4,909
83	4,252	6,157	6,838	1,801	5,666	4,976
84	4,304	6,230	6,912	1,822	5,732	5,042
85	4,353	6,309	6,993	1,846	5,799	5,095
86	4,400	6,378	7,060	1,860	5,854	5,150
87	4,449	6,446	7,135	1,880	5,918	5,204
88	4,492	6,515	7,201	1,899	5,965	5,258
89	4,533	6,576	7,262	1,912	6,020	5,308
90	4,572	6,624	7,326	1,930	6,069	5,354
91	4,609	6,686	7,381	1,945	6,118	5,396
92	4,651	6,737	7,429	1,958	6,153	5,441
93	4,679	6,786	7,482	1,976	6,200	5,477
94	4,713	6,825	7,508	1,981	6,226	5,515
95	4,735	6,866	7,549	1,990	6,262	5,548
96	4,770	6,903	7,597	2,001	6,297	5,578
97	4,796	6,948	7,629	2,014	6,324	5,607
98	4,822	6,990	7,673	2,024	6,363	5,641
99	4,850	7,029	7,708	2,031	6,389	5,679

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
0 - 64	3,113	4,515	5,246	1,381	4,352	3,648
65	3,113	4,515	5,246	1,381	4,352	3,648
66	3,113	4,515	5,246	1,381	4,352	3,648
67	3,113	4,515	5,246	1,381	4,352	3,648
68	3,243	4,705	5,460	1,440	4,524	3,796
69	3,387	4,907	5,681	1,502	4,707	3,969
70	3,520	5,101	5,887	1,550	4,881	4,120
71	3,656	5,300	6,087	1,604	5,052	4,278
72	3,784	5,490	6,277	1,657	5,203	4,428
73	3,904	5,655	6,453	1,703	5,350	4,570
74	4,018	5,822	6,618	1,749	5,486	4,706
75	4,114	5,965	6,770	1,784	5,607	4,817
76	4,209	6,104	6,895	1,817	5,719	4,930
77	4,304	6,232	7,015	1,849	5,816	5,042
78	4,386	6,357	7,124	1,880	5,905	5,139
79	4,469	6,470	7,228	1,901	5,986	5,227
80	4,533	6,576	7,312	1,929	6,064	5,308
81	4,597	6,665	7,409	1,952	6,142	5,387
82	4,659	6,759	7,506	1,981	6,223	5,458
83	4,724	6,843	7,599	2,001	6,299	5,529
84	4,782	6,932	7,685	2,024	6,366	5,592
85	4,831	7,007	7,769	2,048	6,442	5,659
86	4,892	7,086	7,848	2,069	6,507	5,728
87	4,945	7,156	7,926	2,090	6,569	5,787
88	4,989	7,229	7,997	2,109	6,627	5,840
89	5,037	7,301	8,071	2,126	6,691	5,904
90	5,083	7,367	8,135	2,144	6,739	5,952
91	5,124	7,422	8,196	2,160	6,790	5,996
92	5,164	7,482	8,256	2,178	6,847	6,048
93	5,198	7,533	8,308	2,186	6,880	6,087
94	5,235	7,585	8,355	2,202	6,924	6,131
95	5,269	7,631	8,393	2,211	6,958	6,169
96	5,293	7,676	8,434	2,220	6,991	6,200
97	5,328	7,718	8,474	2,236	7,028	6,232
98	5,361	7,764	8,523	2,247	7,064	6,270
99	5,395	7,817	8,571	2,256	7,100	6,314

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

To calculate the 5% Household discount:

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

Modal premium **x** .95 **= discounted premium**

If applying during Open Enrollment or Guaranteed Issue periods, use preferred rates.

Modal factors

Semi-annual 0.5200

Quarterly 0.2650

Monthly 0.0833

Continental Life Insurance Company of Brentwood, Tennessee

Annual Attained Age Premiums

For Use in ZIP Codes: Rest of state

Male rates

Rates effective 5/1/2026

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
0 - 64	3,221	4,667	5,433	1,431	4,505	3,771
65	3,221	4,667	5,433	1,431	4,505	3,771
66	3,221	4,667	5,433	1,431	4,505	3,771
67	3,221	4,667	5,433	1,431	4,505	3,771
68	3,355	4,865	5,653	1,489	4,681	3,930
69	3,506	5,086	5,881	1,550	4,873	4,110
70	3,648	5,283	6,095	1,605	5,052	4,272
71	3,786	5,490	6,307	1,663	5,228	4,428
72	3,917	5,675	6,508	1,715	5,390	4,582
73	4,042	5,854	6,677	1,757	5,540	4,728
74	4,156	6,023	6,851	1,806	5,679	4,865
75	4,264	6,173	7,007	1,848	5,808	4,989
76	4,355	6,316	7,135	1,880	5,918	5,101
77	4,451	6,450	7,262	1,912	6,020	5,207
78	4,545	6,577	7,380	1,945	6,118	5,316
79	4,616	6,692	7,483	1,976	6,204	5,406
80	4,692	6,799	7,574	1,994	6,277	5,492
81	4,755	6,897	7,673	2,024	6,363	5,573
82	4,824	6,991	7,769	2,048	6,442	5,648
83	4,888	7,083	7,858	2,075	6,517	5,720
84	4,945	7,162	7,955	2,093	6,594	5,790
85	5,007	7,251	8,040	2,121	6,665	5,864
86	5,063	7,332	8,124	2,142	6,736	5,923
87	5,112	7,414	8,209	2,161	6,806	5,986
88	5,170	7,489	8,280	2,183	6,866	6,057
89	5,210	7,559	8,355	2,202	6,924	6,108
90	5,269	7,627	8,420	2,218	6,982	6,157
91	5,305	7,682	8,476	2,236	7,029	6,207
92	5,346	7,742	8,536	2,252	7,076	6,253
93	5,387	7,803	8,594	2,267	7,125	6,301
94	5,414	7,850	8,647	2,280	7,171	6,340
95	5,446	7,898	8,691	2,291	7,198	6,378
96	5,480	7,944	8,729	2,302	7,235	6,412
97	5,512	7,988	8,773	2,313	7,271	6,450
98	5,546	8,035	8,815	2,324	7,307	6,494
99	5,576	8,079	8,860	2,336	7,343	6,527

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
0 - 64	3,580	5,188	6,028	1,590	5,005	4,191
65	3,580	5,188	6,028	1,590	5,005	4,191
66	3,580	5,188	6,028	1,590	5,005	4,191
67	3,580	5,188	6,028	1,590	5,005	4,191
68	3,733	5,404	6,282	1,657	5,204	4,370
69	3,894	5,648	6,530	1,720	5,406	4,566
70	4,048	5,871	6,770	1,784	5,607	4,746
71	4,208	6,093	7,007	1,848	5,808	4,921
72	4,353	6,309	7,228	1,901	5,986	5,095
73	4,492	6,504	7,413	1,955	6,148	5,253
74	4,616	6,692	7,606	2,008	6,302	5,406
75	4,732	6,856	7,788	2,052	6,450	5,545
76	4,846	7,015	7,934	2,091	6,576	5,674
77	4,948	7,175	8,071	2,126	6,691	5,790
78	5,043	7,306	8,189	2,159	6,790	5,905
79	5,134	7,441	8,308	2,186	6,880	6,006
80	5,210	7,557	8,411	2,218	6,977	6,104
81	5,287	7,665	8,525	2,247	7,071	6,195
82	5,361	7,766	8,626	2,277	7,151	6,276
83	5,435	7,869	8,732	2,302	7,239	6,358
84	5,498	7,965	8,837	2,330	7,329	6,442
85	5,560	8,056	8,938	2,354	7,413	6,507
86	5,626	8,150	9,030	2,378	7,489	6,578
87	5,676	8,235	9,110	2,402	7,557	6,655
88	5,741	8,313	9,195	2,427	7,627	6,724
89	5,796	8,395	9,284	2,447	7,689	6,786
90	5,837	8,466	9,356	2,467	7,756	6,847
91	5,898	8,545	9,428	2,484	7,819	6,902
92	5,947	8,604	9,488	2,501	7,869	6,958
93	5,982	8,660	9,547	2,516	7,912	7,001
94	6,021	8,720	9,601	2,531	7,961	7,044
95	6,051	8,771	9,647	2,545	7,998	7,083
96	6,093	8,825	9,700	2,555	8,047	7,127
97	6,125	8,878	9,747	2,567	8,079	7,174
98	6,162	8,932	9,796	2,582	8,120	7,220
99	6,197	8,982	9,846	2,596	8,164	7,255

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

To calculate the 5% Household discount:

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

Modal premium **x** .95 **= discounted premium**

If applying during Open Enrollment or Guaranteed Issue periods, use preferred rates.

Modal factors

Semi-annual	0.5200
Quarterly	0.2650
Monthly	0.0833

PREMIUM INFORMATION

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

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

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

HOUSEHOLD DISCOUNT

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

DISCLOSURES

Use this outline to compare benefits and premium among policies.

READ YOUR POLICY VERY CAREFULLY

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to Continental Life Insurance Company of Brentwood, Tennessee, P.O. Box 14770, Lexington, KY 40512-4770. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all your payments.

POLICY REPLACEMENT

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

NOTICE

The policy may not cover all of your medical costs.

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

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult *Medicare & You* for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT

When you fill out the application for the new policy, be sure to answer truthfully and completely any questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information.

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

THE FOLLOWING CHARTS DESCRIBE PLANS A, B, F, HIGH DEDUCTIBLE F, G, and N OFFERED BY CONTINENTAL LIFE INSURANCE COMPANY OF BRENTWOOD, TENNESSEE.

PLAN A

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,736	$0	$1,736 (Part A Deductible)
61st thru 90th day	All but $434 a day	$434 a day	$0
91st day and after While using 60 lifetime reserve days	All but $868 a day	$868 a day	$0
Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $217 a day	$0	Up to $217 a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

PLAN A

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

*Once you have been billed $283 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 $283 of Medicare-Approved amounts*	$0	$0	$283 (Part B Deductible)
Remainder of Medicare-Approved amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare-Approved amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $283 of Medicare-Approved amounts*	$0	$0	$283 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
First $283 of Medicare-Approved amounts*	$0	$0	$283 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	$0

PLAN B

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,736	$1,736 (Part A Deductible)	$0
61st thru 90th day	All but $434 a day	$434 a day	$0
91st day and after While using 60 lifetime reserve days	All but $868 a day	$868 a day	$0
Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $217 a day	$0	Up to $217 a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

PLAN B

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

*Once you have been billed $283 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 $283 of Medicare-Approved amounts*	$0	$0	$283 (Part B Deductible)
Remainder of Medicare-Approved amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare-Approved amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $283 of Medicare-Approved amounts*	$0	$0	$283 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
First $283 of Medicare-Approved amounts*	$0	$0	$283 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	$0

PLAN F

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,736	$1,736 (Part A Deductible)	$0
61st thru 90th day	All but $434 a day	$434 a day	$0
91st day and after While using 60 lifetime reserve days	All but $868 a day	$868 a day	$0
Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $217 a day	Up to $217 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

PLAN F

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

*Once you have been billed $283 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 $283 of Medicare-Approved amounts*	$0	$283 (Part B Deductible)	$0
Remainder of Medicare-Approved amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare-Approved amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $283 of Medicare-Approved amounts*	$0	$283 (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 $283 of Medicare-Approved amounts*	$0	$283 (Part B Deductible)	$0
Remainder of Medicare-Approved amounts	80%	20%	$0

PLAN F

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

HIGH DEDUCTIBLE PLAN F

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

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

*****This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2,950 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses are $2,950. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.**

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,950 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2,950 DEDUCTIBLE*** YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,736	$1,736 (Part A Deductible)	$0
61st thru 90th day	All but $434 a day	$434 a day	$0
91st day and after While using 60 lifetime reserve days	All but $868 a day	$868 a day	$0
Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $217 a day	Up to $217 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

HIGH DEDUCTIBLE PLAN F

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

*Once you have been billed $283 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

*****This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2,950 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses are $2,950. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.**

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,950 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2,950 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 $283 of Medicare-Approved amounts*	$0	$283 (Part B Deductible)	$0
Remainder of Medicare-Approved amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare-Approved amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $283 of Medicare-Approved amounts*	$0	$283 (Part B Deductible)	$0
Remainder of Medicare-Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

HIGH DEDUCTIBLE PLAN F

PARTS A & B

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,950 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2,950 DEDUCTIBLE** YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
First $283 of Medicare-Approved amounts*	$0	$283 (Part B Deductible)	$0
Remainder of Medicare-Approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,950 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2,950 DEDUCTIBLE** YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN G

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,736	$1,736 (Part A Deductible)	$0
61st thru 90th day	All but $434 a day	$434 a day	$0
91st day and after While using 60 lifetime reserve days	All but $868 a day	$868 a day	$0
Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $217 a day	Up to $217 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

PLAN G

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

*Once you have been billed $283 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 $283 of Medicare-Approved amounts*	$0	$0	$283 (Part B Deductible)
Remainder of Medicare-Approved amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare-Approved amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $283 of Medicare-Approved amounts*	$0	$0	$283 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
First $283 of Medicare-Approved amounts*	$0	$0	$283 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	$0

PLAN G

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

PLAN N

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,736	$1,736 (Part A Deductible)	$0
61st thru 90th day	All but $434 a day	$434 a day	$0
91st day and after While using 60 lifetime reserve days	All but $868 a day	$868 a day	$0
Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $217 a day	Up to $217 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

PLAN N

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

*Once you have been billed $283 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 $283 of Medicare-Approved amounts*	$0	$0	$283 (Part B Deductible)
Remainder of Medicare-Approved amounts	Generally 80%	Balance, other than up to $20 per office visit and up to $50 per emergency room visit. The co-payment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
PART B EXCESS CHARGES (Above Medicare-Approved amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $283 of Medicare-Approved amounts*	$0	$0	$283 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN N

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
First $283 of Medicare-Approved amounts*	$0	$0	$283 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

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