

Continental Life Insurance Company of Brentwood, Tennessee

An Aetna Company

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Outline of Coverage **Medicare Supplement Insurance**

BENEFIT PLANS A, B, F, High Deductible F, G, N

Underwritten by

An Aetna Company

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

Rhode Island

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

These charts show the benefits included in each of the standard Medicare supplement plans. Every company must make available Plan "A".
 Some plans may not be available in your state.

Basic Benefits:

Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.

Medical Expenses: Part B coinsurance (generally 20% of Medicare-Approved expenses) or, co-payments for hospital outpatient services. Plans K, L, and N require insureds to pay a portion of coinsurance or copayments

Blood: First three pints of blood each year.

Hospice: Part A coinsurance

A	B	C	D	F/F*	G	K	L	M	N
Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance, except up to \$20 copayment for office visit, and up to \$50 copayment for ER
	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
	Part B Deductible	Part B Deductible		Part B Deductible					
				Part B Excess (100%)	Part B Excess (100%)				
	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency			Foreign Travel Emergency	Foreign Travel Emergency
						Out-of-pocket limit \$5560; paid at 100% after limit reached	Out-of-pocket limit \$2780; paid at 100% after limit reached		

*Plan F also has an option called a high deductible plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year \$2300 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed \$2300. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

Continental Life Insurance Company of Brentwood, Tennessee

Annual Attained Age Premiums
For Use in ZIP Codes: Entire state
Female Rates

Rates Effective 3/1/2017

Attained Age	Preferred						Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,393	1,757	1,973	732	1,643	1,258	1,547	1,951	2,194	813	1,826	1,399
66	1,393	1,757	1,973	732	1,643	1,258	1,547	1,951	2,194	813	1,826	1,399
67	1,393	1,757	1,973	732	1,643	1,258	1,547	1,951	2,194	813	1,826	1,399
68	1,452	1,829	2,056	763	1,713	1,311	1,613	2,032	2,283	847	1,904	1,457
69	1,515	1,912	2,136	793	1,789	1,370	1,684	2,123	2,375	881	1,989	1,523
70	1,578	1,989	2,214	823	1,860	1,424	1,750	2,208	2,460	913	2,068	1,583
71	1,638	2,064	2,291	849	1,931	1,478	1,819	2,293	2,545	944	2,147	1,642
72	1,695	2,134	2,363	877	1,998	1,531	1,882	2,373	2,625	975	2,222	1,700
73	1,747	2,202	2,427	901	2,062	1,579	1,940	2,446	2,698	1,001	2,290	1,754
74	1,799	2,267	2,489	923	2,120	1,623	1,997	2,517	2,767	1,027	2,356	1,805
75	1,844	2,322	2,545	944	2,175	1,667	2,048	2,581	2,830	1,049	2,417	1,850
76	1,887	2,376	2,597	964	2,225	1,704	2,095	2,641	2,882	1,070	2,471	1,892
77	1,927	2,424	2,640	979	2,272	1,742	2,141	2,695	2,934	1,089	2,524	1,934
78	1,962	2,474	2,681	995	2,316	1,775	2,182	2,748	2,979	1,106	2,574	1,970
79	1,997	2,517	2,719	1,009	2,356	1,804	2,220	2,797	3,020	1,120	2,618	2,003
80	2,031	2,557	2,753	1,023	2,395	1,834	2,256	2,843	3,058	1,135	2,661	2,038
81	2,059	2,592	2,788	1,035	2,428	1,860	2,287	2,883	3,097	1,149	2,698	2,068
82	2,086	2,628	2,825	1,048	2,461	1,885	2,318	2,923	3,139	1,165	2,736	2,094
83	2,114	2,663	2,859	1,061	2,493	1,910	2,349	2,959	3,176	1,179	2,770	2,122
84	2,140	2,694	2,892	1,073	2,524	1,934	2,377	2,996	3,214	1,193	2,805	2,148
85	2,165	2,728	2,923	1,085	2,554	1,955	2,404	3,031	3,250	1,205	2,837	2,172
86	2,189	2,759	2,954	1,096	2,582	1,978	2,433	3,064	3,282	1,218	2,869	2,197
87	2,212	2,788	2,983	1,107	2,609	1,998	2,458	3,096	3,315	1,230	2,899	2,221
88	2,235	2,816	3,011	1,118	2,635	2,019	2,482	3,128	3,346	1,241	2,929	2,241
89	2,256	2,843	3,036	1,126	2,661	2,038	2,506	3,157	3,373	1,253	2,956	2,264
90	2,275	2,867	3,062	1,136	2,684	2,056	2,528	3,186	3,400	1,261	2,983	2,285
91	2,295	2,891	3,086	1,145	2,707	2,072	2,549	3,212	3,427	1,272	3,006	2,301
92	2,313	2,914	3,105	1,152	2,725	2,088	2,569	3,237	3,451	1,282	3,031	2,322
93	2,326	2,935	3,125	1,161	2,746	2,103	2,586	3,259	3,472	1,289	3,052	2,336
94	2,344	2,953	3,141	1,165	2,764	2,116	2,604	3,281	3,492	1,295	3,072	2,353
95	2,356	2,969	3,158	1,171	2,780	2,129	2,619	3,300	3,509	1,303	3,089	2,367
96	2,372	2,987	3,175	1,179	2,796	2,142	2,632	3,320	3,527	1,308	3,108	2,379
97	2,384	3,005	3,191	1,184	2,813	2,153	2,650	3,340	3,545	1,315	3,125	2,392
98	2,398	3,021	3,208	1,191	2,829	2,165	2,665	3,358	3,564	1,323	3,143	2,406
99	2,414	3,040	3,221	1,196	2,846	2,179	2,683	3,379	3,581	1,329	3,163	2,422

Modal Factors: Semi-Annual: 0.5200 Monthly: 0.083333

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

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

Continental Life Insurance Company of Brentwood, Tennessee

Annual Attained Age Premiums
For Use in ZIP Codes: Entire state
Male Rates

Rates Effective 3/1/2017

Attained Age	Preferred						Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,602	2,017	2,271	843	1,889	1,447	1,780	2,241	2,523	936	2,099	1,608
66	1,602	2,017	2,271	843	1,889	1,447	1,780	2,241	2,523	936	2,099	1,608
67	1,602	2,017	2,271	843	1,889	1,447	1,780	2,241	2,523	936	2,099	1,608
68	1,668	2,105	2,363	877	1,967	1,508	1,854	2,337	2,626	975	2,187	1,675
69	1,744	2,199	2,457	912	2,057	1,577	1,936	2,441	2,731	1,012	2,286	1,750
70	1,813	2,284	2,547	947	2,139	1,639	2,015	2,539	2,830	1,049	2,378	1,821
71	1,883	2,373	2,636	978	2,222	1,700	2,093	2,636	2,929	1,087	2,469	1,890
72	1,949	2,455	2,719	1,009	2,298	1,760	2,165	2,728	3,020	1,120	2,552	1,955
73	2,010	2,532	2,792	1,035	2,371	1,816	2,233	2,812	3,102	1,150	2,633	2,017
74	2,067	2,606	2,864	1,063	2,440	1,867	2,297	2,894	3,181	1,181	2,710	2,075
75	2,120	2,670	2,929	1,087	2,499	1,914	2,355	2,967	3,254	1,208	2,778	2,128
76	2,168	2,732	2,983	1,107	2,557	1,958	2,409	3,035	3,316	1,231	2,843	2,177
77	2,213	2,790	3,036	1,126	2,612	2,000	2,460	3,102	3,373	1,253	2,902	2,222
78	2,258	2,845	3,085	1,145	2,663	2,040	2,508	3,159	3,426	1,271	2,958	2,267
79	2,297	2,894	3,128	1,161	2,710	2,075	2,551	3,216	3,475	1,289	3,009	2,305
80	2,336	2,940	3,167	1,176	2,754	2,108	2,592	3,266	3,517	1,306	3,058	2,343
81	2,366	2,984	3,208	1,191	2,794	2,137	2,629	3,315	3,565	1,323	3,104	2,376
82	2,399	3,023	3,250	1,205	2,830	2,166	2,666	3,359	3,609	1,340	3,145	2,407
83	2,432	3,063	3,288	1,219	2,867	2,195	2,702	3,402	3,654	1,355	3,186	2,440
84	2,459	3,098	3,323	1,234	2,902	2,222	2,733	3,444	3,694	1,371	3,225	2,471
85	2,489	3,136	3,362	1,248	2,937	2,250	2,767	3,484	3,737	1,385	3,264	2,497
86	2,517	3,172	3,396	1,260	2,969	2,273	2,797	3,526	3,775	1,400	3,299	2,526
87	2,543	3,206	3,431	1,273	3,002	2,297	2,825	3,561	3,810	1,413	3,336	2,552
88	2,570	3,238	3,462	1,286	3,032	2,323	2,856	3,596	3,846	1,427	3,368	2,580
89	2,592	3,270	3,494	1,295	3,059	2,344	2,883	3,631	3,882	1,441	3,400	2,604
90	2,618	3,297	3,519	1,306	3,088	2,363	2,906	3,663	3,911	1,452	3,431	2,627
91	2,639	3,324	3,546	1,315	3,112	2,383	2,934	3,695	3,941	1,462	3,459	2,650
92	2,658	3,349	3,570	1,325	3,137	2,401	2,955	3,723	3,968	1,472	3,485	2,670
93	2,677	3,375	3,593	1,333	3,158	2,418	2,975	3,748	3,991	1,482	3,510	2,687
94	2,693	3,397	3,614	1,341	3,178	2,434	2,994	3,771	4,014	1,490	3,532	2,704
95	2,709	3,415	3,632	1,348	3,197	2,448	3,011	3,795	4,033	1,498	3,553	2,718
96	2,727	3,433	3,650	1,354	3,215	2,462	3,030	3,816	4,056	1,504	3,573	2,735
97	2,742	3,455	3,668	1,362	3,234	2,477	3,047	3,838	4,076	1,513	3,592	2,752
98	2,759	3,474	3,688	1,368	3,252	2,492	3,064	3,862	4,097	1,520	3,616	2,769
99	2,774	3,495	3,707	1,375	3,272	2,507	3,081	3,884	4,117	1,529	3,637	2,785

Modal Factors: Semi-Annual: 0.5200 Monthly: 0.083333
 Quarterly: 0.2650

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

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

PREMIUM INFORMATION

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

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

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

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 61st thru 90th day 91st day and after •While using 60 lifetime reserve days •Once lifetime reserve days are used: •Additional 365 days •Beyond the Additional 365 days	All but \$1364 All but \$341 a day All but \$682 a day \$0 \$0	\$0 \$341 a day \$682 a day 100% of Medicare Eligible Expenses \$0	\$1364 (Part A Deductible) \$0 \$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 21st thru 100th day 101st day and after	All approved amounts All but \$170.50 a day \$0	\$0 \$0 \$0	\$0 Up to \$170.50 a day All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$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 \$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* Remainder of Medicare-Approved amounts	\$0 Generally 80%	\$0 Generally 20%	\$185 (Part B Deductible) \$0
Part B Excess Charges (Above Medicare-Approved amounts)	\$0	\$0	All costs
BLOOD First 3 pints Next \$185 of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$185 (Part B Deductible) \$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 •Durable medical equipment •First \$185 of Medicare Approved amounts* •Remainder of Medicare Approved amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$185 (Part B Deductible) \$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
<p>HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after •While using 60 lifetime reserve days •Once lifetime reserve days are used: •Additional 365 days •Beyond the Additional 365 days</p>	<p>All but \$1364 All but \$341 a day All but \$682 a day \$0 \$0</p>	<p>\$1364 (Part A Deductible) \$341 a day \$682 a day 100% of Medicare Eligible Expenses \$0</p>	<p>\$0 \$0 \$0 \$0** All costs</p>
<p>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 21st thru 100th day 101st day and after</p>	<p>All approved amounts All but \$170.50 a day \$0</p>	<p>\$0 \$0 \$0</p>	<p>\$0 Up to \$170.50 a day All costs</p>
<p>BLOOD First 3 pints Additional amounts</p>	<p>\$0 100%</p>	<p>3 pints \$0</p>	<p>\$0 \$0</p>
<p>HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.</p>	<p>All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care</p>	<p>Medicare copayment/ coinsurance</p>	<p>\$0</p>

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

PLAN B

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

* Once you have been billed \$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* Remainder of Medicare-Approved amounts	\$0 Generally 80%	\$0 Generally 20%	\$185 (Part B Deductible) \$0
Part B Excess Charges (Above Medicare-Approved amounts)	\$0	\$0	All costs
BLOOD First 3 pints Next \$185 of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$185 (Part B Deductible) \$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	\$0	\$185 (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
<p>HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days</p> <p>61st thru 90th day 91st day and after</p> <ul style="list-style-type: none"> •While using 60 lifetime reserve days •Once lifetime reserve days are used: •Additional 365 days •Beyond the Additional 365 days 	<p>All but \$1364</p> <p>All but \$341 a day</p> <p>All but \$682 a day</p> <p>\$0</p> <p>\$0</p>	<p>\$1364 (Part A Deductible)</p> <p>\$341 a day</p> <p>\$682 a day</p> <p>100% of Medicare Eligible Expenses</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>\$0</p> <p>\$0**</p> <p>All costs</p>
<p>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</p> <p>First 20 days</p> <p>21st thru 100th day</p> <p>101st day and after</p>	<p>All approved amounts</p> <p>All but \$170.50 a day</p> <p>\$0</p>	<p>\$0</p> <p>Up to \$170.50 a day</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>All costs</p>
<p>BLOOD First 3 pints Additional amounts</p>	<p>\$0</p> <p>100%</p>	<p>3 pints</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p>
<p>HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.</p>	<p>All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care</p>	<p>Medicare copayment/ coinsurance</p>	<p>\$0</p>

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

PLAN F

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

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

PLAN F

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<p>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 Remainder of charges</p>	<p>\$0 \$0</p>	<p>\$0 80% to a lifetime maximum benefit of \$50,000</p>	<p>\$250 20% and amounts over the \$50,000 lifetime maximum</p>

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 \$2300 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses are \$2300. 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 \$2300 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO \$2300 DEDUCTIBLE** YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after •While using 60 lifetime reserve days •Once lifetime reserve days are used: •Additional 365 days •Beyond the Additional 365 days	All but \$1364 All but \$341 a day All but \$682 a day \$0 \$0	\$1364 (Part A Deductible) \$341 a day \$682 a day 100% of Medicare Eligible Expenses \$0	\$0 \$0 \$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 21st thru 100th day 101st day and after	All approved amounts All but \$170.50 a day \$0	\$0 Up to \$170.50 a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$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
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**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

HIGH DEDUCTIBLE PLAN F

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

*Once you have been billed \$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 high deductible plan pays the same benefits as Plan F after one has paid a calendar year \$2300 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses are \$2300. 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 \$2300 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO \$2300 DEDUCTIBLE** YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic test, durable medical equipment First \$185 of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0 Generally 80%	\$185 (Part B Deductible) Generally 20%	\$0 \$0
Part B Excess Charges (Above Medicare-Approved amounts)	\$0	100%	\$0
BLOOD First 3 pints Next \$185 of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0 \$0 80%	All costs \$185 (Part B Deductible) 20%	\$0 \$0 \$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

HIGH DEDUCTIBLE PLAN F

PARTS A & B

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$2300 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO \$2300 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 \$2300 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO \$2300 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
<p>HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days</p> <p>61st thru 90th day 91st day and after</p> <ul style="list-style-type: none"> •While using 60 lifetime reserve days •Once lifetime reserve days are used: •Additional 365 days •Beyond the Additional 365 days 	<p>All but \$1364</p> <p>All but \$341 a day</p> <p>All but \$682 a day</p> <p>\$0</p> <p>\$0</p>	<p>\$1364 (Part A Deductible)</p> <p>\$341 a day</p> <p>\$682 a day</p> <p>100% of Medicare Eligible Expenses</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>\$0</p> <p>\$0**</p> <p>All costs</p>
<p>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</p> <p>First 20 days</p> <p>21st thru 100th day</p> <p>101st day and after</p>	<p>All approved amounts</p> <p>All but \$170.50 a day</p> <p>\$0</p>	<p>\$0</p> <p>Up to \$170.50 a day</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>All costs</p>
<p>BLOOD First 3 pints Additional amounts</p>	<p>\$0</p> <p>100%</p>	<p>3 pints</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p>
<p>HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness services</p>	<p>All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care</p>	<p>Medicare copayment/ coinsurance</p>	<p>\$0</p>

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

PLAN G

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

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

PLAN G

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<p>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 Remainder of charges</p>	<p>\$0 \$0</p>	<p>\$0 80% to a lifetime maximum benefit of \$50,000</p>	<p>\$250 20% and amounts over the \$50,000 lifetime maximum</p>

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 61st thru 90th day 91st day and after •While using 60 lifetime reserve days •Once lifetime reserve days are used: •Additional 365 days •Beyond the Additional 365 days	All but \$1364 All but \$341 a day All but \$682 a day \$0 \$0	\$1364 (Part A Deductible) \$341 a day \$682 a day 100% of Medicare Eligible Expenses \$0	\$0 \$0 \$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 21st thru 100th day 101st day and after	All approved amounts All but \$170.50 a day \$0	\$0 Up to \$170.50 a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness services	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare co-payment/ coinsurance	\$0

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

PLAN N

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

*Once you have been billed \$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
<p>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* Remainder of Medicare-Approved amounts</p>	<p>\$0 Generally 80%</p>	<p>\$0 Balance, other than up to \$20 per office visit and up to \$50 per emergency room visit. The copayment of up to \$50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.</p>	<p>\$185 (Part B Deductible) 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.</p>
<p>Part B Excess Charges (Above Medicare-Approved amounts)</p>	<p>\$0</p>	<p>\$0</p>	<p>All costs</p>
<p>BLOOD First 3 pints Next \$185 of Medicare-Approved amounts* Remainder of Medicare-Approved amounts</p>	<p>\$0 \$0 80%</p>	<p>All costs \$0 20%</p>	<p>\$0 \$185 (Part B Deductible) \$0</p>
<p>CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES</p>	<p>100%</p>	<p>\$0</p>	<p>\$0</p>

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 \$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 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

