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Outline of Coverage

Medicare Supplement Insurance

BENEFIT PLANS A, B, F, HF, G, N

Underwritten by
An Aetna Company **Continental Life Insurance Company**
of Brentwood, Tennessee

SOUTH CAROLINA

**CONTINENTAL LIFE INSURANCE COMPANY OF BRENTWOOD, TENNESSEE
 OUTLINE OF MEDICARE SUPPLEMENT COVERAGE COVER PAGE: Page 1 of 1
 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
						Out-of-pocket limit \$5560; paid at 100% after limit reached	Out-of-pocket limit \$2780; paid at 100% after limit reached		

*Plans 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 Premiums

For Use in ZIP Codes: 294-295, 298-299

Female Rates

Rates Effective 10/1/2018

Attained Age	Preferred						Attained Age	Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N		Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,079	1,271	1,602	642	1,272	989	65	1,198	1,413	1,780	713	1,414	1,099
66	1,079	1,271	1,602	642	1,272	1,006	66	1,198	1,413	1,780	713	1,414	1,118
67	1,079	1,271	1,602	642	1,272	1,024	67	1,198	1,413	1,780	713	1,414	1,138
68	1,091	1,287	1,622	649	1,288	1,052	68	1,212	1,430	1,801	721	1,431	1,169
69	1,115	1,314	1,656	662	1,315	1,093	69	1,240	1,460	1,841	737	1,461	1,213
70	1,144	1,349	1,701	680	1,350	1,140	70	1,272	1,500	1,889	756	1,501	1,266
71	1,178	1,390	1,752	701	1,391	1,174	71	1,310	1,544	1,946	777	1,545	1,305
72	1,218	1,434	1,809	723	1,436	1,213	72	1,353	1,594	2,009	804	1,595	1,347
73	1,259	1,485	1,871	748	1,486	1,255	73	1,399	1,650	2,079	831	1,651	1,394
74	1,309	1,543	1,944	777	1,544	1,304	74	1,454	1,715	2,160	864	1,716	1,449
75	1,363	1,606	2,025	809	1,607	1,358	75	1,514	1,786	2,250	900	1,787	1,508
76	1,418	1,671	2,106	843	1,673	1,413	76	1,575	1,856	2,339	936	1,858	1,569
77	1,471	1,733	2,186	874	1,736	1,465	77	1,633	1,926	2,428	970	1,928	1,628
78	1,521	1,795	2,261	904	1,796	1,517	78	1,690	1,994	2,513	1,004	1,995	1,685
79	1,574	1,855	2,338	935	1,857	1,568	79	1,749	2,061	2,597	1,038	2,063	1,742
80	1,623	1,913	2,412	965	1,915	1,617	80	1,802	2,126	2,679	1,072	2,129	1,797
81	1,674	1,973	2,487	995	1,975	1,669	81	1,859	2,193	2,764	1,106	2,195	1,854
82	1,727	2,035	2,566	1,026	2,038	1,720	82	1,917	2,261	2,850	1,140	2,264	1,912
83	1,780	2,099	2,644	1,058	2,100	1,773	83	1,978	2,332	2,938	1,175	2,333	1,970
84	1,834	2,163	2,725	1,090	2,165	1,828	84	2,039	2,402	3,028	1,211	2,405	2,030
85	1,899	2,238	2,821	1,129	2,240	1,891	85	2,109	2,486	3,134	1,254	2,489	2,102
86	1,952	2,302	2,901	1,161	2,304	1,946	86	2,168	2,558	3,223	1,289	2,560	2,163
87	2,008	2,366	2,984	1,194	2,370	2,001	87	2,231	2,629	3,315	1,326	2,632	2,223
88	2,063	2,433	3,067	1,226	2,436	2,056	88	2,293	2,704	3,408	1,363	2,707	2,285
89	2,122	2,501	3,153	1,260	2,504	2,114	89	2,358	2,779	3,503	1,401	2,782	2,350
90	2,180	2,570	3,239	1,296	2,572	2,172	90	2,422	2,856	3,598	1,440	2,858	2,414
91	2,239	2,640	3,327	1,332	2,642	2,232	91	2,487	2,934	3,697	1,479	2,936	2,480
92	2,300	2,710	3,416	1,367	2,713	2,291	92	2,555	3,011	3,795	1,518	3,016	2,546
93	2,361	2,783	3,507	1,403	2,787	2,353	93	2,623	3,093	3,897	1,559	3,097	2,615
94	2,422	2,856	3,599	1,441	2,859	2,416	94	2,692	3,173	3,999	1,601	3,178	2,684
95	2,486	2,931	3,695	1,478	2,935	2,478	95	2,763	3,257	4,104	1,643	3,261	2,754
96	2,550	3,007	3,790	1,515	3,010	2,541	96	2,834	3,340	4,211	1,684	3,344	2,824
97	2,615	3,084	3,887	1,555	3,087	2,607	97	2,905	3,426	4,319	1,728	3,430	2,896
98	2,682	3,161	3,985	1,594	3,165	2,673	98	2,981	3,512	4,428	1,772	3,517	2,970
99+	2,748	3,241	4,083	1,634	3,244	2,740	99+	3,053	3,600	4,537	1,816	3,606	3,044

Modal Factors:

Semi-Annual: 0.5200

Quarterly: 0.2650

Monthly: 0.0833

The above rates do not include the \$20 one-time policy fee.

To calculate a Household discount:

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

Modal premium x .93 = discounted premium

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

Continental Life Insurance Company of Brentwood, Tennessee

Annual Premiums
For Use in: Rest of State
Female Rates

Rates Effective 10/1/2018

Attained Age	Preferred						Attained Age	Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N		Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	985	1,161	1,463	586	1,162	903	65	1,094	1,290	1,626	651	1,291	1,004
66	985	1,161	1,463	586	1,162	919	66	1,094	1,290	1,626	651	1,291	1,021
67	985	1,161	1,463	586	1,162	935	67	1,094	1,290	1,626	651	1,291	1,039
68	996	1,175	1,481	593	1,176	961	68	1,107	1,306	1,645	658	1,307	1,068
69	1,018	1,200	1,512	605	1,201	998	69	1,132	1,333	1,681	673	1,334	1,108
70	1,045	1,232	1,553	621	1,233	1,041	70	1,162	1,370	1,725	690	1,371	1,156
71	1,076	1,269	1,600	640	1,270	1,072	71	1,196	1,410	1,777	710	1,411	1,192
72	1,112	1,310	1,652	660	1,311	1,108	72	1,236	1,456	1,835	734	1,457	1,230
73	1,150	1,356	1,709	683	1,357	1,146	73	1,278	1,507	1,899	759	1,508	1,273
74	1,195	1,409	1,775	710	1,410	1,191	74	1,328	1,566	1,973	789	1,567	1,323
75	1,245	1,467	1,849	739	1,468	1,240	75	1,383	1,631	2,055	822	1,632	1,377
76	1,295	1,526	1,923	770	1,528	1,290	76	1,438	1,695	2,136	855	1,697	1,433
77	1,343	1,583	1,996	798	1,585	1,338	77	1,491	1,759	2,217	886	1,761	1,487
78	1,389	1,639	2,065	826	1,640	1,385	78	1,543	1,821	2,295	917	1,822	1,539
79	1,437	1,694	2,135	854	1,696	1,432	79	1,597	1,882	2,372	948	1,884	1,591
80	1,482	1,747	2,203	881	1,749	1,477	80	1,646	1,942	2,447	979	1,944	1,641
81	1,529	1,802	2,271	909	1,804	1,524	81	1,698	2,003	2,524	1,010	2,005	1,693
82	1,577	1,858	2,343	937	1,861	1,571	82	1,751	2,065	2,603	1,041	2,068	1,746
83	1,626	1,917	2,415	966	1,918	1,619	83	1,806	2,130	2,683	1,073	2,131	1,799
84	1,675	1,975	2,489	995	1,977	1,669	84	1,862	2,194	2,765	1,106	2,196	1,854
85	1,734	2,044	2,576	1,031	2,046	1,727	85	1,926	2,270	2,862	1,145	2,273	1,920
86	1,783	2,102	2,649	1,060	2,104	1,777	86	1,980	2,336	2,943	1,177	2,338	1,975
87	1,834	2,161	2,725	1,090	2,164	1,827	87	2,037	2,401	3,027	1,211	2,404	2,030
88	1,884	2,222	2,801	1,120	2,225	1,878	88	2,094	2,469	3,112	1,245	2,472	2,087
89	1,938	2,284	2,879	1,151	2,287	1,931	89	2,153	2,538	3,199	1,279	2,541	2,146
90	1,991	2,347	2,958	1,184	2,349	1,984	90	2,212	2,608	3,286	1,315	2,610	2,205
91	2,045	2,411	3,038	1,216	2,413	2,038	91	2,271	2,679	3,376	1,351	2,681	2,265
92	2,100	2,475	3,120	1,248	2,478	2,092	92	2,333	2,750	3,466	1,386	2,754	2,325
93	2,156	2,542	3,203	1,281	2,545	2,149	93	2,395	2,825	3,559	1,424	2,828	2,388
94	2,212	2,608	3,287	1,316	2,611	2,206	94	2,458	2,898	3,652	1,462	2,902	2,451
95	2,270	2,677	3,374	1,350	2,680	2,263	95	2,523	2,974	3,748	1,500	2,978	2,515
96	2,329	2,746	3,461	1,384	2,749	2,321	96	2,588	3,050	3,846	1,538	3,054	2,579
97	2,388	2,816	3,550	1,420	2,819	2,381	97	2,653	3,129	3,944	1,578	3,132	2,645
98	2,449	2,887	3,639	1,456	2,890	2,441	98	2,722	3,207	4,044	1,618	3,212	2,712
99+	2,510	2,960	3,729	1,492	2,963	2,502	99+	2,788	3,288	4,143	1,658	3,293	2,780

Modal Factors:

Semi-Annual: 0.5200

Quarterly: 0.2650

Monthly: 0.0833

The above rates do not include the \$20 one-time policy fee.

To calculate a Household discount:

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

Modal premium x .93 = discounted premium

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

PREMIUM INFORMATION

Continental Life Insurance Company of Brentwood, Tennessee can only raise your premium if we raise the premium for all policies like yours in this state. Premiums 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 an 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 an 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) someone with whom you have continuously resided for the past 12 months. The household discount will only be applicable if a policy for each applicant is issued. The discounted rate will be 7 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, Kentucky 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 tests, 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	100%	\$0	\$0
First \$185 of Medicare Approved amounts* Remainder of Medicare Approved amounts	\$0 80%	\$0 20%	\$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
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 \$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 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 tests, 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* Remainder of Medicare Approved amounts	\$0 80%	\$0 20%	\$185 (Part B Deductible) \$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 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

**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 tests, durable medical equipment			
First \$185 of Medicare-Approved amounts*	\$0	\$185 (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 \$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

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 tests, 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 <ul style="list-style-type: none"> •Medically necessary skilled care services and medical supplies 	100%	\$0	\$0
<ul style="list-style-type: none"> •Durable medical equipment •First \$185 of Medicare Approved amounts* 	\$0	\$185 (Part B Deductible)	\$0
<ul style="list-style-type: none"> •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 Remainder of charges	\$0 \$0	\$0 80% to a lifetime maximum benefit of \$50,000	\$250 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 21st thru 100th day 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 tests, 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 tests, 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