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Franklin, TN 37067
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Outline of Coverage

Medicare Supplement Insurance

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

Underwritten by

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

TEXAS

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	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 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 $[4800]; paid at 100% after limit reached	Out-of-pocket limit $[2400]; 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 [$2110] deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed [$2110]. 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.

ANNUAL ATTAINED AGE PREMIUMS

CONTINENTAL LIFE INSURANCE COMPANY OF BRENTWOOD, TENNESSEE

Medicare Supplement Policy
2010 Standardized Plan A

Attained Age	Preferred		Standard	
	Female	Male	Female	Male
0-64	6,116	7,034	6,795	7,818
65	1,170	1,344	1,299	1,492
66	1,170	1,344	1,299	1,492
67	1,170	1,344	1,299	1,492
68	1,226	1,411	1,363	1,568
69	1,282	1,475	1,424	1,637
70	1,334	1,532	1,481	1,703
71	1,384	1,591	1,538	1,766
72	1,431	1,645	1,591	1,830
73	1,477	1,697	1,641	1,886
74	1,519	1,747	1,688	1,941
75	1,558	1,790	1,730	1,990
76	1,593	1,832	1,771	2,035
77	1,627	1,871	1,808	2,080
78	1,660	1,908	1,843	2,119
79	1,688	1,941	1,875	2,157
80	1,714	1,971	1,906	2,191
81	1,738	2,000	1,933	2,224
82	1,763	2,028	1,959	2,252
83	1,785	2,055	1,985	2,281
84	1,808	2,078	2,008	2,310
85	1,830	2,103	2,032	2,337
86	1,850	2,126	2,056	2,364
87	1,869	2,150	2,076	2,387
88	1,887	2,171	2,097	2,412
89	1,906	2,193	2,117	2,435
90	1,922	2,212	2,137	2,457
91	1,938	2,229	2,153	2,477
92	1,954	2,247	2,170	2,496
93	1,968	2,264	2,186	2,512
94	1,980	2,277	2,200	2,529
95	1,990	2,289	2,213	2,545
96	2,004	2,302	2,226	2,559
97	2,015	2,316	2,239	2,574
98	2,027	2,330	2,251	2,591
99	2,039	2,345	2,265	2,606

Medicare Supplement Policy
2010 Standardized Plan B

Attained Age	Preferred		Standard	
	Female	Male	Female	Male
0-64	N/A	N/A	N/A	N/A
65	1,231	1,415	1,367	1,570
66	1,231	1,415	1,367	1,570
67	1,231	1,415	1,367	1,570
68	1,292	1,485	1,434	1,650
69	1,349	1,552	1,498	1,723
70	1,404	1,613	1,559	1,792
71	1,456	1,674	1,618	1,860
72	1,506	1,733	1,674	1,925
73	1,555	1,786	1,727	1,986
74	1,599	1,839	1,777	2,043
75	1,640	1,885	1,822	2,095
76	1,677	1,928	1,864	2,142
77	1,712	1,970	1,902	2,190
78	1,747	2,008	1,940	2,230
79	1,777	2,043	1,974	2,271
80	1,804	2,076	2,006	2,307
81	1,830	2,105	2,034	2,340
82	1,856	2,134	2,063	2,371
83	1,880	2,163	2,090	2,402
84	1,902	2,188	2,114	2,431
85	1,925	2,213	2,139	2,460
86	1,947	2,238	2,164	2,488
87	1,968	2,263	2,186	2,513
88	1,987	2,286	2,208	2,538
89	2,006	2,309	2,228	2,562
90	2,023	2,327	2,249	2,586
91	2,041	2,346	2,266	2,608
92	2,057	2,364	2,285	2,628
93	2,071	2,383	2,301	2,644
94	2,084	2,397	2,316	2,662
95	2,095	2,410	2,329	2,679
96	2,108	2,424	2,342	2,694
97	2,120	2,438	2,357	2,711
98	2,133	2,452	2,370	2,727
99	2,145	2,468	2,385	2,743

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

Area Factors:

Texas

770-773, 775	1.21
750-753, 760, 761, 774, 776, 777, 782, 784, 793, 794	1.15
Rest of State	1.00

To calculate household discount:

Base rate x area factor=annual premium (round to nearest whole dollar)

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

Modal premium x .95=discounted premium

The rates above do not include a one time $20 policy fee.

ANNUAL ATTAINED AGE PREMIUMS

CONTINENTAL LIFE INSURANCE COMPANY OF BRENTWOOD, TENNESSEE

Medicare Supplement Policy
2010 Standardized Plan F

Attained Age	Preferred		Standard	
	Female	Male	Female	Male
0-64	N/A	N/A	N/A	N/A
65	1,429	1,644	1,588	1,827
66	1,429	1,644	1,588	1,827
67	1,429	1,644	1,588	1,827
68	1,500	1,723	1,666	1,917
69	1,558	1,792	1,733	1,991
70	1,614	1,858	1,795	2,064
71	1,672	1,922	1,857	2,136
72	1,723	1,983	1,914	2,203
73	1,771	2,035	1,968	2,262
74	1,814	2,090	2,017	2,320
75	1,857	2,136	2,064	2,373
76	1,893	2,176	2,103	2,419
77	1,925	2,213	2,139	2,460
78	1,955	2,249	2,173	2,498
79	1,983	2,281	2,203	2,533
80	2,007	2,310	2,230	2,565
81	2,033	2,339	2,260	2,599
82	2,060	2,370	2,289	2,631
83	2,084	2,397	2,316	2,664
84	2,108	2,424	2,342	2,694
85	2,132	2,451	2,370	2,724
86	2,154	2,477	2,394	2,752
87	2,176	2,503	2,418	2,778
88	2,197	2,525	2,438	2,805
89	2,213	2,546	2,460	2,830
90	2,232	2,566	2,480	2,853
91	2,250	2,586	2,498	2,874
92	2,264	2,604	2,518	2,892
93	2,279	2,620	2,532	2,910
94	2,291	2,635	2,546	2,927
95	2,302	2,648	2,558	2,941
96	2,315	2,660	2,571	2,958
97	2,326	2,675	2,584	2,971
98	2,339	2,689	2,598	2,987
99	2,349	2,703	2,611	3,002

Medicare Supplement Policy
2010 Standardized Plan HF

Attained Age	Preferred		Standard	
	Female	Male	Female	Male
0-64	N/A	N/A	N/A	N/A
65	562	647	624	718
66	562	647	624	718
67	562	647	624	718
68	590	677	656	754
69	612	706	682	783
70	636	731	705	811
71	657	756	730	840
72	677	780	754	866
73	697	800	774	890
74	714	822	794	913
75	730	840	811	933
76	745	856	827	951
77	757	871	842	968
78	769	885	855	982
79	780	896	866	996
80	791	908	877	1,010
81	800	920	889	1,023
82	810	931	902	1,035
83	820	942	911	1,048
84	829	954	920	1,060
85	839	965	931	1,072
86	847	975	941	1,082
87	856	984	951	1,093
88	864	994	959	1,103
89	871	1,002	968	1,113
90	878	1,010	975	1,123
91	885	1,017	983	1,130
92	891	1,025	990	1,137
93	896	1,030	996	1,145
94	902	1,036	1,002	1,151
95	906	1,042	1,006	1,157
96	911	1,047	1,012	1,162
97	917	1,052	1,017	1,168
98	920	1,059	1,023	1,175
99	923	1,063	1,027	1,182

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

Area Factors:

Texas	
770-773, 775	1.21
750-753, 760, 761, 774, 776, 777, 782, 784, 793, 794	1.15
Rest of State	1.00

To calculate household discount:

Base rate x area factor=annual premium (round to nearest whole dollar)

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

Modal premium x .95=discounted premium

The rates above do not include a one time $20 policy fee.

ANNUAL ATTAINED AGE PREMIUMS

CONTINENTAL LIFE INSURANCE COMPANY OF BRENTWOOD, TENNESSEE

Medicare Supplement Policy
2010 Standardized Plan G

Attained Age	Preferred		Standard	
	Female	Male	Female	Male
0-64	N/A	N/A	N/A	N/A
65	1,251	1,439	1,391	1,598
66	1,251	1,439	1,391	1,598
67	1,251	1,439	1,391	1,598
68	1,313	1,509	1,459	1,678
69	1,373	1,578	1,526	1,753
70	1,427	1,641	1,583	1,823
71	1,481	1,702	1,645	1,892
72	1,532	1,762	1,702	1,957
73	1,580	1,818	1,757	2,019
74	1,626	1,871	1,807	2,078
75	1,668	1,918	1,853	2,129
76	1,705	1,962	1,894	2,179
77	1,742	2,003	1,936	2,226
78	1,776	2,042	1,973	2,268
79	1,807	2,078	2,007	2,309
80	1,836	2,110	2,041	2,345
81	1,862	2,142	2,069	2,379
82	1,887	2,170	2,097	2,412
83	1,911	2,199	2,124	2,443
84	1,935	2,226	2,151	2,473
85	1,958	2,252	2,176	2,503
86	1,981	2,277	2,201	2,531
87	2,000	2,301	2,223	2,557
88	2,021	2,324	2,247	2,582
89	2,041	2,346	2,266	2,607
90	2,058	2,367	2,287	2,631
91	2,076	2,387	2,307	2,652
92	2,091	2,405	2,323	2,671
93	2,105	2,422	2,340	2,690
94	2,119	2,437	2,354	2,708
95	2,132	2,451	2,369	2,724
96	2,144	2,465	2,383	2,740
97	2,157	2,481	2,396	2,755
98	2,169	2,495	2,410	2,772
99	2,183	2,510	2,425	2,789

Medicare Supplement Policy
2010 Standardized Plan N

Attained Age	Preferred		Standard	
	Female	Male	Female	Male
0-64	N/A	N/A	N/A	N/A
65	993	1,142	1,104	1,270
66	993	1,142	1,104	1,270
67	993	1,142	1,104	1,270
68	1,043	1,200	1,160	1,333
69	1,090	1,253	1,212	1,393
70	1,133	1,304	1,260	1,449
71	1,176	1,353	1,307	1,503
72	1,218	1,400	1,353	1,556
73	1,255	1,444	1,395	1,604
74	1,292	1,485	1,436	1,652
75	1,325	1,524	1,470	1,691
76	1,355	1,558	1,505	1,732
77	1,385	1,591	1,540	1,767
78	1,411	1,624	1,567	1,802
79	1,435	1,652	1,593	1,833
80	1,458	1,677	1,622	1,864
81	1,480	1,701	1,644	1,889
82	1,500	1,723	1,667	1,916
83	1,519	1,747	1,687	1,941
84	1,540	1,767	1,708	1,966
85	1,556	1,789	1,728	1,987
86	1,573	1,809	1,748	2,009
87	1,589	1,827	1,766	2,031
88	1,606	1,847	1,783	2,052
89	1,622	1,864	1,800	2,071
90	1,636	1,880	1,816	2,090
91	1,649	1,895	1,831	2,107
92	1,661	1,909	1,846	2,124
93	1,672	1,923	1,859	2,138
94	1,683	1,936	1,872	2,151
95	1,692	1,947	1,884	2,163
96	1,703	1,958	1,892	2,176
97	1,713	1,971	1,902	2,189
98	1,722	1,982	1,914	2,203
99	1,734	1,995	1,926	2,215

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

Area Factors:

Texas	
770-773, 775	1.21
750-753, 760, 761, 774, 776, 777, 782, 784, 793, 794	1.15
Rest of State	1.00

To calculate household discount:

Base rate x area factor=annual premium (round to nearest whole dollar)

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

Modal premium x .95=discounted premium

The rates above do not include a one time $20 policy fee.

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 annual 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; or (b) 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 2368, Brentwood, Tennessee 37024. 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.

LIMITATIONS AND EXCLUSIONS

This policy does not cover any expenses of the type excluded by Medicare or not covered under the terms of this policy.

Benefits covered by this policy will not duplicate Medicare benefits.

We will not be liable for any loss which was caused by your committing or attempting to commit any felony or from engaging in an illegal occupation.

REFUND OF PREMIUM

The company shall refund any premium paid for the period beyond the end of the policy month in which the death or cancellation occurred. Unearned premium shall be paid in a lump sum to your estate no later than thirty (30) days after receipt of proof of death or cancellation is received by the company.

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) – MEDICAL 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.

**$0 Indicates your liability for covered charges. You are responsible for all other non-covered charges.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [$1184]	$0	[$1184] (Part A Deductible)
61st thru 90th day	All but [$296] a day	[$296] a day	$0**
91st day and after:			
While using 60 lifetime reserve days	All but [$592] a day	[$592] 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 [$148] a day	$0	Up to [$148] 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 [$147] 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.

**$0 Indicates your liability for covered charges. You are responsible for all other non-covered charges.

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 [$147] of Medicare-Approved amounts*	$0	$0	[$147] (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 [$147] of Medicare-Approved amounts*	$0	$0	[$147] (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 [$147] of Medicare Approved amounts*	$0	$0	[$147] (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.

**$0 Indicates your liability for covered charges. You are responsible for all other non-covered charges.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [$1184]	[$1184] (Part A Deductible)	$0**
61st thru 90th day	All but [$296] a day	[$296] a day	$0**
91st day and after:			
While using 60 lifetime reserve days	All but [$592] a day	[$592] 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 [$148] a day	$0	Up to [$148] 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 [$147] 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.

**$0 Indicates your liability for covered charges. You are responsible for all other non-covered charges.

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 [$147] of Medicare-Approved amounts*	$0	$0	[$147] (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 [$147] of Medicare-Approved amounts*	$0	$0	[$147] (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 [$147] of Medicare Approved amounts*	$0	$0	[$147] (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.

**$0 Indicates your liability for covered charges. You are responsible for all other non-covered charges.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [$1184]	[$1184] (Part A Deductible)	$0**
61st thru 90th day	All but [$296] a day	[$296] a day	$0**
91st day and after			
While using 60 lifetime reserve days	All but [$592] a day	[$592] 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 [$148] a day	Up to [$148] 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 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 [$147] 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.

**$0 Indicates your liability for covered charges. You are responsible for all other non-covered charges.

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 [$147] of Medicare-Approved amounts*	$0	[$147] (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 [$147] of Medicare-Approved amounts*	$0	[$147] (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 [$147] of Medicare Approved amounts*	$0	[$147] (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 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.

**$0 Indicates your liability for covered charges. You are responsible for all other non-covered charges.

*****This high deductible plan pays the same benefits as Plan F after one has paid a calendar year [$2110] deductible. Benefits from high deductible Plan F will not begin until out-of-pocket expenses are [$2110]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.**

SERVICES	MEDICARE PAYS	AFTER YOU PAY [$2110] DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO [$2110] DEDUCTIBLE*** YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [$1184]	[$1184] (Part A Deductible)	$0**
61st thru 90th day	All but [$296] a day	[$296] a day	$0**
91st day and after			
While using 60 lifetime reserve days	All but [$592] a day	[$592] 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 [$148] a day	Up to [$148] 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 Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

(continued)

+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 [$147] 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.

**$0 Indicates your liability for covered charges. You are responsible for all other non-covered charges.

****This high deductible plan pays the same benefits as Plan F after one has paid a calendar year [$2110] deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed [$2110]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.**

SERVICES	MEDICARE PAYS	AFTER YOU PAY [$2110] DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO [$2110] 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 [$147] of Medicare-Approved amounts*	$0	[$147] (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 [$147] of Medicare-Approved amounts*	$0	[$147] (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 [$2110] DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO [$2110] DEDUCTIBLE*** YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0**
Durable medical equipment			
First [$147] of Medicare Approved amounts*	$0	[$147] (Part B Deductible)	$0**
Remainder of Medicare Approved amounts	80%	20%	$0**

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY [$2110] DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO [$2110] 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.

**$0 Indicates your liability for covered charges. You are responsible for all other non-covered charges.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [$1184]	[$1184] (Part A Deductible)	$0**
61st thru 90th day	All but [$296] a day	[$296] a day	$0**
91st day and after			
While using 60 lifetime reserve days	All but [$592] a day	[$592] 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 [$148] a day	Up to [$148] a day	$0**
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0**
Additional amounts	100%	$0	$0**
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness services	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$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 [$147] 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.

**$0 Indicates your liability for covered charges. You are responsible for all other non-covered charges.

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 [$147] of Medicare-Approved amounts*	$0	$0	[$147] (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 [$147] of Medicare-Approved amounts*	$0	$0	[$147] (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 [$147] of Medicare Approved amounts*	$0	$0	[$147] (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.

**$0 Indicates your liability for covered charges. You are responsible for all other non-covered charges.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [$1184]	[$1184] (Part A Deductible)	$0**
61st thru 90th day	All but [$296] a day	[$296] a day	$0**
91st day and after			
While using 60 lifetime reserve days	All but [$592] a day	[$592] 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 [$148] a day	Up to [$148] 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 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 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 [$147] 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.

**$0 Indicates your liability for covered charges. You are responsible for all other non-covered charges.

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 [$147] of Medicare-Approved amounts*	$0	$0	[$147] (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 [$147] of Medicare-Approved amounts*	$0	$0	[$147] (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 [$147] of Medicare Approved amounts*	$0	$0	[$147] (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