United American Application Packet

Thank you for your interest in applying for the United American Insurance Company Medicare Supplement plan!

This application packet provides you with access to a printable copy of the Enrollment Form and the Outline of Coverage in addition to a link to the Choosing a Medigap Policy Guide.

Should you decide to apply by secure upload/mail/fax/email, the printable application needs to be reviewed and signed by an Agent before it can be submitted to United American Insurance Company. You may email, fax or mail it in to CDA Insurance:

- Fax: 1.541.284.2994
- Email: cs@cda-insurance.com
- Secure File Upload: Click here
- Mail: CDA Insurance LLC
  PO Box 26540
  Eugene, Oregon 97402

Other Important Information
Download Medicare's Choosing a Medigap Policy Guide (.pdf) Download Policy Outline (.pdf) Download Application (.pdf)

Our website: https://medicare-washington.com

If you should have any questions on the application, please call us at 1.800.884.2343 or 1.541.434.9613.

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, copayments 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 $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: 970-972

Female Rates

Rates Effective 6/1/2018

Attained Age	Preferred					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
0 - 64	1,694	2,136	2,549	974	2,061	1,723
65	1,694	2,136	2,549	974	2,061	1,723
66	1,694	2,136	2,549	974	2,061	1,723
67	1,694	2,136	2,549	974	2,061	1,723
68	1,768	2,225	2,654	1,016	2,146	1,796
69	1,846	2,326	2,758	1,056	2,228	1,878
70	1,919	2,420	2,859	1,095	2,310	1,951
71	1,994	2,509	2,958	1,131	2,391	2,026
72	2,063	2,598	3,051	1,168	2,465	2,098
73	2,125	2,680	3,133	1,199	2,533	2,165
74	2,190	2,759	3,214	1,233	2,600	2,225
75	2,245	2,829	3,285	1,258	2,659	2,284
76	2,298	2,891	3,351	1,284	2,708	2,336
77	2,345	2,951	3,410	1,305	2,758	2,388
78	2,388	3,010	3,461	1,326	2,796	2,434
79	2,431	3,064	3,513	1,345	2,836	2,476
80	2,471	3,114	3,554	1,361	2,874	2,516
81	2,506	3,153	3,601	1,379	2,910	2,550
82	2,539	3,199	3,646	1,398	2,948	2,584
83	2,574	3,243	3,690	1,413	2,981	2,619
84	2,605	3,279	3,730	1,429	3,016	2,654
85	2,634	3,320	3,775	1,448	3,051	2,681
86	2,663	3,356	3,810	1,459	3,080	2,710
87	2,693	3,393	3,851	1,475	3,115	2,739
88	2,719	3,428	3,886	1,490	3,139	2,769
89	2,744	3,460	3,919	1,500	3,168	2,795
90	2,769	3,486	3,953	1,514	3,194	2,819
91	2,790	3,519	3,984	1,525	3,219	2,840
92	2,814	3,546	4,009	1,535	3,239	2,863
93	2,833	3,571	4,038	1,549	3,264	2,883
94	2,853	3,591	4,053	1,554	3,276	2,903
95	2,866	3,613	4,075	1,561	3,295	2,920
96	2,886	3,634	4,099	1,570	3,314	2,936
97	2,903	3,658	4,119	1,579	3,329	2,951
98	2,918	3,678	4,143	1,588	3,348	2,968
99	2,936	3,700	4,160	1,593	3,363	2,989

Attained Age	Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
0 - 64	1,884	2,376	2,833	1,084	2,290	1,919
65	1,884	2,376	2,833	1,084	2,290	1,919
66	1,884	2,376	2,833	1,084	2,290	1,919
67	1,884	2,376	2,833	1,084	2,290	1,919
68	1,964	2,476	2,949	1,129	2,381	1,998
69	2,049	2,583	3,066	1,178	2,479	2,089
70	2,131	2,685	3,176	1,216	2,568	2,170
71	2,213	2,790	3,285	1,258	2,659	2,251
72	2,290	2,889	3,388	1,299	2,738	2,330
73	2,363	2,976	3,483	1,335	2,815	2,405
74	2,431	3,064	3,573	1,371	2,886	2,478
75	2,491	3,139	3,654	1,399	2,951	2,535
76	2,548	3,214	3,721	1,425	3,009	2,595
77	2,605	3,281	3,785	1,451	3,061	2,654
78	2,655	3,345	3,845	1,475	3,108	2,704
79	2,704	3,405	3,901	1,493	3,150	2,750
80	2,744	3,460	3,948	1,513	3,191	2,795
81	2,783	3,508	4,000	1,531	3,231	2,835
82	2,820	3,558	4,051	1,554	3,275	2,873
83	2,859	3,601	4,101	1,570	3,315	2,910
84	2,894	3,648	4,148	1,588	3,351	2,943
85	2,924	3,688	4,194	1,606	3,390	2,979
86	2,961	3,729	4,236	1,624	3,424	3,014
87	2,993	3,766	4,279	1,638	3,456	3,046
88	3,019	3,805	4,316	1,654	3,489	3,074
89	3,049	3,841	4,356	1,668	3,521	3,106
90	3,076	3,878	4,390	1,681	3,548	3,133
91	3,101	3,906	4,425	1,694	3,574	3,155
92	3,125	3,938	4,456	1,709	3,603	3,184
93	3,146	3,965	4,484	1,715	3,623	3,204
94	3,168	3,993	4,509	1,728	3,645	3,228
95	3,189	4,016	4,530	1,735	3,661	3,245
96	3,204	4,040	4,551	1,741	3,679	3,264
97	3,225	4,061	4,574	1,754	3,699	3,281
98	3,244	4,085	4,600	1,763	3,718	3,299
99	3,265	4,113	4,626	1,770	3,738	3,321

Modal Factors: Semi-Annual: 0.5200 Quarterly: 0.2650 Monthly: 0.0833

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

To calculate a Household discount:

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

Modal premium x .95 = discounted premium

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

Continental Life Insurance Company of Brentwood, Tennessee

Annual Attained Age Premiums

For Use in ZIP Codes: 970-972

Male Rates

Rates Effective 6/1/2018

Attained Age	Preferred					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
0 - 64	1,950	2,455	2,933	1,123	2,370	1,984
65	1,950	2,455	2,933	1,123	2,370	1,984
66	1,950	2,455	2,933	1,123	2,370	1,984
67	1,950	2,455	2,933	1,123	2,370	1,984
68	2,031	2,560	3,051	1,168	2,465	2,069
69	2,123	2,676	3,174	1,216	2,564	2,163
70	2,208	2,781	3,290	1,259	2,659	2,249
71	2,291	2,889	3,404	1,305	2,751	2,330
72	2,370	2,988	3,513	1,345	2,836	2,411
73	2,446	3,080	3,604	1,379	2,915	2,489
74	2,516	3,170	3,698	1,416	2,989	2,560
75	2,580	3,249	3,781	1,450	3,056	2,624
76	2,636	3,324	3,851	1,475	3,115	2,685
77	2,694	3,395	3,919	1,500	3,168	2,741
78	2,750	3,461	3,983	1,525	3,219	2,798
79	2,795	3,523	4,039	1,549	3,265	2,846
80	2,840	3,578	4,088	1,564	3,304	2,891
81	2,879	3,630	4,143	1,588	3,348	2,934
82	2,920	3,679	4,194	1,606	3,390	2,971
83	2,959	3,728	4,243	1,626	3,430	3,010
84	2,993	3,769	4,294	1,641	3,470	3,048
85	3,030	3,816	4,340	1,663	3,508	3,086
86	3,064	3,859	4,385	1,680	3,545	3,118
87	3,094	3,903	4,430	1,695	3,581	3,150
88	3,129	3,940	4,469	1,713	3,613	3,188
89	3,153	3,979	4,509	1,728	3,645	3,215
90	3,189	4,014	4,545	1,740	3,674	3,243
91	3,210	4,044	4,575	1,754	3,700	3,268
92	3,235	4,074	4,608	1,766	3,724	3,291
93	3,259	4,108	4,639	1,778	3,750	3,316
94	3,276	4,133	4,668	1,789	3,774	3,336
95	3,296	4,158	4,690	1,796	3,789	3,356
96	3,318	4,181	4,711	1,806	3,806	3,375
97	3,335	4,203	4,735	1,814	3,828	3,395
98	3,356	4,229	4,758	1,823	3,845	3,418
99	3,375	4,253	4,783	1,833	3,865	3,435

Attained Age	Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
0 - 64	2,166	2,730	3,255	1,248	2,633	2,205
65	2,166	2,730	3,255	1,248	2,633	2,205
66	2,166	2,730	3,255	1,248	2,633	2,205
67	2,166	2,730	3,255	1,248	2,633	2,205
68	2,259	2,844	3,391	1,299	2,739	2,299
69	2,356	2,971	3,524	1,349	2,846	2,403
70	2,451	3,090	3,654	1,399	2,951	2,498
71	2,546	3,206	3,781	1,450	3,056	2,590
72	2,634	3,320	3,901	1,493	3,150	2,681
73	2,719	3,423	4,001	1,534	3,235	2,765
74	2,795	3,523	4,105	1,575	3,318	2,846
75	2,864	3,609	4,203	1,610	3,395	2,918
76	2,934	3,691	4,281	1,639	3,460	2,986
77	2,994	3,776	4,356	1,668	3,521	3,048
78	3,051	3,844	4,420	1,693	3,574	3,108
79	3,106	3,915	4,484	1,715	3,623	3,161
80	3,153	3,978	4,540	1,740	3,673	3,214
81	3,200	4,034	4,601	1,763	3,721	3,259
82	3,244	4,086	4,658	1,785	3,764	3,303
83	3,289	4,141	4,715	1,806	3,810	3,346
84	3,328	4,191	4,770	1,828	3,856	3,390
85	3,366	4,240	4,824	1,846	3,901	3,424
86	3,405	4,290	4,874	1,866	3,940	3,463
87	3,435	4,334	4,918	1,884	3,978	3,501
88	3,475	4,375	4,964	1,904	4,014	3,538
89	3,508	4,418	5,011	1,919	4,046	3,571
90	3,534	4,455	5,050	1,935	4,083	3,603
91	3,570	4,496	5,090	1,949	4,115	3,633
92	3,599	4,529	5,121	1,963	4,141	3,661
93	3,621	4,558	5,154	1,974	4,164	3,685
94	3,645	4,590	5,181	1,985	4,189	3,706
95	3,663	4,618	5,206	1,995	4,210	3,728
96	3,688	4,645	5,236	2,005	4,234	3,751
97	3,706	4,673	5,260	2,014	4,253	3,775
98	3,729	4,701	5,288	2,025	4,274	3,799
99	3,751	4,728	5,315	2,035	4,296	3,818

Modal Factors: Semi-Annual: 0.5200 Quarterly: 0.2650 Monthly: 0.0833

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

To calculate a Household discount:

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

Modal premium x .95 = discounted premium

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

Continental Life Insurance Company of Brentwood, Tennessee

Annual Attained Age Premiums

For Use in ZIP Codes: Rest of state

Female Rates

Rates Effective 6/1/2018

Attained Age	Preferred					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
0 - 64	1,558	1,965	2,345	896	1,896	1,585
65	1,558	1,965	2,345	896	1,896	1,585
66	1,558	1,965	2,345	896	1,896	1,585
67	1,558	1,965	2,345	896	1,896	1,585
68	1,626	2,047	2,441	935	1,975	1,653
69	1,699	2,140	2,537	972	2,049	1,727
70	1,765	2,226	2,630	1,007	2,125	1,795
71	1,834	2,308	2,721	1,041	2,200	1,864
72	1,898	2,390	2,807	1,074	2,268	1,930
73	1,955	2,466	2,882	1,103	2,330	1,992
74	2,015	2,538	2,957	1,134	2,392	2,047
75	2,065	2,602	3,022	1,157	2,446	2,101
76	2,114	2,660	3,083	1,181	2,491	2,149
77	2,157	2,715	3,137	1,201	2,537	2,197
78	2,197	2,769	3,184	1,220	2,573	2,239
79	2,237	2,819	3,232	1,237	2,609	2,278
80	2,274	2,865	3,269	1,252	2,644	2,315
81	2,306	2,900	3,313	1,268	2,677	2,346
82	2,336	2,943	3,355	1,286	2,712	2,377
83	2,368	2,983	3,395	1,300	2,743	2,409
84	2,397	3,016	3,432	1,314	2,775	2,441
85	2,423	3,054	3,473	1,332	2,807	2,467
86	2,450	3,088	3,505	1,342	2,834	2,493
87	2,477	3,121	3,543	1,357	2,866	2,520
88	2,501	3,153	3,575	1,371	2,888	2,547
89	2,524	3,183	3,605	1,380	2,914	2,571
90	2,547	3,207	3,636	1,393	2,938	2,593
91	2,567	3,237	3,665	1,403	2,961	2,613
92	2,589	3,263	3,688	1,412	2,980	2,634
93	2,606	3,286	3,715	1,425	3,003	2,652
94	2,624	3,304	3,728	1,429	3,014	2,670
95	2,637	3,324	3,749	1,436	3,031	2,686
96	2,655	3,343	3,771	1,444	3,049	2,701
97	2,670	3,365	3,789	1,452	3,062	2,715
98	2,684	3,383	3,811	1,461	3,080	2,730
99	2,701	3,404	3,827	1,465	3,094	2,750

Attained Age	Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
0 - 64	1,733	2,186	2,606	997	2,107	1,765
65	1,733	2,186	2,606	997	2,107	1,765
66	1,733	2,186	2,606	997	2,107	1,765
67	1,733	2,186	2,606	997	2,107	1,765
68	1,807	2,278	2,713	1,038	2,191	1,838
69	1,885	2,376	2,821	1,083	2,280	1,922
70	1,961	2,470	2,922	1,119	2,362	1,996
71	2,036	2,567	3,022	1,157	2,446	2,071
72	2,107	2,658	3,117	1,195	2,519	2,144
73	2,174	2,738	3,204	1,228	2,590	2,213
74	2,237	2,819	3,287	1,262	2,655	2,279
75	2,292	2,888	3,361	1,287	2,715	2,332
76	2,344	2,957	3,424	1,311	2,768	2,387
77	2,397	3,019	3,482	1,335	2,816	2,441
78	2,443	3,077	3,537	1,357	2,859	2,487
79	2,487	3,133	3,589	1,373	2,898	2,530
80	2,524	3,183	3,632	1,392	2,936	2,571
81	2,560	3,227	3,680	1,409	2,973	2,608
82	2,594	3,273	3,727	1,429	3,013	2,643
83	2,630	3,313	3,773	1,444	3,050	2,677
84	2,662	3,356	3,816	1,461	3,083	2,707
85	2,690	3,393	3,858	1,478	3,119	2,740
86	2,724	3,430	3,897	1,494	3,150	2,773
87	2,753	3,465	3,936	1,507	3,180	2,803
88	2,777	3,501	3,971	1,521	3,210	2,828
89	2,805	3,534	4,008	1,534	3,240	2,858
90	2,830	3,567	4,039	1,547	3,264	2,882
91	2,853	3,594	4,071	1,558	3,288	2,903
92	2,875	3,623	4,100	1,572	3,314	2,929
93	2,895	3,648	4,125	1,578	3,333	2,947
94	2,914	3,673	4,148	1,589	3,353	2,969
95	2,934	3,695	4,168	1,596	3,368	2,985
96	2,947	3,717	4,187	1,602	3,384	3,003
97	2,967	3,736	4,208	1,613	3,403	3,019
98	2,984	3,758	4,232	1,622	3,420	3,035
99	3,004	3,784	4,256	1,628	3,439	3,056

Modal Factors: Semi-Annual: 0.5200 Quarterly: 0.2650 Monthly: 0.0833

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

To calculate a Household discount:

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

Modal premium x .95 = discounted premium

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

Continental Life Insurance Company of Brentwood, Tennessee

Annual Attained Age Premiums

For Use in ZIP Codes: Rest of state

Male Rates

Rates Effective 6/1/2018

Attained Age	Preferred					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
0 - 64	1,794	2,259	2,698	1,033	2,180	1,825
65	1,794	2,259	2,698	1,033	2,180	1,825
66	1,794	2,259	2,698	1,033	2,180	1,825
67	1,794	2,259	2,698	1,033	2,180	1,825
68	1,869	2,355	2,807	1,074	2,268	1,903
69	1,953	2,462	2,920	1,119	2,359	1,990
70	2,031	2,559	3,027	1,158	2,446	2,069
71	2,108	2,658	3,131	1,201	2,531	2,144
72	2,180	2,749	3,232	1,237	2,609	2,218
73	2,251	2,834	3,315	1,268	2,682	2,290
74	2,315	2,916	3,402	1,303	2,750	2,355
75	2,374	2,989	3,479	1,334	2,812	2,414
76	2,425	3,058	3,543	1,357	2,866	2,470
77	2,478	3,123	3,605	1,380	2,914	2,522
78	2,530	3,184	3,664	1,403	2,961	2,574
79	2,571	3,241	3,716	1,425	3,004	2,619
80	2,613	3,291	3,761	1,439	3,039	2,660
81	2,648	3,340	3,811	1,461	3,080	2,699
82	2,686	3,384	3,858	1,478	3,119	2,734
83	2,722	3,429	3,903	1,496	3,156	2,769
84	2,753	3,467	3,950	1,510	3,192	2,804
85	2,788	3,511	3,993	1,530	3,227	2,839
86	2,819	3,550	4,034	1,546	3,261	2,868
87	2,846	3,590	4,076	1,559	3,295	2,898
88	2,878	3,625	4,111	1,576	3,324	2,933
89	2,900	3,660	4,148	1,589	3,353	2,958
90	2,934	3,693	4,181	1,601	3,380	2,983
91	2,953	3,720	4,209	1,613	3,404	3,006
92	2,976	3,748	4,239	1,625	3,426	3,028
93	2,998	3,779	4,268	1,635	3,450	3,051
94	3,014	3,802	4,294	1,646	3,472	3,069
95	3,033	3,825	4,315	1,653	3,486	3,088
96	3,052	3,847	4,334	1,662	3,502	3,105
97	3,068	3,866	4,356	1,669	3,521	3,123
98	3,088	3,890	4,377	1,677	3,537	3,144
99	3,105	3,912	4,400	1,686	3,556	3,160

Attained Age	Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
0 - 64	1,993	2,512	2,995	1,148	2,422	2,029
65	1,993	2,512	2,995	1,148	2,422	2,029
66	1,993	2,512	2,995	1,148	2,422	2,029
67	1,993	2,512	2,995	1,148	2,422	2,029
68	2,078	2,616	3,120	1,195	2,520	2,115
69	2,168	2,734	3,242	1,241	2,619	2,210
70	2,255	2,843	3,361	1,287	2,715	2,298
71	2,343	2,950	3,479	1,334	2,812	2,383
72	2,423	3,054	3,589	1,373	2,898	2,467
73	2,501	3,149	3,681	1,411	2,976	2,544
74	2,571	3,241	3,777	1,449	3,052	2,619
75	2,635	3,320	3,866	1,481	3,123	2,684
76	2,699	3,396	3,939	1,508	3,183	2,747
77	2,754	3,474	4,008	1,534	3,240	2,804
78	2,807	3,536	4,066	1,557	3,288	2,859
79	2,858	3,602	4,125	1,578	3,333	2,908
80	2,900	3,659	4,177	1,601	3,379	2,957
81	2,944	3,711	4,233	1,622	3,424	2,998
82	2,984	3,759	4,285	1,642	3,463	3,038
83	3,026	3,810	4,338	1,662	3,505	3,079
84	3,061	3,856	4,388	1,681	3,548	3,119
85	3,097	3,901	4,438	1,699	3,589	3,150
86	3,133	3,947	4,484	1,717	3,625	3,186
87	3,160	3,987	4,524	1,733	3,659	3,221
88	3,197	4,025	4,567	1,751	3,693	3,255
89	3,227	4,064	4,610	1,765	3,723	3,286
90	3,251	4,099	4,646	1,780	3,756	3,314
91	3,284	4,137	4,683	1,793	3,786	3,342
92	3,311	4,166	4,712	1,806	3,810	3,368
93	3,332	4,193	4,741	1,816	3,831	3,390
94	3,353	4,223	4,767	1,826	3,854	3,410
95	3,370	4,248	4,790	1,835	3,873	3,429
96	3,393	4,273	4,817	1,845	3,895	3,451
97	3,410	4,299	4,839	1,853	3,912	3,473
98	3,430	4,325	4,865	1,863	3,932	3,495
99	3,451	4,349	4,890	1,872	3,953	3,512

Modal Factors: Semi-Annual: 0.5200 Quarterly: 0.2650 Monthly: 0.0833

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

To calculate a Household discount:

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

Modal premium x .95 = discounted premium

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

DISCLOSURES

Use this outline to compare benefits and premium among policies.

READ YOUR POLICY VERY CAREFULLY

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

RIGHT TO RETURN POLICY

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

POLICY REPLACEMENT

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

NOTICE

The policy may not cover all of your medical costs.

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

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

COMPLETE ANSWERS ARE VERY IMPORTANT

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

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

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

PLAN A

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1364	$0	$1364 (Part A Deductible)
61st thru 90th day	All but $341 a day	$341 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $682 a day	$682 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 $170.50 a day	$0	Up to $170.50 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 $185 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic test, durable medical equipment			
First $185 of Medicare-Approved amounts*	$0	$0	$185 (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 $185 of Medicare-Approved amounts*	$0	$0	$185 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

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 B

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1364	$1364 (Part A Deductible)	$0
61st thru 90th day	All but $341 a day	$341 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $682 a day	$682 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 $170.50 a day	$0	Up to $170.50 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 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*	$0	$0	$185 (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 $185 of Medicare-Approved amounts*	$0	$0	$185 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

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
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1364	$1364 (Part A Deductible)	$0
61st thru 90th day	All but $341 a day	$341 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $682 a day	$682 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 $170.50 a day	Up to $170.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited 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 test, 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
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

HIGH DEDUCTIBLE PLAN F

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

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

*****This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $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	All but $1364	$1364 (Part A Deductible)	$0
61st thru 90th day	All but $341 a day	$341 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $682 a day	$682 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 $170.50 a day	Up to $170.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0

HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited 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.

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*	$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

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
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1364	$1364 (Part A Deductible)	$0
61st thru 90th day	All but $341 a day	$341 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $682 a day	$682 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 $170.50 a day	Up to $170.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness services	All but very limited 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 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*	$0	$0	$185 (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 $185 of Medicare-Approved amounts*	$0	$0	$185 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

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 G

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

PLAN N

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1364	$1364 (Part A Deductible)	$0
61st thru 90th day	All but $341 a day	$341 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $682 a day	$682 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 $170.50 a day	Up to $170.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness services	All but very limited 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 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
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic test, durable medical equipment			
First $185 of Medicare-Approved amounts*	$0	$0	$185 (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 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.	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 $185 of Medicare-Approved amounts*	$0	$0	$185 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

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