Aetna Application Packet

Thank you for your interest in the Aetna 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 Aetna. You may upload, 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-oregon.com

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

Outline of coverage

Medicare Supplement Insurance

Benefit plans: A, B, F, HF, G, N

Oregon

Underwritten by

Continental Life Insurance Company of Brentwood, Tennessee

An Aetna Company

aetnaseniorproducts.com

CLIMS05023OR

Rates effective: 06/2019 B

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

This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plan "A" available. Some plans may not be available. Only applicants **first** eligible for Medicare before 2020 may purchase Plans C, F, and high deductible F.
Note: A ✓ means 100% of the benefit is paid.

Benefits	Plans Available to All Applicants								Medicare first eligible before 2020 only	
	A	B	D	G[1]	K	L	M	N	C	F[1]
Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Medicare Part B coinsurance or copayment	✓	✓	✓	✓	50%	75%	✓	✓ copays apply[3]	✓	✓
Blood (first three pints)	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Part A hospice care coinsurance or copayment	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Skilled nursing facility coinsurance			✓	✓	50%	75%	✓	✓	✓	✓
Medicare Part A deductible		✓	✓	✓	50%	75%	50%	✓	✓	✓
Medicare Part B deductible									✓	✓
Medicare Part B excess charges				✓						✓
Foreign travel emergency (up to plan limits)			✓	✓			✓	✓	✓	✓
Out-of-pocket limit in 2020[2]					$5,880[2]	$2,940[2]				

[1] Plans F and G also have a high deductible option, which require first paying a plan deductible of $2,340 before the plan begins to pay. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High deductible plan G does not cover the Medicare Part B deductible. However, high deductible plans F and G count your payment of the Medicare Part B deductible toward meeting the plan deductible.

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

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

Continental Life Insurance Company of Brentwood, Tennessee

Annual Attained Age Premiums
For Use in ZIP Codes: 970-972
Female Rates

Rates Effective 6/1/2019

Attained Age	Preferred					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
0 - 64	1,846	2,329	2,779	1,061	2,246	1,878
65	1,846	2,329	2,779	1,061	2,246	1,878
66	1,846	2,329	2,779	1,061	2,246	1,878
67	1,846	2,329	2,779	1,061	2,246	1,878
68	1,926	2,425	2,893	1,108	2,340	1,958
69	2,013	2,535	3,006	1,151	2,428	2,046
70	2,091	2,638	3,116	1,194	2,518	2,126
71	2,174	2,735	3,224	1,233	2,606	2,209
72	2,249	2,831	3,326	1,273	2,686	2,286
73	2,316	2,921	3,415	1,306	2,760	2,360
74	2,388	3,008	3,503	1,344	2,834	2,425
75	2,448	3,084	3,581	1,371	2,898	2,489
76	2,504	3,151	3,653	1,399	2,951	2,546
77	2,556	3,216	3,718	1,423	3,006	2,603
78	2,603	3,281	3,773	1,445	3,048	2,653
79	2,650	3,340	3,829	1,466	3,091	2,699
80	2,694	3,394	3,874	1,484	3,133	2,743
81	2,731	3,436	3,925	1,503	3,173	2,780
82	2,768	3,486	3,975	1,524	3,213	2,816
83	2,805	3,534	4,023	1,540	3,250	2,855
84	2,840	3,574	4,066	1,558	3,288	2,893
85	2,871	3,619	4,115	1,578	3,326	2,923
86	2,903	3,659	4,153	1,590	3,358	2,954
87	2,935	3,698	4,198	1,608	3,395	2,985
88	2,964	3,736	4,236	1,624	3,421	3,018
89	2,991	3,771	4,271	1,635	3,453	3,046
90	3,018	3,800	4,309	1,650	3,481	3,073
91	3,041	3,835	4,343	1,663	3,509	3,095
92	3,068	3,865	4,370	1,674	3,530	3,120
93	3,088	3,893	4,401	1,689	3,558	3,143
94	3,109	3,915	4,418	1,694	3,571	3,164
95	3,124	3,938	4,441	1,701	3,591	3,183
96	3,146	3,961	4,468	1,711	3,613	3,200
97	3,164	3,986	4,490	1,721	3,629	3,216
98	3,180	4,009	4,515	1,730	3,649	3,235
99	3,200	4,033	4,535	1,736	3,665	3,258

Modal Factors: Semi-Annual: 0.5200

Attained Age	Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
0 - 64	2,054	2,590	3,088	1,181	2,496	2,091
65	2,054	2,590	3,088	1,181	2,496	2,091
66	2,054	2,590	3,088	1,181	2,496	2,091
67	2,054	2,590	3,088	1,181	2,496	2,091
68	2,140	2,699	3,214	1,230	2,595	2,178
69	2,234	2,815	3,343	1,284	2,701	2,276
70	2,323	2,926	3,463	1,326	2,799	2,365
71	2,411	3,041	3,581	1,371	2,898	2,454
72	2,496	3,149	3,693	1,416	2,984	2,540
73	2,575	3,244	3,796	1,455	3,069	2,621
74	2,650	3,340	3,894	1,495	3,146	2,700
75	2,715	3,421	3,983	1,525	3,216	2,764
76	2,776	3,503	4,056	1,554	3,280	2,829
77	2,840	3,576	4,126	1,581	3,336	2,893
78	2,894	3,646	4,191	1,608	3,388	2,948
79	2,948	3,711	4,253	1,626	3,434	2,998
80	2,991	3,771	4,303	1,649	3,479	3,046
81	3,033	3,824	4,360	1,669	3,523	3,090
82	3,074	3,878	4,416	1,694	3,570	3,131
83	3,116	3,925	4,470	1,711	3,614	3,173
84	3,154	3,976	4,521	1,730	3,653	3,208
85	3,188	4,020	4,571	1,751	3,695	3,246
86	3,228	4,064	4,618	1,770	3,733	3,285
87	3,261	4,105	4,664	1,785	3,768	3,320
88	3,290	4,148	4,705	1,803	3,803	3,350
89	3,324	4,188	4,749	1,818	3,839	3,386
90	3,353	4,226	4,785	1,833	3,866	3,415
91	3,380	4,258	4,824	1,846	3,895	3,439
92	3,406	4,293	4,858	1,863	3,926	3,470
93	3,430	4,321	4,888	1,869	3,949	3,493
94	3,453	4,351	4,915	1,883	3,973	3,518
95	3,476	4,378	4,938	1,891	3,991	3,538
96	3,493	4,404	4,961	1,898	4,010	3,558
97	3,515	4,426	4,985	1,911	4,031	3,576
98	3,536	4,453	5,014	1,921	4,053	3,596
99	3,559	4,483	5,043	1,929	4,074	3,620

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 6/1/2019

Attained	Preferred					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
0 - 64	2,125	2,676	3,196	1,224	2,584	2,163
65	2,125	2,676	3,196	1,224	2,584	2,163
66	2,125	2,676	3,196	1,224	2,584	2,163
67	2,125	2,676	3,196	1,224	2,584	2,163
68	2,214	2,790	3,326	1,273	2,686	2,255
69	2,314	2,918	3,460	1,326	2,795	2,358
70	2,406	3,031	3,586	1,373	2,898	2,451
71	2,498	3,149	3,710	1,423	2,999	2,540
72	2,584	3,256	3,829	1,466	3,091	2,629
73	2,666	3,358	3,928	1,503	3,178	2,713
74	2,743	3,455	4,030	1,544	3,258	2,790
75	2,813	3,541	4,121	1,580	3,331	2,860
76	2,874	3,623	4,198	1,608	3,395	2,926
77	2,936	3,700	4,271	1,635	3,453	2,988
78	2,998	3,773	4,341	1,663	3,509	3,049
79	3,046	3,840	4,403	1,689	3,559	3,103
80	3,095	3,900	4,455	1,705	3,601	3,151
81	3,138	3,956	4,515	1,730	3,649	3,198
82	3,183	4,010	4,571	1,751	3,695	3,239
83	3,225	4,063	4,624	1,773	3,739	3,281
84	3,261	4,108	4,680	1,789	3,783	3,321
85	3,303	4,160	4,730	1,813	3,824	3,364
86	3,340	4,206	4,780	1,831	3,864	3,398
87	3,373	4,254	4,829	1,848	3,904	3,434
88	3,410	4,295	4,871	1,866	3,938	3,475
89	3,436	4,336	4,915	1,883	3,973	3,504
90	3,476	4,375	4,954	1,896	4,005	3,534
91	3,499	4,408	4,986	1,911	4,033	3,561
92	3,526	4,440	5,023	1,925	4,059	3,588
93	3,553	4,478	5,056	1,938	4,088	3,615
94	3,571	4,505	5,088	1,950	4,114	3,636
95	3,593	4,531	5,113	1,958	4,130	3,659
96	3,616	4,558	5,135	1,969	4,149	3,679
97	3,635	4,581	5,161	1,978	4,173	3,700
98	3,659	4,609	5,186	1,986	4,191	3,725
99	3,679	4,635	5,213	1,998	4,213	3,744

Modal Factors: Semi-Annual: 0.5200

Attained	Standard					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
0 - 64	2,361	2,976	3,548	1,360	2,870	2,404
65	2,361	2,976	3,548	1,360	2,870	2,404
66	2,361	2,976	3,548	1,360	2,870	2,404
67	2,361	2,976	3,548	1,360	2,870	2,404
68	2,463	3,100	3,696	1,416	2,985	2,506
69	2,569	3,239	3,841	1,470	3,103	2,619
70	2,671	3,368	3,983	1,525	3,216	2,723
71	2,775	3,495	4,121	1,580	3,331	2,823
72	2,871	3,619	4,253	1,626	3,434	2,923
73	2,964	3,730	4,361	1,671	3,526	3,014
74	3,046	3,840	4,475	1,716	3,616	3,103
75	3,121	3,934	4,581	1,755	3,700	3,180
76	3,198	4,024	4,666	1,786	3,771	3,255
77	3,264	4,116	4,749	1,818	3,839	3,321
78	3,326	4,190	4,818	1,845	3,895	3,388
79	3,386	4,268	4,888	1,869	3,949	3,446
80	3,436	4,335	4,949	1,896	4,003	3,503
81	3,488	4,396	5,015	1,921	4,056	3,553
82	3,536	4,454	5,076	1,946	4,103	3,600
83	3,585	4,514	5,139	1,969	4,153	3,648
84	3,628	4,569	5,199	1,993	4,204	3,695
85	3,669	4,621	5,258	2,013	4,253	3,733
86	3,711	4,676	5,313	2,034	4,295	3,774
87	3,744	4,724	5,360	2,054	4,335	3,816
88	3,788	4,769	5,410	2,075	4,375	3,856
89	3,824	4,815	5,463	2,091	4,410	3,893
90	3,851	4,856	5,505	2,109	4,450	3,926
91	3,891	4,901	5,548	2,124	4,485	3,960
92	3,923	4,936	5,583	2,139	4,514	3,991
93	3,948	4,968	5,618	2,151	4,539	4,016
94	3,973	5,003	5,648	2,164	4,566	4,040
95	3,993	5,033	5,675	2,175	4,589	4,063
96	4,020	5,063	5,708	2,185	4,615	4,089
97	4,040	5,093	5,734	2,195	4,635	4,115
98	4,064	5,124	5,764	2,208	4,659	4,141
99	4,089	5,153	5,794	2,219	4,683	4,161

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 6/1/2019

Attained	Preferred					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
0 - 64	1,699	2,142	2,556	976	2,067	1,727
65	1,699	2,142	2,556	976	2,067	1,727
66	1,699	2,142	2,556	976	2,067	1,727
67	1,699	2,142	2,556	976	2,067	1,727
68	1,772	2,231	2,661	1,019	2,153	1,801
69	1,852	2,332	2,766	1,059	2,233	1,883
70	1,924	2,427	2,867	1,098	2,316	1,956
71	2,000	2,516	2,966	1,134	2,398	2,032
72	2,069	2,605	3,060	1,171	2,471	2,103
73	2,131	2,688	3,142	1,202	2,539	2,171
74	2,197	2,767	3,222	1,236	2,607	2,231
75	2,252	2,837	3,295	1,262	2,666	2,290
76	2,303	2,899	3,360	1,287	2,715	2,343
77	2,352	2,959	3,420	1,309	2,766	2,394
78	2,394	3,019	3,471	1,329	2,804	2,440
79	2,438	3,073	3,522	1,349	2,844	2,483
80	2,478	3,122	3,564	1,365	2,882	2,523
81	2,513	3,161	3,611	1,382	2,919	2,558
82	2,546	3,207	3,657	1,402	2,956	2,591
83	2,581	3,251	3,701	1,417	2,990	2,627
84	2,613	3,288	3,741	1,433	3,025	2,661
85	2,642	3,329	3,786	1,451	3,060	2,689
86	2,670	3,366	3,820	1,463	3,089	2,717
87	2,700	3,402	3,862	1,479	3,123	2,746
88	2,727	3,437	3,897	1,494	3,148	2,776
89	2,752	3,470	3,930	1,504	3,176	2,803
90	2,776	3,496	3,964	1,518	3,203	2,827
91	2,798	3,528	3,995	1,530	3,228	2,847
92	2,822	3,556	4,020	1,540	3,248	2,870
93	2,841	3,581	4,049	1,554	3,273	2,891
94	2,860	3,602	4,064	1,558	3,286	2,911
95	2,874	3,623	4,086	1,565	3,304	2,928
96	2,895	3,644	4,110	1,574	3,324	2,944
97	2,911	3,667	4,131	1,584	3,338	2,959
98	2,926	3,688	4,154	1,592	3,357	2,976
99	2,944	3,710	4,172	1,597	3,372	2,997

Modal Factors: Semi-Annual: 0.5200

Attained	Standard					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
0 - 64	1,889	2,383	2,841	1,087	2,297	1,924
65	1,889	2,383	2,841	1,087	2,297	1,924
66	1,889	2,383	2,841	1,087	2,297	1,924
67	1,889	2,383	2,841	1,087	2,297	1,924
68	1,969	2,483	2,957	1,132	2,387	2,003
69	2,055	2,590	3,075	1,181	2,485	2,094
70	2,137	2,692	3,186	1,220	2,575	2,176
71	2,218	2,798	3,295	1,262	2,666	2,257
72	2,297	2,897	3,397	1,303	2,745	2,337
73	2,369	2,984	3,493	1,339	2,823	2,412
74	2,438	3,073	3,582	1,375	2,895	2,484
75	2,498	3,148	3,664	1,403	2,959	2,543
76	2,554	3,222	3,732	1,429	3,018	2,602
77	2,613	3,290	3,796	1,455	3,069	2,661
78	2,662	3,355	3,856	1,479	3,117	2,712
79	2,712	3,414	3,912	1,496	3,159	2,758
80	2,752	3,470	3,958	1,517	3,200	2,803
81	2,790	3,518	4,011	1,535	3,241	2,843
82	2,828	3,567	4,063	1,558	3,284	2,881
83	2,867	3,611	4,112	1,574	3,325	2,919
84	2,901	3,658	4,160	1,592	3,360	2,951
85	2,933	3,698	4,206	1,611	3,399	2,987
86	2,969	3,739	4,248	1,628	3,434	3,022
87	3,000	3,777	4,291	1,642	3,466	3,054
88	3,027	3,816	4,329	1,658	3,498	3,082
89	3,058	3,853	4,369	1,672	3,532	3,115
90	3,084	3,888	4,402	1,686	3,557	3,142
91	3,110	3,917	4,438	1,699	3,583	3,164
92	3,134	3,949	4,469	1,714	3,612	3,192
93	3,156	3,976	4,497	1,719	3,633	3,213
94	3,176	4,003	4,522	1,732	3,655	3,236
95	3,198	4,027	4,543	1,740	3,672	3,255
96	3,213	4,051	4,564	1,746	3,689	3,273
97	3,234	4,072	4,586	1,758	3,709	3,290
98	3,253	4,096	4,613	1,768	3,728	3,309
99	3,274	4,124	4,639	1,774	3,748	3,330

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 6/1/2019

Attained Age	Preferred					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
0 - 64	1,955	2,462	2,941	1,126	2,377	1,990
65	1,955	2,462	2,941	1,126	2,377	1,990
66	1,955	2,462	2,941	1,126	2,377	1,990
67	1,955	2,462	2,941	1,126	2,377	1,990
68	2,037	2,567	3,060	1,171	2,471	2,075
69	2,129	2,684	3,183	1,220	2,571	2,169
70	2,214	2,789	3,299	1,263	2,666	2,255
71	2,298	2,897	3,413	1,309	2,759	2,337
72	2,377	2,996	3,522	1,349	2,844	2,418
73	2,453	3,089	3,613	1,382	2,923	2,496
74	2,523	3,179	3,708	1,420	2,997	2,567
75	2,588	3,258	3,792	1,454	3,065	2,631
76	2,644	3,333	3,862	1,479	3,123	2,692
77	2,701	3,404	3,930	1,504	3,176	2,749
78	2,758	3,471	3,994	1,530	3,228	2,805
79	2,803	3,533	4,050	1,554	3,274	2,854
80	2,847	3,588	4,099	1,569	3,313	2,899
81	2,887	3,640	4,154	1,592	3,357	2,942
82	2,928	3,689	4,206	1,611	3,399	2,980
83	2,967	3,738	4,254	1,631	3,440	3,019
84	3,000	3,779	4,306	1,646	3,480	3,056
85	3,038	3,827	4,352	1,668	3,518	3,095
86	3,073	3,870	4,398	1,685	3,555	3,126
87	3,103	3,913	4,442	1,700	3,591	3,159
88	3,137	3,951	4,482	1,717	3,623	3,197
89	3,161	3,989	4,522	1,732	3,655	3,223
90	3,198	4,025	4,557	1,745	3,685	3,251
91	3,219	4,055	4,587	1,758	3,710	3,276
92	3,244	4,085	4,621	1,771	3,734	3,301
93	3,268	4,119	4,652	1,783	3,761	3,326
94	3,286	4,145	4,681	1,794	3,785	3,345
95	3,305	4,169	4,704	1,801	3,800	3,366
96	3,327	4,193	4,724	1,811	3,817	3,384
97	3,344	4,215	4,748	1,819	3,839	3,404
98	3,366	4,240	4,771	1,827	3,856	3,427
99	3,384	4,264	4,796	1,838	3,876	3,444

Modal Factors: Semi-Annual: 0.5200

Attained Age	Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
0 - 64	2,172	2,738	3,264	1,251	2,640	2,211
65	2,172	2,738	3,264	1,251	2,640	2,211
66	2,172	2,738	3,264	1,251	2,640	2,211
67	2,172	2,738	3,264	1,251	2,640	2,211
68	2,266	2,852	3,401	1,303	2,746	2,306
69	2,363	2,980	3,534	1,352	2,854	2,409
70	2,458	3,098	3,664	1,403	2,959	2,505
71	2,553	3,215	3,792	1,454	3,065	2,597
72	2,642	3,329	3,912	1,496	3,159	2,689
73	2,727	3,432	4,012	1,538	3,244	2,773
74	2,803	3,533	4,117	1,579	3,327	2,854
75	2,872	3,619	4,215	1,615	3,404	2,926
76	2,942	3,702	4,293	1,643	3,470	2,995
77	3,003	3,787	4,369	1,672	3,532	3,056
78	3,060	3,855	4,432	1,697	3,583	3,117
79	3,115	3,926	4,497	1,719	3,633	3,171
80	3,161	3,988	4,553	1,745	3,682	3,222
81	3,209	4,045	4,614	1,768	3,732	3,268
82	3,253	4,097	4,670	1,791	3,774	3,312
83	3,298	4,153	4,728	1,811	3,820	3,356
84	3,337	4,203	4,783	1,833	3,867	3,399
85	3,375	4,252	4,837	1,852	3,912	3,434
86	3,414	4,302	4,888	1,871	3,951	3,472
87	3,444	4,346	4,931	1,889	3,988	3,511
88	3,485	4,387	4,977	1,909	4,025	3,548
89	3,518	4,430	5,026	1,924	4,057	3,581
90	3,543	4,468	5,065	1,940	4,094	3,612
91	3,580	4,509	5,104	1,954	4,126	3,643
92	3,609	4,541	5,136	1,968	4,153	3,672
93	3,632	4,570	5,168	1,979	4,176	3,695
94	3,655	4,602	5,196	1,991	4,201	3,717
95	3,673	4,630	5,221	2,001	4,222	3,738
96	3,698	4,658	5,251	2,010	4,246	3,762
97	3,717	4,685	5,275	2,019	4,264	3,786
98	3,739	4,714	5,303	2,031	4,286	3,810
99	3,762	4,740	5,330	2,041	4,308	3,828

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 $1,408	$0	$1,408 (Part A Deductible)
61st thru 90th day	All but $352 a day	$352 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $704 a day	$704 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 $176 a day	$0	Up to $176 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 $198 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 $198 of Medicare-Approved amounts*	$0	$0	$198 (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 $198 of Medicare-Approved amounts*	$0	$0	$198 (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 $198 of Medicare Approved amounts*	$0	$0	$198 (Part B Deductible)
•Remainder of Medicare Approved amounts	80%	20%	$0

PLAN B

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,408	$1,408 (Part A Deductible)	$0
61st thru 90th day	All but $352 a day	$352 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $704 a day	$704 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 $176 a day	$0	Up to $176 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 $198 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 $198 of Medicare-Approved amounts*	$0	$0	$198 (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 $198 of Medicare-Approved amounts*	$0	$0	$198 (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 $198 of Medicare Approved amounts*	$0	$0	$198 (Part B Deductible)
•Remainder of Medicare Approved amounts	80%	20%	$0

PLAN F

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,408	$1,408 (Part A Deductible)	$0
61st thru 90th day	All but $352 a day	$352 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $704 a day	$704 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 $176 a day	Up to $176 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 $198 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 $198 of Medicare-Approved amounts*	$0	$198 (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 $198 of Medicare-Approved amounts*	$0	$198 (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 $198 of Medicare Approved amounts*	$0	$198 (Part B Deductible)	$0
•Remainder of Medicare Approved amounts	80%	20%	$0

PLAN F

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

HIGH DEDUCTIBLE PLAN F

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

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

*****This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2,340 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses are $2,340. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.**

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,340 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2,340 DEDUCTIBLE*** YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,408	$1,408 (Part A Deductible)	$0
61st thru 90th day	All but $352 a day	$352 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $704 a day	$704 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 $176 a day	Up to $176 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 $198 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

*****This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2,340 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses are $2,340. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.**

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,340 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2,340 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 $198 of Medicare-Approved amounts*	$0	$198 (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 $198 of Medicare-Approved amounts*	$0	$198 (Part B Deductible)	$0
Remainder of Medicare-Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

HIGH DEDUCTIBLE PLAN F

PARTS A & B

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,340 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2,340 DEDUCTIBLE*** YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
•Medically necessary skilled care services and medical supplies	100%	$0	$0
•Durable medical equipment			
•First $198 of Medicare Approved amounts*	$0	$198 (Part B Deductible)	$0
•Remainder of Medicare Approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,340 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2,340 DEDUCTIBLE** YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN G

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,408	$1,408 (Part A Deductible)	$0
61st thru 90th day	All but $352 a day	$352 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $704 a day	$704 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 $176 a day	Up to $176 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 $198 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 $198 of Medicare-Approved amounts*	$0	$0	$198 (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 $198 of Medicare-Approved amounts*	$0	$0	$198 (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 $198 of Medicare Approved amounts*	$0	$0	$198 (Part B Deductible)
•Remainder of Medicare Approved amounts	80%	20%	$0

PLAN G

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

PLAN N

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,408	$1,408 (Part A Deductible)	$0
61st thru 90th day	All but $352 a day	$352 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $704 a day	$704 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 $176 a day	Up to $176 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 $198 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 $198 of Medicare-Approved amounts*	$0	$0	$198 (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 $198 of Medicare-Approved amounts*	$0	$0	$198 (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 $198 of Medicare Approved amounts*	$0	$0	$198 (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