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, G, High Deductible F, N

Oregon

Underwritten by

Continental Life Insurance Company of Brentwood, Tennessee

An Aetna Company

aetnaseniorproducts.com

CLIMS05023OR

Rates effective: 06/2021 A

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 2021[2]					$6,220[2]	$3,110[2]				

[1] Plans F and G also have a high deductible option, which require first paying a plan deductible of $2,370 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: Rest of state

Female Rates

Rates Effective 6/1/2021

Attained	Preferred					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
0 - 64	2,000	2,522	3,010	1,064	2,433	2,033
65	2,000	2,522	3,010	1,064	2,433	2,033
66	2,000	2,522	3,010	1,064	2,433	2,033
67	2,000	2,522	3,010	1,064	2,433	2,033
68	2,086	2,627	3,133	1,111	2,533	2,121
69	2,179	2,746	3,256	1,155	2,629	2,216
70	2,266	2,857	3,374	1,197	2,727	2,302
71	2,355	2,962	3,491	1,236	2,823	2,392
72	2,436	3,067	3,602	1,277	2,908	2,477
73	2,509	3,164	3,698	1,310	2,990	2,556
74	2,586	3,258	3,793	1,348	3,069	2,627
75	2,651	3,340	3,879	1,375	3,138	2,696
76	2,712	3,413	3,956	1,403	3,196	2,758
77	2,768	3,483	4,026	1,426	3,256	2,819
78	2,819	3,554	4,086	1,449	3,301	2,873
79	2,870	3,617	4,147	1,471	3,349	2,922
80	2,918	3,675	4,195	1,488	3,394	2,969
81	2,959	3,721	4,252	1,507	3,435	3,011
82	2,997	3,775	4,304	1,528	3,479	3,050
83	3,038	3,826	4,357	1,544	3,520	3,092
84	3,075	3,870	4,405	1,562	3,560	3,133
85	3,110	3,919	4,456	1,582	3,602	3,165
86	3,143	3,962	4,498	1,594	3,636	3,199
87	3,179	4,004	4,546	1,612	3,677	3,233
88	3,210	4,047	4,589	1,628	3,705	3,267
89	3,240	4,085	4,626	1,640	3,740	3,298
90	3,267	4,116	4,667	1,655	3,771	3,327
91	3,294	4,154	4,704	1,668	3,801	3,352
92	3,322	4,186	4,733	1,679	3,823	3,380
93	3,343	4,216	4,767	1,694	3,853	3,403
94	3,367	4,240	4,784	1,699	3,867	3,427
95	3,383	4,265	4,810	1,705	3,890	3,447
96	3,409	4,290	4,839	1,716	3,912	3,465
97	3,427	4,317	4,862	1,726	3,930	3,483
98	3,444	4,342	4,890	1,735	3,953	3,504
99	3,465	4,367	4,912	1,741	3,970	3,528

Attained	Standard					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
0 - 64	2,224	2,805	3,343	1,185	2,704	2,266
65	2,224	2,805	3,343	1,185	2,704	2,266
66	2,224	2,805	3,343	1,185	2,704	2,266
67	2,224	2,805	3,343	1,185	2,704	2,266
68	2,317	2,922	3,480	1,234	2,811	2,359
69	2,420	3,049	3,620	1,287	2,924	2,466
70	2,515	3,169	3,750	1,329	3,031	2,561
71	2,612	3,294	3,879	1,375	3,138	2,658
72	2,704	3,411	4,000	1,420	3,232	2,751
73	2,789	3,513	4,111	1,459	3,324	2,839
74	2,870	3,617	4,217	1,500	3,409	2,923
75	2,939	3,705	4,314	1,530	3,483	2,993
76	3,007	3,793	4,393	1,558	3,552	3,064
77	3,075	3,872	4,469	1,586	3,613	3,133
78	3,134	3,949	4,539	1,612	3,669	3,192
79	3,192	4,019	4,606	1,631	3,719	3,246
80	3,240	4,085	4,660	1,654	3,767	3,298
81	3,284	4,141	4,722	1,673	3,816	3,347
82	3,328	4,199	4,783	1,699	3,866	3,390
83	3,374	4,252	4,842	1,716	3,913	3,435
84	3,416	4,306	4,897	1,735	3,956	3,474
85	3,452	4,353	4,951	1,756	4,002	3,516
86	3,495	4,402	5,000	1,774	4,042	3,558
87	3,533	4,446	5,051	1,791	4,080	3,596
88	3,564	4,492	5,096	1,808	4,118	3,628
89	3,600	4,536	5,143	1,823	4,157	3,667
90	3,631	4,577	5,183	1,838	4,187	3,698
91	3,660	4,612	5,223	1,852	4,218	3,725
92	3,689	4,648	5,261	1,868	4,253	3,758
93	3,715	4,679	5,293	1,875	4,276	3,782
94	3,740	4,713	5,323	1,888	4,302	3,809
95	3,764	4,740	5,348	1,896	4,322	3,832
96	3,782	4,769	5,373	1,903	4,344	3,853
97	3,807	4,794	5,399	1,917	4,365	3,872
98	3,831	4,823	5,430	1,926	4,390	3,895
99	3,854	4,855	5,461	1,934	4,411	3,922

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

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

To calculate the 5% 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 6/1/2021

Attained	Preferred					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
0 - 64	2,301	2,899	3,462	1,227	2,798	2,343
65	2,301	2,899	3,462	1,227	2,798	2,343
66	2,301	2,899	3,462	1,227	2,798	2,343
67	2,301	2,899	3,462	1,227	2,798	2,343
68	2,397	3,022	3,602	1,277	2,908	2,441
69	2,506	3,160	3,747	1,329	3,027	2,553
70	2,606	3,282	3,884	1,377	3,138	2,654
71	2,705	3,411	4,018	1,426	3,248	2,751
72	2,798	3,526	4,147	1,471	3,349	2,846
73	2,888	3,636	4,254	1,507	3,442	2,937
74	2,969	3,742	4,364	1,548	3,528	3,022
75	3,046	3,835	4,464	1,585	3,608	3,098
76	3,112	3,924	4,546	1,612	3,677	3,169
77	3,180	4,007	4,626	1,640	3,740	3,235
78	3,246	4,086	4,702	1,668	3,801	3,303
79	3,298	4,158	4,768	1,694	3,854	3,359
80	3,352	4,224	4,825	1,710	3,900	3,413
81	3,398	4,285	4,890	1,735	3,953	3,463
82	3,447	4,344	4,951	1,756	4,002	3,508
83	3,493	4,400	5,008	1,778	4,049	3,554
84	3,533	4,449	5,068	1,794	4,096	3,597
85	3,577	4,506	5,123	1,818	4,141	3,643
86	3,617	4,555	5,176	1,837	4,185	3,680
87	3,652	4,607	5,230	1,853	4,227	3,719
88	3,694	4,652	5,276	1,871	4,265	3,763
89	3,721	4,695	5,323	1,888	4,302	3,794
90	3,764	4,738	5,366	1,902	4,337	3,826
91	3,789	4,773	5,400	1,917	4,367	3,856
92	3,819	4,809	5,440	1,931	4,395	3,885
93	3,848	4,848	5,476	1,944	4,426	3,915
94	3,867	4,878	5,510	1,955	4,455	3,939
95	3,892	4,907	5,537	1,963	4,472	3,962
96	3,916	4,936	5,561	1,975	4,493	3,985
97	3,938	4,962	5,590	1,983	4,518	4,007
98	3,962	4,992	5,617	1,992	4,539	4,034
99	3,985	5,020	5,645	2,003	4,562	4,055

Attained	Standard					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
0 - 64	2,558	3,223	3,841	1,364	3,108	2,604
65	2,558	3,223	3,841	1,364	3,108	2,604
66	2,558	3,223	3,841	1,364	3,108	2,604
67	2,558	3,223	3,841	1,364	3,108	2,604
68	2,667	3,357	4,003	1,420	3,233	2,714
69	2,782	3,508	4,161	1,474	3,359	2,837
70	2,892	3,647	4,314	1,530	3,483	2,949
71	3,006	3,786	4,464	1,585	3,608	3,057
72	3,110	3,919	4,606	1,631	3,719	3,165
73	3,210	4,040	4,723	1,676	3,819	3,264
74	3,298	4,158	4,846	1,722	3,916	3,359
75	3,381	4,260	4,962	1,760	4,007	3,444
76	3,463	4,359	5,054	1,792	4,085	3,525
77	3,535	4,457	5,143	1,823	4,157	3,597
78	3,602	4,538	5,218	1,850	4,218	3,669
79	3,667	4,622	5,293	1,875	4,276	3,732
80	3,721	4,694	5,359	1,902	4,334	3,793
81	3,777	4,762	5,431	1,926	4,393	3,848
82	3,831	4,824	5,497	1,952	4,442	3,899
83	3,882	4,889	5,565	1,975	4,498	3,950
84	3,928	4,948	5,630	1,998	4,553	4,002
85	3,973	5,005	5,695	2,018	4,606	4,042
86	4,019	5,065	5,755	2,039	4,652	4,087
87	4,055	5,116	5,805	2,060	4,694	4,133
88	4,102	5,165	5,859	2,080	4,738	4,177
89	4,141	5,215	5,916	2,098	4,777	4,216
90	4,171	5,260	5,962	2,115	4,819	4,253
91	4,214	5,308	6,008	2,130	4,858	4,288
92	4,248	5,345	6,046	2,145	4,889	4,322
93	4,275	5,381	6,084	2,157	4,916	4,349
94	4,302	5,418	6,117	2,170	4,946	4,376
95	4,323	5,450	6,147	2,182	4,969	4,400
96	4,353	5,483	6,181	2,191	4,998	4,428
97	4,376	5,515	6,210	2,201	5,020	4,456
98	4,402	5,549	6,242	2,214	5,045	4,485
99	4,428	5,580	6,274	2,225	5,072	4,507

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

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

To calculate the 5% 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

Female Rates

Rates Effective 6/1/2021

Attained Age	Preferred					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
0 - 64	2,174	2,741	3,271	1,156	2,645	2,210
65	2,174	2,741	3,271	1,156	2,645	2,210
66	2,174	2,741	3,271	1,156	2,645	2,210
67	2,174	2,741	3,271	1,156	2,645	2,210
68	2,268	2,855	3,405	1,208	2,754	2,305
69	2,369	2,985	3,539	1,255	2,858	2,409
70	2,463	3,105	3,668	1,301	2,964	2,503
71	2,560	3,220	3,795	1,344	3,069	2,600
72	2,648	3,334	3,915	1,388	3,161	2,693
73	2,728	3,439	4,020	1,424	3,250	2,779
74	2,811	3,541	4,123	1,465	3,336	2,855
75	2,881	3,630	4,216	1,495	3,411	2,930
76	2,948	3,710	4,300	1,525	3,474	2,998
77	3,009	3,786	4,376	1,550	3,539	3,064
78	3,064	3,863	4,441	1,575	3,588	3,123
79	3,120	3,931	4,508	1,599	3,640	3,176
80	3,171	3,995	4,560	1,618	3,689	3,228
81	3,216	4,045	4,621	1,638	3,734	3,273
82	3,258	4,104	4,679	1,661	3,781	3,315
83	3,303	4,159	4,736	1,679	3,826	3,361
84	3,343	4,206	4,788	1,698	3,870	3,405
85	3,380	4,260	4,844	1,720	3,915	3,440
86	3,416	4,306	4,889	1,733	3,953	3,478
87	3,455	4,353	4,941	1,753	3,996	3,514
88	3,489	4,399	4,988	1,770	4,028	3,551
89	3,521	4,440	5,029	1,783	4,065	3,585
90	3,551	4,474	5,073	1,799	4,099	3,616
91	3,580	4,515	5,113	1,813	4,131	3,644
92	3,611	4,550	5,145	1,825	4,155	3,674
93	3,634	4,583	5,181	1,841	4,188	3,699
94	3,660	4,609	5,200	1,846	4,204	3,725
95	3,678	4,636	5,229	1,854	4,229	3,746
96	3,705	4,663	5,260	1,865	4,253	3,766
97	3,725	4,693	5,285	1,876	4,271	3,786
98	3,744	4,720	5,315	1,886	4,296	3,809
99	3,766	4,746	5,339	1,893	4,315	3,835

Attained Age	Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
0 - 64	2,418	3,049	3,634	1,288	2,939	2,463
65	2,418	3,049	3,634	1,288	2,939	2,463
66	2,418	3,049	3,634	1,288	2,939	2,463
67	2,418	3,049	3,634	1,288	2,939	2,463
68	2,519	3,176	3,783	1,341	3,055	2,564
69	2,630	3,314	3,935	1,399	3,179	2,680
70	2,734	3,445	4,076	1,445	3,295	2,784
71	2,839	3,580	4,216	1,495	3,411	2,889
72	2,939	3,708	4,348	1,544	3,513	2,990
73	3,031	3,819	4,469	1,586	3,613	3,086
74	3,120	3,931	4,584	1,630	3,705	3,178
75	3,195	4,028	4,689	1,663	3,786	3,254
76	3,269	4,123	4,775	1,694	3,861	3,330
77	3,343	4,209	4,858	1,724	3,928	3,405
78	3,406	4,293	4,934	1,753	3,988	3,470
79	3,470	4,369	5,006	1,773	4,043	3,529
80	3,521	4,440	5,065	1,798	4,095	3,585
81	3,570	4,501	5,133	1,819	4,148	3,638
82	3,618	4,564	5,199	1,846	4,203	3,685
83	3,668	4,621	5,263	1,865	4,254	3,734
84	3,713	4,680	5,323	1,886	4,300	3,776
85	3,753	4,731	5,381	1,909	4,350	3,821
86	3,799	4,785	5,435	1,929	4,394	3,868
87	3,840	4,833	5,490	1,946	4,435	3,909
88	3,874	4,883	5,539	1,965	4,476	3,944
89	3,913	4,930	5,590	1,981	4,519	3,986
90	3,946	4,975	5,634	1,998	4,551	4,020
91	3,979	5,013	5,678	2,013	4,585	4,049
92	4,010	5,053	5,719	2,030	4,623	4,085
93	4,038	5,086	5,754	2,038	4,648	4,111
94	4,065	5,123	5,786	2,053	4,676	4,140
95	4,091	5,153	5,813	2,061	4,698	4,165
96	4,111	5,184	5,840	2,069	4,721	4,188
97	4,138	5,211	5,869	2,084	4,745	4,209
98	4,164	5,243	5,903	2,094	4,771	4,234
99	4,189	5,278	5,936	2,103	4,795	4,263

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

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

To calculate the 5% 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 6/1/2021

Attained Age	Preferred					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
0 - 64	2,501	3,151	3,763	1,334	3,041	2,546
65	2,501	3,151	3,763	1,334	3,041	2,546
66	2,501	3,151	3,763	1,334	3,041	2,546
67	2,501	3,151	3,763	1,334	3,041	2,546
68	2,605	3,285	3,915	1,388	3,161	2,654
69	2,724	3,435	4,073	1,445	3,290	2,775
70	2,833	3,568	4,221	1,496	3,411	2,885
71	2,940	3,708	4,368	1,550	3,530	2,990
72	3,041	3,833	4,508	1,599	3,640	3,094
73	3,139	3,953	4,624	1,638	3,741	3,193
74	3,228	4,068	4,744	1,683	3,835	3,285
75	3,311	4,169	4,853	1,723	3,921	3,368
76	3,383	4,265	4,941	1,753	3,996	3,445
77	3,456	4,355	5,029	1,783	4,065	3,516
78	3,529	4,441	5,111	1,813	4,131	3,590
79	3,585	4,520	5,183	1,841	4,189	3,651
80	3,644	4,591	5,245	1,859	4,239	3,710
81	3,694	4,658	5,315	1,886	4,296	3,764
82	3,746	4,721	5,381	1,909	4,350	3,813
83	3,796	4,783	5,444	1,933	4,401	3,863
84	3,840	4,836	5,509	1,950	4,453	3,910
85	3,888	4,898	5,569	1,976	4,501	3,960
86	3,931	4,951	5,626	1,996	4,549	4,000
87	3,970	5,008	5,685	2,014	4,595	4,043
88	4,015	5,056	5,735	2,034	4,636	4,090
89	4,045	5,104	5,786	2,053	4,676	4,124
90	4,091	5,150	5,833	2,068	4,714	4,159
91	4,119	5,188	5,870	2,084	4,746	4,191
92	4,151	5,228	5,913	2,099	4,778	4,223
93	4,183	5,270	5,953	2,113	4,811	4,255
94	4,204	5,303	5,989	2,125	4,843	4,281
95	4,230	5,334	6,019	2,134	4,861	4,306
96	4,256	5,365	6,045	2,146	4,884	4,331
97	4,280	5,394	6,076	2,155	4,911	4,355
98	4,306	5,426	6,105	2,165	4,934	4,385
99	4,331	5,456	6,136	2,178	4,959	4,408

Attained Age	Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
0 - 64	2,780	3,504	4,175	1,483	3,379	2,830
65	2,780	3,504	4,175	1,483	3,379	2,830
66	2,780	3,504	4,175	1,483	3,379	2,830
67	2,780	3,504	4,175	1,483	3,379	2,830
68	2,899	3,649	4,351	1,544	3,514	2,950
69	3,024	3,813	4,523	1,603	3,651	3,084
70	3,144	3,964	4,689	1,663	3,786	3,205
71	3,268	4,115	4,853	1,723	3,921	3,323
72	3,380	4,260	5,006	1,773	4,043	3,440
73	3,489	4,391	5,134	1,821	4,151	3,548
74	3,585	4,520	5,268	1,871	4,256	3,651
75	3,675	4,630	5,394	1,913	4,355	3,744
76	3,764	4,738	5,494	1,948	4,440	3,831
77	3,843	4,845	5,590	1,981	4,519	3,910
78	3,915	4,933	5,671	2,011	4,585	3,988
79	3,986	5,024	5,754	2,038	4,648	4,056
80	4,045	5,103	5,825	2,068	4,711	4,123
81	4,105	5,176	5,904	2,094	4,775	4,183
82	4,164	5,244	5,975	2,121	4,829	4,238
83	4,220	5,314	6,049	2,146	4,889	4,294
84	4,270	5,379	6,120	2,171	4,949	4,350
85	4,319	5,440	6,190	2,194	5,006	4,394
86	4,369	5,505	6,255	2,216	5,056	4,443
87	4,408	5,561	6,310	2,239	5,103	4,493
88	4,459	5,614	6,369	2,261	5,150	4,540
89	4,501	5,669	6,430	2,280	5,193	4,583
90	4,534	5,718	6,480	2,299	5,238	4,623
91	4,580	5,770	6,530	2,315	5,280	4,661
92	4,618	5,810	6,571	2,331	5,314	4,698
93	4,646	5,849	6,613	2,345	5,344	4,728
94	4,676	5,889	6,649	2,359	5,376	4,756
95	4,699	5,924	6,681	2,371	5,401	4,783
96	4,731	5,960	6,719	2,381	5,433	4,813
97	4,756	5,995	6,750	2,393	5,456	4,844
98	4,785	6,031	6,785	2,406	5,484	4,875
99	4,813	6,065	6,820	2,419	5,513	4,899

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

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

To calculate the 5% 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 $1,484	$0	$1,484 (Part A Deductible)
61st thru 90th day	All but $371 a day	$371 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $742 a day	$742 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 $185.50 a day	$0	Up to $185.50 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 $203 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 $203 of Medicare-Approved amounts*	$0	$0	$203 (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 $203 of Medicare-Approved amounts*	$0	$0	$203 (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 $203 of Medicare Approved amounts*	$0	$0	$203 (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 $1,484	$1,484 (Part A Deductible)	$0
61st thru 90th day	All but $371 a day	$371 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $742 a day	$742 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 $185.50 a day	$0	Up to $185.50 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 $203 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 $203 of Medicare-Approved amounts*	$0	$0	$203 (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 $203 of Medicare-Approved amounts*	$0	$0	$203 (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 $203 of Medicare Approved amounts*	$0	$0	$203 (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 $1,484	$1,484 (Part A Deductible)	$0
61st thru 90th day	All but $371 a day	$371 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $742 a day	$742 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 $185.50 a day	Up to $185.50 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 $203 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 $203 of Medicare-Approved amounts*	$0	$203 (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 $203 of Medicare-Approved amounts*	$0	$203 (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 $203 of Medicare Approved amounts*	$0	$203 (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 $2,370 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses are $2,370. 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 $2,370 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2,370 DEDUCTIBLE*** YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,484	$1,484 (Part A Deductible)	$0
61st thru 90th day	All but $371 a day	$371 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $742 a day	$742 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 $185.50 a day	Up to $185.50 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 $203 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 $2,370 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses are $2,370. 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 $2,370 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2,370 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 $203 of Medicare-Approved amounts*	$0	$203 (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 $203 of Medicare-Approved amounts*	$0	$203 (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 $2,370 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2,370 DEDUCTIBLE*** YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
•Medically necessary skilled care services and medical supplies	100%	$0	$0
•Durable medical equipment			
•First $203 of Medicare Approved amounts*	$0	$203 (Part B Deductible)	$0
•Remainder of Medicare Approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,370 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2,370 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 $1,484	$1,484 (Part A Deductible)	$0
61st thru 90th day	All but $371 a day	$371 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $742 a day	$742 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 $185.50 a day	Up to $185.50 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 $203 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 $203 of Medicare-Approved amounts*	$0	$0	$203 (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 $203 of Medicare-Approved amounts*	$0	$0	$203 (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 $203 of Medicare Approved amounts*	$0	$0	$203 (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 $1,484	$1,484 (Part A Deductible)	$0
61st thru 90th day	All but $371 a day	$371 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $742 a day	$742 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 $185.50 a day	Up to $185.50 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 $203 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 $203 of Medicare-Approved amounts*	$0	$0	$203 (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 $203 of Medicare-Approved amounts*	$0	$0	$203 (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 $203 of Medicare Approved amounts*	$0	$0	$203 (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