Outline of coverage

Medicare Supplement Insurance

Benefit Plans A, B, F, High Deductible F, G, N

Oregon

Underwritten by

Continental Life Insurance Company of Brentwood, Tennessee

An Aetna Company

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CLIMS05023OR

Rates effective: 02/2024 A

CONTINENTAL LIFE INSURANCE COMPANY OF BRENTWOOD, TENNESSEE
OUTLINE OF MEDICARE SUPPLEMENT COVERAGE COVER PAGE
BENEFIT PLANS AVAILABLE: A, B, F, HIGH DEDUCTIBLE F, 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 2024[2]					**$7,060[2]**	**$3,530[2]**				

[1] Plans F and G also have a high deductible option, which require first paying a plan deductible of **$2,800** 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 2/1/2024

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
0 - 64	2,535	3,196	3,815	1,349	3,085	2,578
65	2,535	3,196	3,815	1,349	3,085	2,578
66	2,535	3,196	3,815	1,349	3,085	2,578
67	2,535	3,196	3,815	1,349	3,085	2,578
68	2,645	3,330	3,971	1,408	3,211	2,689
69	2,764	3,481	4,128	1,464	3,334	2,809
70	2,873	3,623	4,279	1,518	3,458	2,919
71	2,986	3,756	4,426	1,568	3,579	3,033
72	3,088	3,888	4,568	1,619	3,686	3,140
73	3,183	4,011	4,689	1,660	3,791	3,241
74	3,279	4,131	4,809	1,709	3,893	3,330
75	3,360	4,234	4,918	1,744	3,979	3,419
76	3,439	4,326	5,015	1,779	4,051	3,496
77	3,510	4,416	5,104	1,808	4,128	3,574
78	3,574	4,505	5,180	1,838	4,185	3,643
79	3,640	4,586	5,258	1,864	4,246	3,705
80	3,699	4,660	5,319	1,888	4,303	3,765
81	3,751	4,719	5,390	1,910	4,355	3,816
82	3,799	4,788	5,456	1,938	4,410	3,866
83	3,851	4,850	5,524	1,958	4,463	3,920
84	3,899	4,906	5,584	1,980	4,515	3,971
85	3,943	4,969	5,650	2,006	4,568	4,013
86	3,985	5,024	5,703	2,021	4,610	4,056
87	4,030	5,078	5,764	2,044	4,661	4,099
88	4,069	5,131	5,818	2,064	4,698	4,141
89	4,106	5,179	5,866	2,079	4,741	4,181
90	4,141	5,218	5,918	2,098	4,780	4,218
91	4,175	5,266	5,963	2,114	4,819	4,250
92	4,213	5,306	6,001	2,129	4,846	4,285
93	4,239	5,345	6,044	2,148	4,884	4,315
94	4,269	5,376	6,065	2,154	4,904	4,344
95	4,289	5,408	6,099	2,163	4,933	4,370
96	4,321	5,438	6,136	2,175	4,960	4,393
97	4,344	5,473	6,164	2,189	4,981	4,416
98	4,368	5,505	6,199	2,200	5,011	4,443
99	4,393	5,536	6,228	2,208	5,033	4,473

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
0 - 64	2,820	3,556	4,239	1,501	3,428	2,873
65	2,820	3,556	4,239	1,501	3,428	2,873
66	2,820	3,556	4,239	1,501	3,428	2,873
67	2,820	3,556	4,239	1,501	3,428	2,873
68	2,938	3,705	4,411	1,565	3,564	2,990
69	3,068	3,865	4,590	1,633	3,708	3,126
70	3,189	4,018	4,755	1,685	3,844	3,246
71	3,311	4,175	4,918	1,744	3,979	3,370
72	3,428	4,324	5,070	1,801	4,098	3,488
73	3,536	4,454	5,213	1,851	4,214	3,600
74	3,640	4,586	5,346	1,901	4,321	3,706
75	3,726	4,698	5,469	1,939	4,416	3,795
76	3,813	4,809	5,570	1,975	4,504	3,884
77	3,899	4,909	5,666	2,010	4,580	3,971
78	3,973	5,008	5,755	2,044	4,651	4,048
79	4,048	5,096	5,839	2,066	4,715	4,116
80	4,106	5,179	5,908	2,096	4,776	4,181
81	4,164	5,250	5,986	2,121	4,838	4,243
82	4,220	5,323	6,064	2,154	4,901	4,299
83	4,279	5,390	6,139	2,175	4,961	4,355
84	4,331	5,460	6,209	2,200	5,015	4,405
85	4,376	5,519	6,276	2,226	5,074	4,458
86	4,431	5,581	6,340	2,249	5,125	4,511
87	4,479	5,636	6,403	2,271	5,174	4,559
88	4,519	5,694	6,460	2,293	5,220	4,600
89	4,563	5,751	6,520	2,311	5,270	4,650
90	4,604	5,803	6,571	2,330	5,309	4,689
91	4,641	5,846	6,621	2,348	5,348	4,723
92	4,678	5,893	6,670	2,368	5,393	4,764
93	4,709	5,934	6,711	2,376	5,420	4,795
94	4,741	5,975	6,749	2,394	5,454	4,829
95	4,773	6,010	6,780	2,404	5,480	4,859
96	4,795	6,046	6,813	2,413	5,506	4,884
97	4,826	6,079	6,846	2,430	5,535	4,909
98	4,856	6,115	6,885	2,443	5,565	4,939
99	4,886	6,156	6,924	2,453	5,593	4,973

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 periods, use preferred rates.

Modal factors

Semi-annual 0.5200

Quarterly 0.2650

Monthly.....0.0833

Continental Life Insurance Company of Brentwood, Tennessee

Annual Attained Age Premiums

For Use in ZIP Codes: 970-972

Male rates

Rates effective 2/1/2024

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
0 - 64	2,918	3,676	4,389	1,555	3,548	2,970
65	2,918	3,676	4,389	1,555	3,548	2,970
66	2,918	3,676	4,389	1,555	3,548	2,970
67	2,918	3,676	4,389	1,555	3,548	2,970
68	3,039	3,831	4,568	1,619	3,686	3,095
69	3,176	4,006	4,751	1,685	3,838	3,238
70	3,304	4,161	4,924	1,745	3,979	3,365
71	3,429	4,324	5,095	1,808	4,118	3,488
72	3,548	4,470	5,258	1,864	4,246	3,609
73	3,661	4,610	5,394	1,910	4,364	3,724
74	3,765	4,744	5,534	1,963	4,473	3,831
75	3,863	4,863	5,660	2,009	4,574	3,929
76	3,945	4,975	5,764	2,044	4,661	4,018
77	4,031	5,080	5,866	2,079	4,741	4,101
78	4,116	5,180	5,961	2,114	4,819	4,188
79	4,181	5,271	6,045	2,148	4,886	4,259
80	4,250	5,355	6,119	2,168	4,944	4,326
81	4,308	5,433	6,199	2,200	5,011	4,390
82	4,370	5,506	6,276	2,226	5,074	4,448
83	4,428	5,579	6,349	2,255	5,134	4,505
84	4,479	5,641	6,426	2,275	5,194	4,560
85	4,535	5,711	6,495	2,305	5,250	4,619
86	4,586	5,775	6,563	2,329	5,305	4,665
87	4,630	5,840	6,631	2,349	5,360	4,715
88	4,684	5,899	6,689	2,373	5,408	4,771
89	4,719	5,954	6,749	2,394	5,454	4,810
90	4,773	6,008	6,803	2,411	5,499	4,850
91	4,805	6,051	6,848	2,430	5,536	4,889
92	4,843	6,098	6,896	2,448	5,573	4,925
93	4,879	6,146	6,943	2,464	5,613	4,963
94	4,904	6,184	6,985	2,479	5,649	4,994
95	4,934	6,221	7,020	2,490	5,670	5,024
96	4,964	6,258	7,051	2,503	5,698	5,051
97	4,993	6,291	7,088	2,514	5,728	5,080
98	5,024	6,329	7,121	2,526	5,755	5,115
99	5,051	6,364	7,158	2,539	5,784	5,141

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
0 - 64	3,243	4,086	4,870	1,729	3,941	3,301
65	3,243	4,086	4,870	1,729	3,941	3,301
66	3,243	4,086	4,870	1,729	3,941	3,301
67	3,243	4,086	4,870	1,729	3,941	3,301
68	3,381	4,256	5,075	1,801	4,099	3,441
69	3,528	4,448	5,275	1,870	4,259	3,596
70	3,666	4,624	5,469	1,939	4,416	3,739
71	3,811	4,799	5,660	2,009	4,574	3,876
72	3,943	4,969	5,839	2,066	4,715	4,013
73	4,069	5,123	5,989	2,125	4,843	4,138
74	4,181	5,271	6,144	2,183	4,964	4,259
75	4,286	5,400	6,291	2,230	5,080	4,368
76	4,390	5,525	6,409	2,273	5,179	4,469
77	4,483	5,651	6,520	2,311	5,270	4,560
78	4,568	5,754	6,615	2,346	5,348	4,651
79	4,650	5,860	6,711	2,376	5,420	4,731
80	4,719	5,953	6,795	2,411	5,496	4,809
81	4,789	6,038	6,886	2,443	5,570	4,879
82	4,856	6,116	6,969	2,475	5,633	4,943
83	4,923	6,198	7,055	2,503	5,703	5,009
84	4,980	6,274	7,139	2,533	5,773	5,074
85	5,036	6,345	7,220	2,559	5,839	5,125
86	5,096	6,420	7,295	2,585	5,899	5,181
87	5,141	6,486	7,360	2,611	5,953	5,241
88	5,200	6,548	7,429	2,638	6,008	5,296
89	5,250	6,613	7,500	2,660	6,056	5,345
90	5,288	6,669	7,559	2,681	6,109	5,393
91	5,343	6,730	7,616	2,700	6,159	5,436
92	5,386	6,778	7,665	2,719	6,198	5,480
93	5,419	6,821	7,713	2,735	6,233	5,515
94	5,454	6,869	7,756	2,751	6,271	5,548
95	5,481	6,909	7,794	2,766	6,300	5,579
96	5,519	6,951	7,836	2,778	6,338	5,614
97	5,548	6,993	7,874	2,790	6,364	5,650
98	5,581	7,035	7,914	2,806	6,396	5,686
99	5,614	7,074	7,954	2,821	6,430	5,715

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 periods, use preferred rates.

Modal factors

Semi-annual 0.5200

Quarterly 0.2650

Monthly 0.0833

Continental Life Insurance Company of Brentwood, Tennessee

Annual Attained Age Premiums

For Use in ZIP Codes: Rest of state

Female rates

Rates effective 2/1/2024

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
0 - 64	2,332	2,941	3,510	1,241	2,838	2,371
65	2,332	2,941	3,510	1,241	2,838	2,371
66	2,332	2,941	3,510	1,241	2,838	2,371
67	2,332	2,941	3,510	1,241	2,838	2,371
68	2,433	3,064	3,654	1,295	2,954	2,474
69	2,543	3,203	3,797	1,347	3,067	2,584
70	2,643	3,333	3,936	1,396	3,181	2,685
71	2,747	3,456	4,072	1,442	3,292	2,790
72	2,841	3,577	4,202	1,489	3,391	2,889
73	2,928	3,690	4,314	1,527	3,488	2,982
74	3,016	3,801	4,424	1,572	3,581	3,064
75	3,091	3,895	4,524	1,604	3,660	3,145
76	3,164	3,980	4,614	1,636	3,727	3,217
77	3,229	4,063	4,695	1,663	3,797	3,288
78	3,288	4,145	4,766	1,691	3,850	3,351
79	3,349	4,219	4,837	1,715	3,907	3,409
80	3,403	4,287	4,893	1,737	3,958	3,464
81	3,451	4,341	4,959	1,757	4,007	3,511
82	3,495	4,405	5,020	1,783	4,057	3,557
83	3,543	4,462	5,082	1,801	4,106	3,606
84	3,587	4,514	5,137	1,822	4,154	3,654
85	3,627	4,571	5,198	1,846	4,202	3,692
86	3,666	4,622	5,246	1,860	4,241	3,732
87	3,708	4,671	5,303	1,880	4,288	3,771
88	3,743	4,721	5,352	1,899	4,322	3,810
89	3,778	4,764	5,397	1,912	4,362	3,847
90	3,810	4,800	5,444	1,930	4,398	3,880
91	3,841	4,845	5,486	1,945	4,433	3,910
92	3,876	4,882	5,521	1,958	4,459	3,942
93	3,900	4,917	5,560	1,976	4,493	3,970
94	3,927	4,946	5,580	1,981	4,511	3,996
95	3,946	4,975	5,611	1,990	4,538	4,020
96	3,976	5,003	5,645	2,001	4,563	4,041
97	3,996	5,035	5,671	2,014	4,583	4,063
98	4,018	5,065	5,703	2,024	4,610	4,087
99	4,041	5,093	5,729	2,031	4,630	4,115

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
0 - 64	2,594	3,272	3,900	1,381	3,153	2,643
65	2,594	3,272	3,900	1,381	3,153	2,643
66	2,594	3,272	3,900	1,381	3,153	2,643
67	2,594	3,272	3,900	1,381	3,153	2,643
68	2,703	3,409	4,058	1,440	3,279	2,751
69	2,822	3,556	4,223	1,502	3,411	2,876
70	2,934	3,696	4,375	1,550	3,536	2,987
71	3,046	3,841	4,524	1,604	3,660	3,100
72	3,153	3,978	4,664	1,657	3,770	3,209
73	3,253	4,097	4,796	1,703	3,877	3,312
74	3,349	4,219	4,919	1,749	3,976	3,410
75	3,428	4,322	5,031	1,784	4,063	3,491
76	3,508	4,424	5,124	1,817	4,143	3,573
77	3,587	4,516	5,213	1,849	4,214	3,654
78	3,655	4,607	5,295	1,880	4,279	3,724
79	3,724	4,689	5,372	1,901	4,338	3,787
80	3,778	4,764	5,435	1,929	4,394	3,847
81	3,831	4,830	5,507	1,952	4,451	3,903
82	3,882	4,897	5,579	1,981	4,509	3,955
83	3,936	4,959	5,648	2,001	4,564	4,007
84	3,985	5,023	5,712	2,024	4,614	4,053
85	4,026	5,077	5,774	2,048	4,668	4,101
86	4,077	5,135	5,833	2,069	4,715	4,150
87	4,120	5,185	5,890	2,090	4,760	4,194
88	4,157	5,238	5,943	2,109	4,802	4,232
89	4,198	5,291	5,998	2,126	4,848	4,278
90	4,235	5,338	6,046	2,144	4,884	4,314
91	4,270	5,379	6,092	2,160	4,920	4,345
92	4,303	5,421	6,136	2,178	4,961	4,383
93	4,332	5,459	6,174	2,186	4,986	4,411
94	4,362	5,497	6,209	2,202	5,017	4,442
95	4,391	5,529	6,238	2,211	5,042	4,470
96	4,411	5,563	6,268	2,220	5,066	4,493
97	4,440	5,592	6,299	2,236	5,092	4,516
98	4,468	5,626	6,334	2,247	5,120	4,544
99	4,495	5,664	6,370	2,256	5,145	4,575

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 periods, use preferred rates.

Modal factors

Semi-annual 0.5200

Quarterly 0.2650

Monthly 0.0833

Continental Life Insurance Company of Brentwood, Tennessee

Annual Attained Age Premiums

For Use in ZIP Codes: Rest of state

Male rates

Rates effective 2/1/2024

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
0 - 64	2,684	3,382	4,038	1,431	3,264	2,732
65	2,684	3,382	4,038	1,431	3,264	2,732
66	2,684	3,382	4,038	1,431	3,264	2,732
67	2,684	3,382	4,038	1,431	3,264	2,732
68	2,796	3,525	4,202	1,489	3,391	2,847
69	2,922	3,686	4,371	1,550	3,531	2,979
70	3,039	3,828	4,530	1,605	3,660	3,096
71	3,154	3,978	4,687	1,663	3,788	3,209
72	3,264	4,112	4,837	1,715	3,907	3,320
73	3,368	4,241	4,962	1,757	4,015	3,426
74	3,464	4,364	5,091	1,806	4,115	3,525
75	3,554	4,474	5,207	1,848	4,208	3,614
76	3,629	4,577	5,303	1,880	4,288	3,696
77	3,709	4,674	5,397	1,912	4,362	3,773
78	3,787	4,766	5,484	1,945	4,433	3,853
79	3,847	4,850	5,561	1,976	4,495	3,918
80	3,910	4,927	5,629	1,994	4,548	3,980
81	3,963	4,998	5,703	2,024	4,610	4,039
82	4,020	5,066	5,774	2,048	4,668	4,092
83	4,073	5,132	5,841	2,075	4,723	4,145
84	4,120	5,190	5,912	2,093	4,778	4,195
85	4,172	5,254	5,975	2,121	4,830	4,249
86	4,219	5,313	6,038	2,142	4,881	4,292
87	4,260	5,373	6,101	2,161	4,931	4,338
88	4,309	5,427	6,154	2,183	4,975	4,390
89	4,341	5,477	6,209	2,202	5,017	4,425
90	4,391	5,527	6,258	2,218	5,059	4,462
91	4,421	5,567	6,300	2,236	5,093	4,498
92	4,455	5,610	6,345	2,252	5,127	4,531
93	4,488	5,655	6,387	2,267	5,164	4,566
94	4,511	5,689	6,426	2,280	5,197	4,594
95	4,539	5,724	6,458	2,291	5,216	4,622
96	4,567	5,757	6,487	2,302	5,242	4,647
97	4,593	5,788	6,521	2,313	5,269	4,674
98	4,622	5,822	6,552	2,324	5,295	4,706
99	4,647	5,855	6,585	2,336	5,321	4,730

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
0 - 64	2,983	3,759	4,480	1,590	3,626	3,037
65	2,983	3,759	4,480	1,590	3,626	3,037
66	2,983	3,759	4,480	1,590	3,626	3,037
67	2,983	3,759	4,480	1,590	3,626	3,037
68	3,111	3,916	4,669	1,657	3,771	3,166
69	3,245	4,092	4,853	1,720	3,918	3,309
70	3,373	4,254	5,031	1,784	4,063	3,440
71	3,506	4,415	5,207	1,848	4,208	3,566
72	3,627	4,571	5,372	1,901	4,338	3,692
73	3,743	4,713	5,510	1,955	4,455	3,807
74	3,847	4,850	5,652	2,008	4,567	3,918
75	3,943	4,968	5,788	2,052	4,674	4,018
76	4,039	5,083	5,896	2,091	4,764	4,111
77	4,124	5,199	5,998	2,126	4,848	4,195
78	4,202	5,293	6,086	2,159	4,920	4,279
79	4,278	5,391	6,174	2,186	4,986	4,353
80	4,341	5,476	6,251	2,218	5,057	4,424
81	4,406	5,555	6,335	2,247	5,124	4,488
82	4,468	5,627	6,411	2,277	5,182	4,547
83	4,529	5,702	6,491	2,302	5,246	4,608
84	4,582	5,772	6,568	2,330	5,311	4,668
85	4,633	5,837	6,642	2,354	5,372	4,715
86	4,689	5,906	6,711	2,378	5,427	4,767
87	4,730	5,967	6,771	2,402	5,476	4,822
88	4,784	6,024	6,834	2,427	5,527	4,873
89	4,830	6,084	6,900	2,447	5,572	4,917
90	4,865	6,135	6,954	2,467	5,620	4,961
91	4,915	6,192	7,007	2,484	5,666	5,001
92	4,955	6,235	7,052	2,501	5,702	5,042
93	4,985	6,276	7,096	2,516	5,734	5,074
94	5,017	6,319	7,136	2,531	5,770	5,104
95	5,043	6,356	7,170	2,545	5,796	5,132
96	5,077	6,395	7,209	2,555	5,831	5,165
97	5,104	6,433	7,244	2,567	5,855	5,198
98	5,135	6,472	7,281	2,582	5,885	5,231
99	5,165	6,508	7,317	2,596	5,916	5,258

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 periods, use preferred rates.

Modal factors

Semi-annual 0.5200

Quarterly 0.2650

Monthly 0.0833

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 $1,632	$0	$1,632 (Part A Deductible)
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after While using 60 lifetime reserve days	All but $816 a day	$816 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 $204 a day	$0	Up to $204 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 $240 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $240 of Medicare-Approved amounts*	$0	$0	$240 (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 $240 of Medicare-Approved amounts*	$0	$0	$240 (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 $240 of Medicare-Approved amounts*	$0	$0	$240 (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 $1,632	$1,632 (Part A Deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after While using 60 lifetime reserve days	All but $816 a day	$816 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 $204 a day	$0	Up to $204 a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN B

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed $240 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $240 of Medicare-Approved amounts*	$0	$0	$240 (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 $240 of Medicare-Approved amounts*	$0	$0	$240 (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 $240 of Medicare-Approved amounts*	$0	$0	$240 (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 $1,632	$1,632 (Part A Deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after While using 60 lifetime reserve days	All but $816 a day	$816 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 $204 a day	Up to $204 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 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 F

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed $240 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $240 of Medicare-Approved amounts*	$0	$240 (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 $240 of Medicare-Approved amounts*	$0	$240 (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 $240 of Medicare-Approved amounts*	$0	$240 (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 $2,800 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses are $2,800. 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 $2,800 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2,800 DEDUCTIBLE*** YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,632	$1,632 (Part A Deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after While using 60 lifetime reserve days	All but $816 a day	$816 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 $204 a day	Up to $204 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 an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

HIGH DEDUCTIBLE PLAN F

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed $240 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 $2,800 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses are $2,800. 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 $2,800 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2,800 DEDUCTIBLE*** YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $240 of Medicare-Approved amounts*	$0	$240 (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 $240 of Medicare-Approved amounts*	$0	$240 (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 $2,800 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2,800 DEDUCTIBLE** YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
First $240 of Medicare-Approved amounts*	$0	$240 (Part B Deductible)	$0
Remainder of Medicare-Approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,800 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2,800 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 $1,632	$1,632 (Part A Deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after While using 60 lifetime reserve days	All but $816 a day	$816 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 $204 a day	Up to $204 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 an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN G

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed $240 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $240 of Medicare-Approved amounts*	$0	$0	$240 (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 $240 of Medicare-Approved amounts*	$0	$0	$240 (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 $240 of Medicare-Approved amounts*	$0	$0	$240 (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 $1,632	$1,632 (Part A Deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after While using 60 lifetime reserve days	All but $816 a day	$816 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 $204 a day	Up to $204 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 an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN N

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed $240 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $240 of Medicare-Approved amounts*	$0	$0	$240 (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 $240 of Medicare-Approved amounts*	$0	$0	$240 (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 $240 of Medicare-Approved amounts*	$0	$0	$240 (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