CONTINENTAL LIFE INSURANCE COMPANY OF BRENTWOOD, TENNESSEE
OUTLINE OF MEDICARE SUPPLEMENT COVERAGE COVER PAGE: Page 1 of 1
BENEFIT PLANS AVAILABLE: A, B, F, HIGH DEDUCTIBLE F, G, N

These charts show the benefits included in each of the standard Medicare supplement plans. Every company must make available Plan "A" Some plans may not be available in your state.

Basic Benefits:
Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
Medical Expenses: Part B coinsurance (generally 20% of Medicare-Approved expenses) or, co-payments for hospital outpatient services.
Plans K, L, and N require insureds to pay a portion of coinsurance or copayments
Blood: First three pints of blood each year.
Hospice-Part A coinsurance

A	B	C	D	F/F*	G	K	L	M	N
Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance, except up to $20 copayment for office visit, and up to $50 copayment for ER
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Part B Deductible		Part B Deductible					
				Part B Excess (100%)	Part B Excess (100%)				
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency			Foreign Travel Emergency	Foreign Travel Emergency
						Out-of-pocket limit $5560; paid at 100% after limit reached	Out-of-pocket limit $2780; paid at 100% after limit reached		

*Plans F also has an option called a high deductible plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2300 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed $2300. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

Continental Life Insurance Company of Brentwood, Tennessee

Annual Premiums

For Use in ZIP Codes: 600-608

Female Rates

Rates Effective 05/1/2019

Attained Age	Preferred					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	3,442	4,029	5,111	1,987	3,700	2,991
65	1,350	1,581	2,003	779	1,452	1,027
66	1,350	1,581	2,003	779	1,452	1,057
67	1,350	1,581	2,003	779	1,452	1,086
68	1,365	1,599	2,029	789	1,468	1,129
69	1,395	1,633	2,071	805	1,500	1,184
70	1,432	1,677	2,127	827	1,541	1,246
71	1,477	1,727	2,191	852	1,585	1,282
72	1,525	1,784	2,263	879	1,638	1,324
73	1,577	1,846	2,341	909	1,695	1,371
74	1,638	1,918	2,432	945	1,761	1,424
75	1,706	1,997	2,533	985	1,833	1,484
76	1,775	2,078	2,634	1,025	1,908	1,543
77	1,842	2,155	2,733	1,062	1,978	1,601
78	1,905	2,230	2,829	1,099	2,048	1,657
79	1,970	2,307	2,924	1,136	2,118	1,713
80	2,031	2,380	3,017	1,172	2,184	1,766
81	2,097	2,453	3,112	1,211	2,253	1,822
82	2,162	2,531	3,210	1,247	2,322	1,879
83	2,228	2,609	3,308	1,286	2,395	1,936
84	2,297	2,689	3,411	1,324	2,469	1,996
85	2,377	2,782	3,528	1,371	2,554	2,066
86	2,445	2,862	3,628	1,411	2,627	2,125
87	2,514	2,944	3,732	1,451	2,702	2,186
88	2,585	3,024	3,838	1,491	2,778	2,246
89	2,656	3,111	3,943	1,533	2,855	2,310
90	2,730	3,194	4,052	1,575	2,933	2,373
91	2,804	3,283	4,163	1,617	3,013	2,436
92	2,879	3,371	4,275	1,661	3,095	2,503
93	2,957	3,460	4,389	1,705	3,177	2,569
94	3,035	3,552	4,505	1,749	3,261	2,637
95	3,113	3,645	4,622	1,797	3,346	2,707
96	3,193	3,739	4,742	1,843	3,433	2,775
97	3,275	3,835	4,863	1,890	3,521	2,847
98	3,358	3,931	4,985	1,936	3,609	2,919
99+	3,442	4,029	5,111	1,987	3,700	2,991

Attained Age	Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	3,824	4,478	5,678	2,205	4,110	3,325
65	1,500	1,755	2,227	866	1,613	1,142
66	1,500	1,755	2,227	866	1,613	1,175
67	1,500	1,755	2,227	866	1,613	1,207
68	1,517	1,777	2,255	876	1,632	1,254
69	1,550	1,816	2,301	895	1,667	1,314
70	1,591	1,861	2,363	920	1,712	1,383
71	1,640	1,919	2,435	945	1,762	1,425
72	1,694	1,982	2,514	976	1,821	1,472
73	1,753	2,052	2,601	1,010	1,884	1,523
74	1,819	2,131	2,704	1,052	1,956	1,582
75	1,897	2,219	2,815	1,094	2,037	1,647
76	1,971	2,308	2,927	1,137	2,120	1,715
77	2,045	2,395	3,037	1,181	2,198	1,778
78	2,118	2,479	3,144	1,221	2,276	1,840
79	2,190	2,562	3,249	1,262	2,352	1,902
80	2,257	2,644	3,353	1,302	2,427	1,962
81	2,329	2,726	3,457	1,344	2,504	2,024
82	2,401	2,812	3,567	1,386	2,581	2,090
83	2,477	2,899	3,675	1,429	2,661	2,152
84	2,552	2,987	3,788	1,472	2,742	2,218
85	2,641	3,091	3,921	1,523	2,837	2,297
86	2,717	3,180	4,033	1,569	2,919	2,361
87	2,794	3,271	4,148	1,612	3,002	2,429
88	2,874	3,360	4,263	1,657	3,086	2,496
89	2,952	3,456	4,380	1,702	3,172	2,567
90	3,033	3,551	4,502	1,749	3,260	2,636
91	3,116	3,647	4,624	1,797	3,347	2,709
92	3,199	3,744	4,749	1,845	3,439	2,780
93	3,285	3,845	4,877	1,894	3,530	2,855
94	3,372	3,948	5,004	1,945	3,623	2,931
95	3,459	4,049	5,135	1,996	3,718	3,007
96	3,549	4,154	5,269	2,049	3,813	3,084
97	3,639	4,260	5,402	2,099	3,911	3,163
98	3,731	4,368	5,540	2,152	4,011	3,243
99+	3,824	4,478	5,678	2,205	4,110	3,325

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

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

To calculate a Household discount:

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

Modal premium x .93 = discounted premium

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

Continental Life Insurance Company of Brentwood, Tennessee

Annual Premiums

For Use in ZIP Codes: 600-608

Male Rates

Rates Effective 05/1/2019

Attained	Preferred					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	3,957	4,634	5,877	2,284	4,254	3,440
65	1,554	1,817	2,306	897	1,670	1,182
66	1,554	1,817	2,306	897	1,670	1,216
67	1,554	1,817	2,306	897	1,670	1,248
68	1,571	1,839	2,334	907	1,689	1,299
69	1,604	1,880	2,382	927	1,726	1,361
70	1,647	1,928	2,448	951	1,771	1,432
71	1,698	1,985	2,520	979	1,823	1,475
72	1,753	2,052	2,602	1,010	1,884	1,523
73	1,814	2,124	2,692	1,046	1,949	1,577
74	1,884	2,207	2,796	1,088	2,025	1,638
75	1,963	2,297	2,914	1,133	2,108	1,706
76	2,042	2,389	3,029	1,178	2,194	1,775
77	2,117	2,479	3,144	1,221	2,276	1,840
78	2,193	2,565	3,254	1,264	2,354	1,905
79	2,266	2,652	3,363	1,307	2,435	1,969
80	2,336	2,737	3,470	1,349	2,512	2,032
81	2,411	2,822	3,579	1,391	2,592	2,095
82	2,487	2,910	3,690	1,434	2,671	2,161
83	2,562	3,000	3,804	1,479	2,754	2,228
84	2,642	3,091	3,922	1,523	2,838	2,296
85	2,733	3,201	4,056	1,577	2,938	2,375
86	2,810	3,291	4,172	1,622	3,021	2,444
87	2,891	3,385	4,292	1,668	3,106	2,513
88	2,973	3,480	4,412	1,715	3,194	2,582
89	3,055	3,577	4,535	1,762	3,283	2,656
90	3,140	3,674	4,660	1,810	3,374	2,728
91	3,225	3,774	4,786	1,860	3,464	2,802
92	3,312	3,876	4,915	1,909	3,558	2,878
93	3,400	3,979	5,046	1,960	3,654	2,955
94	3,489	4,084	5,178	2,012	3,750	3,034
95	3,580	4,191	5,315	2,065	3,849	3,113
96	3,673	4,300	5,452	2,120	3,948	3,191
97	3,766	4,410	5,593	2,172	4,048	3,274
98	3,862	4,521	5,734	2,227	4,150	3,357
99+	3,957	4,634	5,877	2,284	4,254	3,440

Modal Factors: Semi-Annual: 0.5200

Attained	Standard					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	4,397	5,148	6,530	2,538	4,727	3,824
65	1,726	2,017	2,561	996	1,856	1,313
66	1,726	2,017	2,561	996	1,856	1,350
67	1,726	2,017	2,561	996	1,856	1,388
68	1,746	2,044	2,593	1,007	1,877	1,443
69	1,783	2,087	2,648	1,028	1,918	1,512
70	1,830	2,142	2,718	1,057	1,969	1,590
71	1,887	2,208	2,800	1,088	2,026	1,639
72	1,949	2,279	2,891	1,124	2,093	1,693
73	2,015	2,360	2,991	1,162	2,166	1,753
74	2,093	2,451	3,109	1,210	2,250	1,818
75	2,182	2,552	3,236	1,258	2,342	1,895
76	2,267	2,654	3,367	1,308	2,437	1,973
77	2,352	2,754	3,494	1,357	2,528	2,044
78	2,436	2,850	3,615	1,405	2,617	2,117
79	2,519	2,947	3,738	1,452	2,705	2,188
80	2,595	3,041	3,855	1,499	2,790	2,257
81	2,680	3,136	3,977	1,546	2,881	2,328
82	2,762	3,234	4,101	1,594	2,968	2,401
83	2,848	3,335	4,226	1,643	3,061	2,475
84	2,936	3,435	4,358	1,693	3,154	2,551
85	3,037	3,556	4,508	1,750	3,263	2,641
86	3,123	3,657	4,637	1,804	3,357	2,714
87	3,214	3,760	4,770	1,854	3,452	2,794
88	3,304	3,866	4,902	1,906	3,551	2,871
89	3,395	3,976	5,038	1,957	3,648	2,952
90	3,488	4,083	5,176	2,012	3,749	3,033
91	3,583	4,196	5,318	2,065	3,850	3,115
92	3,680	4,306	5,462	2,122	3,955	3,196
93	3,779	4,421	5,609	2,180	4,059	3,283
94	3,877	4,538	5,755	2,235	4,168	3,370
95	3,978	4,657	5,906	2,294	4,276	3,457
96	4,081	4,777	6,059	2,354	4,385	3,546
97	4,183	4,900	6,212	2,414	4,497	3,638
98	4,290	5,022	6,372	2,476	4,612	3,731
99+	4,397	5,148	6,530	2,538	4,727	3,824

Quarterly: 0.2650 Monthly: 0.0833

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

To calculate a Household discount:

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

Modal premium x .93 = discounted premium

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

Continental Life Insurance Company of Brentwood, Tennessee

Annual Premiums

For Use in: Rest of State

Female Rates

Rates Effective 05/1/2019

Attained Age	Preferred					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	2,942	3,444	4,368	1,698	3,162	2,556
65	1,154	1,351	1,712	666	1,241	878
66	1,154	1,351	1,712	666	1,241	903
67	1,154	1,351	1,712	666	1,241	928
68	1,167	1,367	1,734	674	1,255	965
69	1,192	1,396	1,770	688	1,282	1,012
70	1,224	1,433	1,818	707	1,317	1,065
71	1,262	1,476	1,873	728	1,355	1,096
72	1,303	1,525	1,934	751	1,400	1,132
73	1,348	1,578	2,001	777	1,449	1,172
74	1,400	1,639	2,079	808	1,505	1,217
75	1,458	1,707	2,165	842	1,567	1,268
76	1,517	1,776	2,251	876	1,631	1,319
77	1,574	1,842	2,336	908	1,691	1,368
78	1,628	1,906	2,418	939	1,750	1,416
79	1,684	1,972	2,499	971	1,810	1,464
80	1,736	2,034	2,579	1,002	1,867	1,509
81	1,792	2,097	2,660	1,035	1,926	1,557
82	1,848	2,163	2,744	1,066	1,985	1,606
83	1,904	2,230	2,827	1,099	2,047	1,655
84	1,963	2,298	2,915	1,132	2,110	1,706
85	2,032	2,378	3,015	1,172	2,183	1,766
86	2,090	2,446	3,101	1,206	2,245	1,816
87	2,149	2,516	3,190	1,240	2,309	1,868
88	2,209	2,585	3,280	1,274	2,374	1,920
89	2,270	2,659	3,370	1,310	2,440	1,974
90	2,333	2,730	3,463	1,346	2,507	2,028
91	2,397	2,806	3,558	1,382	2,575	2,082
92	2,461	2,881	3,654	1,420	2,645	2,139
93	2,527	2,957	3,751	1,457	2,715	2,196
94	2,594	3,036	3,850	1,495	2,787	2,254
95	2,661	3,115	3,950	1,536	2,860	2,314
96	2,729	3,196	4,053	1,575	2,934	2,372
97	2,799	3,278	4,156	1,615	3,009	2,433
98	2,870	3,360	4,261	1,655	3,085	2,495
99+	2,942	3,444	4,368	1,698	3,162	2,556

Attained Age	Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	3,268	3,827	4,853	1,885	3,513	2,842
65	1,282	1,500	1,903	740	1,379	976
66	1,282	1,500	1,903	740	1,379	1,004
67	1,282	1,500	1,903	740	1,379	1,032
68	1,297	1,519	1,927	749	1,395	1,072
69	1,325	1,552	1,967	765	1,425	1,123
70	1,360	1,591	2,020	786	1,463	1,182
71	1,402	1,640	2,081	808	1,506	1,218
72	1,448	1,694	2,149	834	1,556	1,258
73	1,498	1,754	2,223	863	1,610	1,302
74	1,555	1,821	2,311	899	1,672	1,352
75	1,621	1,897	2,406	935	1,741	1,408
76	1,685	1,973	2,502	972	1,812	1,466
77	1,748	2,047	2,596	1,009	1,879	1,520
78	1,810	2,119	2,687	1,044	1,945	1,573
79	1,872	2,190	2,777	1,079	2,010	1,626
80	1,929	2,260	2,866	1,113	2,074	1,677
81	1,991	2,330	2,955	1,149	2,140	1,730
82	2,052	2,403	3,049	1,185	2,206	1,786
83	2,117	2,478	3,141	1,221	2,274	1,839
84	2,181	2,553	3,238	1,258	2,344	1,896
85	2,257	2,642	3,351	1,302	2,425	1,963
86	2,322	2,718	3,447	1,341	2,495	2,018
87	2,388	2,796	3,545	1,378	2,566	2,076
88	2,456	2,872	3,644	1,416	2,638	2,133
89	2,523	2,954	3,744	1,455	2,711	2,194
90	2,592	3,035	3,848	1,495	2,786	2,253
91	2,663	3,117	3,952	1,536	2,861	2,315
92	2,734	3,200	4,059	1,577	2,939	2,376
93	2,808	3,286	4,168	1,619	3,017	2,440
94	2,882	3,374	4,277	1,662	3,097	2,505
95	2,956	3,461	4,389	1,706	3,178	2,570
96	3,033	3,550	4,503	1,751	3,259	2,636
97	3,110	3,641	4,617	1,794	3,343	2,703
98	3,189	3,733	4,735	1,839	3,428	2,772
99+	3,268	3,827	4,853	1,885	3,513	2,842

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

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

To calculate a Household discount:

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

Modal premium x .93 = discounted premium

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

Continental Life Insurance Company of Brentwood, Tennessee

Annual Premiums

For Use in: Rest of State

Male Rates

Rates Effective 05/1/2019

Attained Age	Preferred					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	3,382	3,961	5,023	1,952	3,636	2,940
65	1,328	1,553	1,971	767	1,427	1,010
66	1,328	1,553	1,971	767	1,427	1,039
67	1,328	1,553	1,971	767	1,427	1,067
68	1,343	1,572	1,995	775	1,444	1,110
69	1,371	1,607	2,036	792	1,475	1,163
70	1,408	1,648	2,092	813	1,514	1,224
71	1,451	1,697	2,154	837	1,558	1,261
72	1,498	1,754	2,224	863	1,610	1,302
73	1,550	1,815	2,301	894	1,666	1,348
74	1,610	1,886	2,390	930	1,731	1,400
75	1,678	1,963	2,491	968	1,802	1,458
76	1,745	2,042	2,589	1,007	1,875	1,517
77	1,809	2,119	2,687	1,044	1,945	1,573
78	1,874	2,192	2,781	1,080	2,012	1,628
79	1,937	2,267	2,874	1,117	2,081	1,683
80	1,997	2,339	2,966	1,153	2,147	1,737
81	2,061	2,412	3,059	1,189	2,215	1,791
82	2,126	2,487	3,154	1,226	2,283	1,847
83	2,190	2,564	3,251	1,264	2,354	1,904
84	2,258	2,642	3,352	1,302	2,426	1,962
85	2,336	2,736	3,467	1,348	2,511	2,030
86	2,402	2,813	3,566	1,386	2,582	2,089
87	2,471	2,893	3,668	1,426	2,655	2,148
88	2,541	2,974	3,771	1,466	2,730	2,207
89	2,611	3,057	3,876	1,506	2,806	2,270
90	2,684	3,140	3,983	1,547	2,884	2,332
91	2,756	3,226	4,091	1,590	2,961	2,395
92	2,831	3,313	4,201	1,632	3,041	2,460
93	2,906	3,401	4,313	1,675	3,123	2,526
94	2,982	3,491	4,426	1,720	3,205	2,593
95	3,060	3,582	4,543	1,765	3,290	2,661
96	3,139	3,675	4,660	1,812	3,374	2,727
97	3,219	3,769	4,780	1,856	3,460	2,798
98	3,301	3,864	4,901	1,903	3,547	2,869
99+	3,382	3,961	5,023	1,952	3,636	2,940

Attained Age	Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	3,758	4,400	5,581	2,169	4,040	3,268
65	1,475	1,724	2,189	851	1,586	1,122
66	1,475	1,724	2,189	851	1,586	1,154
67	1,475	1,724	2,189	851	1,586	1,186
68	1,492	1,747	2,216	861	1,604	1,233
69	1,524	1,784	2,263	879	1,639	1,292
70	1,564	1,831	2,323	903	1,683	1,359
71	1,613	1,887	2,393	930	1,732	1,401
72	1,666	1,948	2,471	961	1,789	1,447
73	1,722	2,017	2,556	993	1,851	1,498
74	1,789	2,095	2,657	1,034	1,923	1,554
75	1,865	2,181	2,766	1,075	2,002	1,620
76	1,938	2,268	2,878	1,118	2,083	1,686
77	2,010	2,354	2,986	1,160	2,161	1,747
78	2,082	2,436	3,090	1,201	2,237	1,809
79	2,153	2,519	3,195	1,241	2,312	1,870
80	2,218	2,599	3,295	1,281	2,385	1,929
81	2,291	2,680	3,399	1,321	2,462	1,990
82	2,361	2,764	3,505	1,362	2,537	2,052
83	2,434	2,850	3,612	1,404	2,616	2,115
84	2,509	2,936	3,725	1,447	2,696	2,180
85	2,596	3,039	3,853	1,496	2,789	2,257
86	2,669	3,126	3,963	1,542	2,869	2,320
87	2,747	3,214	4,077	1,585	2,950	2,388
88	2,824	3,304	4,190	1,629	3,035	2,454
89	2,902	3,398	4,306	1,673	3,118	2,523
90	2,981	3,490	4,424	1,720	3,204	2,592
91	3,062	3,586	4,545	1,765	3,291	2,662
92	3,145	3,680	4,668	1,814	3,380	2,732
93	3,230	3,779	4,794	1,863	3,469	2,806
94	3,314	3,879	4,919	1,910	3,562	2,880
95	3,400	3,980	5,048	1,961	3,655	2,955
96	3,488	4,083	5,179	2,012	3,748	3,031
97	3,575	4,188	5,309	2,063	3,844	3,109
98	3,667	4,292	5,446	2,116	3,942	3,189
99+	3,758	4,400	5,581	2,169	4,040	3,268

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

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

To calculate a Household discount:

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

Modal premium x .93 = 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 7 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, Kentucky 40512-4770. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all your payments.

POLICY REPLACEMENT

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

NOTICE

The policy may not cover all of your medical costs.

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

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

COMPLETE ANSWERS ARE VERY IMPORTANT

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

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

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

PLAN A

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1364	$0	$1364 (Part A Deductible)
61st thru 90th day	All but $341 a day	$341 a day	$0
91st day and after			
While using 60 lifetime reserve days	All but $682 a day	$682 a day	$0
Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $170.50 a day	$0	Up to $170.50 a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

PLAN A

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

*Once you have been billed $185 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $185 of Medicare-Approved amounts*	$0	$0	$185 (Part B Deductible)
Remainder of Medicare-Approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-Approved amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $185 of Medicare-Approved amounts*	$0	$0	$185 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
First $185 of Medicare Approved amounts*	$0	$0	$185 (Part B Deductible)
Remainder of Medicare Approved amounts	80%	20%	$0

PLAN B

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1364	$1364 (Part A Deductible)	$0
61st thru 90th day	All but $341 a day	$341 a day	$0
91st day and after While using 60 lifetime reserve days	All but $682 a day	$682 a day	$0
Once lifetime reserve days are used: Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $170.50 a day	$0	Up to $170.50 a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

PLAN B

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

* Once you have been billed $185 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $185 of Medicare-Approved amounts*	$0	$0	$185 (Part B Deductible)
Remainder of Medicare-Approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-Approved amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $185 of Medicare-Approved amounts*	$0	$0	$185 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
First $185 of Medicare Approved amounts*	$0	$0	$185 (Part B Deductible)
Remainder of Medicare Approved amounts	80%	20%	$0

PLAN F

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1364	$1364 (Part A Deductible)	$0
61st thru 90th day	All but $341 a day	$341 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $682 a day	$682 a day	$0
•Once lifetime reserve days are used:			
•Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
•Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $170.50 a day	Up to $170.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

PLAN F

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

*Once you have been billed $185 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $185 of Medicare-Approved amounts*	$0	$185 (Part B Deductible)	$0
Remainder of Medicare-Approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-Approved amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $185 of Medicare-Approved amounts*	$0	$185 (Part B Deductible)	$0
Remainder of Medicare-Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
•Medically necessary skilled care services and medical supplies	100%	$0	$0
•Durable medical equipment			
•First $185 of Medicare Approved amounts*	$0	$185 (Part B Deductible)	$0
•Remainder of Medicare Approved amounts	80%	20%	$0

PLAN F

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

HIGH DEDUCTIBLE PLAN F

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

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

*****This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2300 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses are $2300. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.**

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2300 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2300 DEDUCTIBLE*** YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1364	$1364 (Part A Deductible)	$0
61st thru 90th day	All but $341 a day	$341 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $682 a day	$682 a day	$0
•Once lifetime reserve days are used:			
•Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
•Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $170.50 a day	Up to $170.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0

HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

HIGH DEDUCTIBLE PLAN F

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

*Once you have been billed $185 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

*****This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2300 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses are $2300. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.**

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2300 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2300 DEDUCTIBLE*** YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $185 of Medicare-Approved amounts*	$0	$185 (Part B Deductible)	$0
Remainder of Medicare-Approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-Approved amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $185 of Medicare-Approved amounts*	$0	$185 (Part B Deductible)	$0
Remainder of Medicare-Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

HIGH DEDUCTIBLE PLAN F

PARTS A & B

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2300 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2300 DEDUCTIBLE*** YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
•Medically necessary skilled care services and medical supplies	100%	$0	$0
•Durable medical equipment •First $185 of Medicare Approved amounts*	$0	$185 (Part B Deductible)	$0
•Remainder of Medicare Approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2300 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2300 DEDUCTIBLE** YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN G

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1364	$1364 (Part A Deductible)	$0
61st thru 90th day	All but $341 a day	$341 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $682 a day	$682 a day	$0
•Once lifetime reserve days are used:			
•Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
•Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $170.50 a day	Up to $170.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness services	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

PLAN G

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

*Once you have been billed $185 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $185 of Medicare-Approved amounts*	$0	$0	$185 (Part B Deductible)
Remainder of Medicare-Approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-Approved amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $185 of Medicare-Approved amounts*	$0	$0	$185 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
•Medically necessary skilled care services and medical supplies	100%	$0	$0
•Durable medical equipment			
•First $185 of Medicare Approved amounts*	$0	$0	$185 (Part B Deductible)
•Remainder of Medicare Approved amounts	80%	20%	$0

PLAN G

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

PLAN N

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1364	$1364 (Part A Deductible)	$0
61st thru 90th day	All but $341 a day	$341 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $682 a day	$682 a day	$0
•Once lifetime reserve days are used:			
•Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
•Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $170.50 a day	Up to $170.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness services	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare co-payment/ coinsurance	$0

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

PLAN N

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

*Once you have been billed $185 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $185 of Medicare-Approved amounts*	$0	$0	$185 (Part B Deductible)
Remainder of Medicare-Approved amounts	Generally 80%	Balance, other than up to $20 per office visit and up to $50 per emergency room visit. The 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 $185 of Medicare-Approved amounts*	$0	$0	$185 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN N

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
•Medically necessary skilled care services and medical supplies	100%	$0	$0
•Durable medical equipment •First $185 of Medicare Approved amounts*	$0	$0	$185 (Part B Deductible)
•Remainder of Medicare Approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

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