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# Outline of Coverage

## **Medicare Supplement Insurance**

**BENEFIT PLANS A, B, F, HIGH DEDUCTIBLE F, G, N**

Underwritten by  
An Aetna Company **Continental Life Insurance Company**  
**of Brentwood, Tennessee**

**NEW HAMPSHIRE**



**CONTINENTAL LIFE INSURANCE COMPANY OF BRENTWOOD, TENNESSEE  
OUTLINE OF MEDICARE SUPPLEMENT COVERAGE COVER PAGE: Page 1 of 2  
BENEFIT PLANS AVAILABLE: A, B, F, HIGH DEDUCTIBLE F, G, N**

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

**Basic Benefits:**

Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.

Medical Expenses: Part B coinsurance (generally 20% of Medicare-Approved expenses) or, 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
Basic, including 100% Part B co-insurance	Basic, including 100% Part B co-insurance	Basic, including 100% Part B co-insurance	Basic, including 100% Part B co-insurance	Basic, including 100% Part B co-insurance	Basic, including 100% Part B co-insurance	Basic, including 100% Part B co-insurance	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%
	Skilled Nursing Facility Co-insurance	Skilled Nursing Facility Co-insurance	Skilled Nursing Facility Co-insurance	Skilled Nursing Facility Co-insurance	Skilled Nursing Facility Co-insurance	Skilled Nursing Facility Co-insurance	50% Skilled Nursing Facility Co-insurance	75% Skilled Nursing Facility Co-insurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	50% Part A Deductible	75% Part A Deductible
	Part B Deductible	Part B Deductible	Part B Deductible	Part B Deductible	Part B Deductible			
				Part B Excess (100%)	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 \$5240; paid at 100% after limit reached	Out-of-pocket limit \$2620; paid at 100% after limit reached

\*Plan F also has an option called a high deductible Plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year \$2240 deductible. Benefits from high deductible Plan F will not begin until out-of-pocket expenses exceed \$2240. 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  
 OUTLINE OF MEDICARE SUPPLEMENT COVERAGE COVER PAGE: Page 2 of 2  
 BENEFIT PLANS AVAILABLE: A, B, F, HIGH DEDUCTIBLE F, G, N**

M	N
Basic, including 100% Part B co-insurance	Basic, including 100% Part B coinsurance, except up to \$20 co-payment for office visit, and up to \$50 copayment for ER
Skilled Nursing Facility Co-insurance	Skilled Nursing Facility Coinsurance
50% Part A Deductible	Part A Deductible
Foreign Travel Emergency	Foreign Travel Emergency

**Continental Life Insurance Company of Brentwood, Tennessee**

Annual Issue Age Premiums  
For Use in ZIP Codes: Entire State  
Female Rates

Rates Effective 01/01/2018

Issue Age	Preferred					Standard						
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	2,286	2,879	3,151	1,241	2,472	2,133	2,539	3,200	3,503	1,378	2,747	2,371
65	1,585	1,997	2,285	912	1,791	1,478	1,759	2,218	2,538	1,014	1,989	1,644
66	1,585	1,997	2,285	912	1,791	1,478	1,759	2,218	2,538	1,014	1,989	1,644
67	1,585	1,997	2,285	912	1,791	1,478	1,759	2,218	2,538	1,014	1,989	1,644
68	1,631	2,050	2,346	937	1,839	1,522	1,810	2,280	2,603	1,040	2,043	1,690
69	1,679	2,117	2,404	962	1,885	1,568	1,864	2,350	2,672	1,069	2,096	1,743
70	1,724	2,174	2,461	985	1,929	1,609	1,913	2,413	2,735	1,093	2,144	1,789
71	1,768	2,225	2,512	1,003	1,969	1,649	1,963	2,474	2,791	1,115	2,190	1,831
72	1,806	2,276	2,557	1,023	2,006	1,685	2,006	2,528	2,842	1,138	2,229	1,874
73	1,839	2,320	2,592	1,038	2,032	1,720	2,044	2,577	2,881	1,154	2,260	1,910
74	1,872	2,359	2,627	1,052	2,060	1,745	2,079	2,619	2,919	1,170	2,290	1,942
75	1,897	2,391	2,655	1,066	2,082	1,773	2,106	2,656	2,952	1,183	2,314	1,967
76	1,919	2,417	2,678	1,074	2,100	1,792	2,132	2,689	2,976	1,191	2,335	1,991
77	1,938	2,441	2,702	1,079	2,119	1,811	2,156	2,713	3,001	1,201	2,352	2,014
78	1,957	2,467	2,727	1,088	2,138	1,830	2,176	2,741	3,030	1,208	2,375	2,032
79	1,976	2,489	2,748	1,094	2,157	1,845	2,196	2,768	3,052	1,215	2,395	2,050
80	1,995	2,512	2,766	1,101	2,168	1,863	2,215	2,793	3,073	1,220	2,411	2,070
81	2,011	2,534	2,787	1,107	2,187	1,878	2,233	2,816	3,096	1,229	2,426	2,088
82	2,025	2,554	2,810	1,115	2,205	1,893	2,252	2,840	3,121	1,241	2,448	2,104
83	2,045	2,576	2,831	1,123	2,221	1,909	2,271	2,860	3,145	1,247	2,468	2,121
84	2,059	2,592	2,855	1,131	2,239	1,925	2,288	2,883	3,174	1,256	2,489	2,135
85	2,071	2,613	2,879	1,138	2,259	1,934	2,300	2,900	3,201	1,264	2,511	2,149
86	2,084	2,628	2,899	1,142	2,274	1,947	2,316	2,919	3,222	1,269	2,526	2,164
87	2,097	2,641	2,920	1,149	2,290	1,958	2,330	2,933	3,243	1,277	2,544	2,176
88	2,117	2,667	2,945	1,158	2,310	1,978	2,351	2,962	3,273	1,289	2,566	2,195
89	2,136	2,691	2,968	1,169	2,328	1,995	2,372	2,989	3,300	1,298	2,588	2,215
90	2,154	2,713	2,994	1,178	2,347	2,012	2,395	3,016	3,326	1,308	2,609	2,236
91	2,173	2,738	3,017	1,186	2,367	2,028	2,413	3,040	3,351	1,320	2,628	2,252
92	2,187	2,759	3,037	1,193	2,382	2,043	2,432	3,064	3,375	1,328	2,649	2,271
93	2,204	2,777	3,057	1,205	2,398	2,059	2,448	3,086	3,395	1,336	2,664	2,286
94	2,219	2,795	3,071	1,208	2,409	2,071	2,465	3,106	3,415	1,343	2,678	2,303
95	2,232	2,810	3,088	1,215	2,421	2,083	2,479	3,126	3,430	1,348	2,691	2,316
96	2,245	2,827	3,105	1,221	2,436	2,097	2,492	3,143	3,449	1,357	2,704	2,328
97	2,257	2,844	3,120	1,228	2,447	2,107	2,509	3,162	3,467	1,365	2,719	2,342
98	2,270	2,860	3,138	1,233	2,460	2,119	2,522	3,178	3,485	1,371	2,733	2,354
99	2,286	2,879	3,151	1,241	2,472	2,133	2,539	3,200	3,503	1,378	2,747	2,371

Modular Factors: Semi-Annual: 0.5200 Monthly: 0.0833

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

To calculate a Household discount:

Annual premium x modal factor = modal premium (round to nearest whole cent)  
Modal premium x .95 = discounted premium

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

**Continental Life Insurance Company of Brentwood, Tennessee**

Annual Issue Age Premiums  
For Use in ZIP Codes: Entire State  
Male Rates

Rates Effective 01/01/2018

Issue Age	Preferred						Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	2,627	3,309	3,624	1,425	2,842	2,453	2,918	3,678	4,027	1,585	3,158	2,725
65	1,821	2,293	2,627	1,050	2,060	1,701	2,024	2,550	2,918	1,166	2,290	1,891
66	1,821	2,293	2,627	1,050	2,060	1,701	2,024	2,550	2,918	1,166	2,290	1,891
67	1,821	2,293	2,627	1,050	2,060	1,701	2,024	2,550	2,918	1,166	2,290	1,891
68	1,873	2,361	2,694	1,077	2,113	1,750	2,081	2,622	2,995	1,196	2,348	1,944
69	1,932	2,435	2,766	1,106	2,168	1,805	2,145	2,703	3,073	1,228	2,411	2,004
70	1,983	2,499	2,830	1,132	2,220	1,853	2,204	2,776	3,144	1,257	2,465	2,059
71	2,032	2,558	2,890	1,155	2,268	1,895	2,257	2,843	3,211	1,284	2,518	2,107
72	2,078	2,616	2,943	1,178	2,309	1,940	2,308	2,908	3,268	1,307	2,564	2,156
73	2,117	2,666	2,981	1,193	2,338	1,976	2,351	2,962	3,314	1,327	2,598	2,195
74	2,150	2,711	3,023	1,211	2,371	2,007	2,390	3,012	3,357	1,344	2,632	2,233
75	2,182	2,747	3,053	1,223	2,396	2,036	2,424	3,052	3,393	1,361	2,662	2,264
76	2,207	2,780	3,080	1,232	2,416	2,061	2,451	3,088	3,422	1,371	2,685	2,291
77	2,227	2,809	3,106	1,243	2,437	2,081	2,477	3,121	3,451	1,379	2,706	2,312
78	2,252	2,839	3,136	1,251	2,459	2,104	2,501	3,151	3,482	1,388	2,731	2,338
79	2,271	2,862	3,163	1,257	2,480	2,123	2,524	3,183	3,510	1,397	2,754	2,355
80	2,293	2,889	3,181	1,264	2,494	2,142	2,548	3,209	3,534	1,405	2,771	2,379
81	2,312	2,914	3,206	1,272	2,515	2,158	2,567	3,238	3,564	1,415	2,797	2,400
82	2,332	2,937	3,231	1,283	2,535	2,176	2,590	3,264	3,589	1,425	2,816	2,419
83	2,350	2,962	3,257	1,291	2,554	2,195	2,613	3,290	3,620	1,435	2,839	2,440
84	2,366	2,981	3,283	1,299	2,575	2,210	2,630	3,314	3,650	1,445	2,863	2,456
85	2,384	3,001	3,311	1,307	2,596	2,226	2,649	3,335	3,680	1,453	2,885	2,472
86	2,397	3,019	3,335	1,316	2,615	2,239	2,665	3,358	3,705	1,459	2,906	2,487
87	2,411	3,038	3,358	1,321	2,632	2,250	2,676	3,374	3,731	1,469	2,926	2,501
88	2,435	3,068	3,388	1,334	2,656	2,273	2,704	3,405	3,763	1,481	2,950	2,525
89	2,453	3,095	3,416	1,343	2,679	2,295	2,728	3,438	3,796	1,492	2,976	2,548
90	2,478	3,121	3,442	1,355	2,700	2,313	2,750	3,468	3,824	1,506	3,000	2,572
91	2,499	3,147	3,468	1,365	2,720	2,332	2,776	3,498	3,854	1,516	3,024	2,593
92	2,516	3,171	3,491	1,373	2,738	2,349	2,798	3,524	3,880	1,526	3,044	2,613
93	2,536	3,195	3,514	1,381	2,757	2,367	2,817	3,547	3,905	1,535	3,062	2,630
94	2,551	3,214	3,534	1,392	2,771	2,382	2,834	3,571	3,925	1,545	3,079	2,647
95	2,564	3,232	3,552	1,398	2,784	2,397	2,851	3,592	3,946	1,553	3,095	2,661
96	2,581	3,252	3,570	1,404	2,800	2,410	2,868	3,614	3,966	1,560	3,110	2,677
97	2,595	3,269	3,586	1,411	2,812	2,423	2,885	3,634	3,985	1,567	3,126	2,693
98	2,613	3,289	3,606	1,418	2,828	2,440	2,901	3,657	4,006	1,576	3,143	2,710
99	2,627	3,309	3,624	1,425	2,842	2,453	2,918	3,678	4,027	1,585	3,158	2,725

Modal Factors: Semi-Annual: 0.5200 Monthly: 0.0833

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

To calculate a Household discount:

Annual premium x modal factor = modal premium (round to nearest whole cent)  
Modal premium x .95 = discounted premium

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

## **PREMIUM INFORMATION**

Continental Life Insurance Company of Brentwood, Tennessee can only raise your premium if we raise the premium for all policies like yours in this state. Premiums 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.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<p><b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days</p> <p>61st thru 90th day 91st day and after</p> <ul style="list-style-type: none"> <li>•While using 60 lifetime reserve days</li> <li>•Once lifetime reserve days are used:</li> <li>•Additional 365 days</li> <li>•Beyond the Additional 365 days</li> </ul>	<p>All but \$1340</p> <p>All but \$335 a day</p> <p>All but \$670 a day</p> <p>\$0</p> <p>\$0</p>	<p>\$0</p> <p>\$335 a day</p> <p>\$670 a day</p> <p>100% of Medicare Eligible Expenses</p> <p>\$0</p>	<p>\$1340 (Part A Deductible)</p> <p>\$0</p> <p>\$0</p> <p>\$0**</p> <p>All costs</p>
<p><b>SKILLED NURSING FACILITY CARE*</b> 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</p> <p>First 20 days 21st thru 100th day</p> <p>101st day and after</p>	<p>All approved amounts</p> <p>All but \$167.50 a day</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>\$0</p>	<p>\$0</p> <p>Up to \$167.50 a day</p> <p>All costs</p>
<p><b>BLOOD</b> First 3 pints Additional amounts</p>	<p>\$0</p> <p>100%</p>	<p>3 pints</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p>
<p><b>HOSPICE CARE</b> You must meet Medicare's requirements, including a doctor's certification of terminal illness.</p>	<p>All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care</p>	<p>Medicare copayment/ coinsurance</p>	<p>\$0</p>

\*\*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 \$183 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.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>MEDICAL EXPENSES –</b> 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 \$183 of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0  Generally 80%	\$0  Generally 20%	\$183 (Part B Deductible)  \$0
<b>Part B Excess Charges</b> (Above Medicare-Approved amounts)	\$0	\$0	All costs
<b>BLOOD</b> First 3 pints Next \$183 of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$183 (Part B Deductible) \$0
<b>CLINICAL LABORATORY SERVICES –</b> TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

**PARTS A & B**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>HOME HEALTH CARE –</b> MEDICARE APPROVED SERVICES •Medically necessary skilled care services and medical supplies  •Durable medical equipment •First \$183 of Medicare Approved amounts*  •Remainder of Medicare Approved amounts	100%  \$0  80%	\$0  \$0  20%	\$0  \$183 (Part B Deductible)  \$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
<p><b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days</p> <p>61st thru 90th day 91st day and after</p> <ul style="list-style-type: none"> <li>•While using 60 lifetime reserve days</li> <li>•Once lifetime reserve days are used:</li> <li>•Additional 365 days</li> <li>•Beyond the Additional 365 days</li> </ul>	<p>All but \$1340</p> <p>All but \$335 a day</p> <p>All but \$670 a day</p> <p>\$0</p> <p>\$0</p>	<p>\$1340 (Part A Deductible)</p> <p>\$335 a day</p> <p>\$670 a day</p> <p>100% of Medicare Eligible Expenses</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>\$0</p> <p>\$0**</p> <p>All costs</p>
<p><b>SKILLED NURSING FACILITY CARE*</b> 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</p> <p>First 20 days</p> <p>21st thru 100th day</p> <p>101st day and after</p>	<p>All approved amounts</p> <p>All but \$167.50 a day</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>\$0</p>	<p>\$0</p> <p>Up to \$167.50 a day</p> <p>All costs</p>
<p><b>BLOOD</b> First 3 pints Additional amounts</p>	<p>\$0</p> <p>100%</p>	<p>3 pints</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p>
<p><b>HOSPICE CARE</b> You must meet Medicare's requirements, including a doctor's certification of terminal illness.</p>	<p>All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care</p>	<p>Medicare copayment/ coinsurance</p>	<p>\$0</p>

\*\*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 \$183 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.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>MEDICAL EXPENSES –</b> 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 \$183 of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0  Generally 80%	\$0  Generally 20%	\$183 (Part B Deductible)  \$0
<b>Part B Excess Charges</b> (Above Medicare-Approved amounts)	\$0	\$0	All costs
<b>BLOOD</b> First 3 pints Next \$183 of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$183 (Part B Deductible) \$0
<b>CLINICAL LABORATORY SERVICES –</b> TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

**PARTS A & B**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>HOME HEALTH CARE –</b> MEDICARE APPROVED SERVICES •Medically necessary skilled care services and medical supplies	100%	\$0	\$0
•Durable medical equipment •First \$183 of Medicare Approved amounts*	\$0	\$0	\$183 (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.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<p><b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days</p> <p>61st thru 90th day 91st day and after</p> <ul style="list-style-type: none"> <li>•While using 60 lifetime reserve days</li> <li>•Once lifetime reserve days are used:</li> <li>•Additional 365 days</li> <li>•Beyond the Additional 365 days</li> </ul>	<p>All but \$1340</p> <p>All but \$335 a day</p> <p>All but \$670 a day</p> <p>\$0</p> <p>\$0</p>	<p>\$1340 (Part A Deductible)</p> <p>\$335 a day</p> <p>\$670 a day</p> <p>100% of Medicare Eligible Expenses</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>\$0</p> <p>\$0**</p> <p>All costs</p>
<p><b>SKILLED NURSING FACILITY CARE*</b> 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</p> <p>First 20 days</p> <p>21st thru 100th day</p> <p>101st day and after</p>	<p>All approved amounts</p> <p>All but \$167.50 a day</p> <p>\$0</p>	<p>\$0</p> <p>Up to \$167.50 a day</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>All costs</p>
<p><b>BLOOD</b> First 3 pints Additional amounts</p>	<p>\$0</p> <p>100%</p>	<p>3 pints</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p>
<p><b>HOSPICE CARE</b> You must meet Medicare's requirements, including a doctor's certification of terminal illness.</p>	<p>All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care</p>	<p>Medicare copayment/ coinsurance</p>	<p>\$0</p>

\*\*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 \$183 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.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>MEDICAL EXPENSES –</b> 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 \$183 of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0  Generally 80%	\$183 (Part B Deductible)  Generally 20%	\$0  \$0
<b>Part B Excess Charges</b> (Above Medicare-Approved amounts)	\$0	100%	\$0
<b>BLOOD</b> First 3 pints Next \$183 of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0 \$0 80%	All costs \$183 (Part B Deductible)  20%	\$0 \$0 \$0
<b>CLINICAL LABORATORY SERVICES –</b> TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

**PARTS A & B**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>HOME HEALTH CARE –</b> MEDICARE APPROVED SERVICES •Medically necessary skilled care services and medical supplies	100%	\$0	\$0
•Durable medical equipment •First \$183 of Medicare Approved amounts*	\$0	\$183 (Part B Deductible)	\$0
•Remainder of Medicare Approved amounts	80%	20%	\$0

**PLAN F**

**OTHER BENEFITS – NOT COVERED BY MEDICARE**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</b> Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of charges	\$0 \$0	\$0 80% to a lifetime maximum benefit of \$50,000	\$250 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 \$2240 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses are \$2240. 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 \$2240 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO \$2240 DEDUCTIBLE** YOU PAY
<p><b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days</p> <p>61st thru 90th day 91st day and after</p> <ul style="list-style-type: none"> <li>•While using 60 lifetime reserve days</li> <li>•Once lifetime reserve days are used:</li> <li>•Additional 365 days</li> <li>•Beyond the Additional 365 days</li> </ul>	<p>All but \$1340</p> <p>All but \$335 a day</p> <p>All but \$670 a day</p> <p>\$0</p> <p>\$0</p>	<p>\$1340 (Part A Deductible)</p> <p>\$335 a day</p> <p>\$670 a day</p> <p>100% of Medicare Eligible Expenses</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>\$0</p> <p>\$0**</p> <p>All costs</p>
<p><b>SKILLED NURSING FACILITY CARE*</b> 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</p> <p>First 20 days</p> <p>21st thru 100th day</p> <p>101st day and after</p>	<p>All approved amounts</p> <p>All but \$167.50 a day</p> <p>\$0</p>	<p>\$0</p> <p>Up to \$167.50 a day</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>All costs</p>
<p><b>BLOOD</b> First 3 pints Additional amounts</p>	<p>\$0</p> <p>100%</p>	<p>3 pints</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p>

<b>HOSPICE CARE</b> 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
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\*\*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 \$183 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 \$2240 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses are \$2240. 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 \$2240 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO \$2240 DEDUCTIBLE** YOU PAY
<b>MEDICAL EXPENSES –</b> 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 \$183 of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0  Generally 80%	\$183 (Part B Deductible)  Generally 20%	\$0  \$0
<b>Part B Excess Charges</b> (Above Medicare-Approved amounts)	\$0	100%	\$0
<b>BLOOD</b> First 3 pints Next \$183 of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0 \$0  80%	All costs \$183 (Part B Deductible)  20%	\$0 \$0  \$0
<b>CLINICAL LABORATORY SERVICES –</b> TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

## HIGH DEDUCTIBLE PLAN F

### PARTS A & B

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$2240 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO \$2240 DEDUCTIBLE** YOU PAY
<b>HOME HEALTH CARE – MEDICARE APPROVED SERVICES</b> <ul style="list-style-type: none"> <li>•Medically necessary skilled care services and medical supplies</li> </ul>	100%	\$0	\$0
<ul style="list-style-type: none"> <li>•Durable medical equipment</li> <li>•First \$183 of Medicare Approved amounts*</li> </ul>	\$0	\$183 (Part B Deductible)	\$0
<ul style="list-style-type: none"> <li>•Remainder of Medicare Approved amounts</li> </ul>	80%	20%	\$0

### OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$2240 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO \$2240 DEDUCTIBLE** YOU PAY
<b>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</b> Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of charges	 \$0 \$0	 \$0 80% to a lifetime maximum benefit of \$50,000	 \$250 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.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days  61st thru 90th day 91st day and after •While using 60 lifetime reserve days •Once lifetime reserve days are used: •Additional 365 days  •Beyond the Additional 365 days	All but \$1340  All but \$335 a day  All but \$670 a day  \$0  \$0	\$1340 (Part A Deductible) \$335 a day  \$670 a day  100% of Medicare Eligible Expenses \$0	\$0  \$0  \$0  \$0**  All costs
<b>SKILLED NURSING FACILITY CARE*</b> 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  21st thru 100th day  101st day and after	All approved amounts All but \$167.50 a day \$0	\$0  Up to \$167.50 a day \$0	\$0  \$0  All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> 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 \$183 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.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>MEDICAL EXPENSES –</b> 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 \$183 of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0  Generally 80%	\$0  Generally 20%	\$183 (Part B Deductible)  \$0
<b>Part B Excess Charges</b> (Above Medicare-Approved amounts)	\$0	100%	\$0
<b>BLOOD</b> First 3 pints Next \$183 of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$183 (Part B Deductible) \$0
<b>CLINICAL LABORATORY SERVICES –</b> TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

**PARTS A & B**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>HOME HEALTH CARE –</b> MEDICARE APPROVED SERVICES •Medically necessary skilled care services and medical supplies •Durable medical equipment •First \$183 of Medicare Approved amounts* •Remainder of Medicare Approved amounts	100%  \$0 80%	\$0  \$0 20%	\$0  \$183 (Part B Deductible) \$0

**PLAN G**

**OTHER BENEFITS – NOT COVERED BY MEDICARE**

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

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days  61st thru 90th day 91st day and after •While using 60 lifetime reserve days •Once lifetime reserve days are used: •Additional 365 days  •Beyond the Additional 365 days	All but \$1340  All but \$335 a day  All but \$670 a day  \$0  \$0	\$1340 (Part A Deductible) \$335 a day  \$670 a day  100% of Medicare Eligible Expenses \$0	\$0  \$0  \$0  \$0**  All costs
<b>SKILLED NURSING FACILITY CARE*</b> 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  21st thru 100th day  101st day and after	All approved amounts All but \$167.50 a day \$0	\$0  Up to \$167.50 a day \$0	\$0  \$0  All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> 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 \$183 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.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<p><b>MEDICAL EXPENSES –</b>            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 \$183 of Medicare-Approved amounts*            Remainder of Medicare-Approved amounts</p>	<p>\$0             Generally 80%</p>	<p>\$0             Balance, other than up to \$20 per office visit and up to \$50 per emergency room visit. The copayment of up to \$50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.</p>	<p>\$183            (Part B Deductible)            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.</p>
<p><b>Part B Excess Charges</b>            (Above Medicare-Approved amounts)</p>	<p>\$0</p>	<p>0%</p>	<p>All costs</p>
<p><b>BLOOD</b>            First 3 pints            Next \$183 of Medicare-Approved amounts*            Remainder of Medicare-Approved amounts</p>	<p>\$0            \$0            80%</p>	<p>All costs            \$0            20%</p>	<p>\$0            \$183            (Part B Deductible)            \$0</p>
<p><b>CLINICAL LABORATORY SERVICES –</b>            TESTS FOR DIAGNOSTIC SERVICES</p>	<p>100%</p>	<p>\$0</p>	<p>\$0</p>

**PLAN N**

**PARTS A & B**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>HOME HEALTH CARE – MEDICARE APPROVED SERVICES</b>			
•Medically necessary skilled care services and medical supplies	100%	\$0	\$0
•Durable medical equipment			
•First \$183 of Medicare Approved amounts*	\$0	\$0	\$183 (Part B Deductible)
•Remainder of Medicare Approved amounts	80%	20%	\$0

**OTHER BENEFITS – NOT COVERED BY MEDICARE**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</b>			
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