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Outline of Coverage

Medicare Supplement Insurance

BENEFIT PLANS A, B, F, G High Deductible F, N

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

TEXAS

**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	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 \$[4800]; paid at 100% after limit reached	Out-of-pocket limit \$[2400]; 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 \$[2110] deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed \$[2110]. 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.

ANNUAL ATTAINED AGE PREMIUMS

CONTINENTAL LIFE INSURANCE COMPANY OF BRENTWOOD, TENNESSEE

Medicare Supplement Policy
2010 Standardized Plan A

Medicare Supplement Policy
2010 Standardized Plan B

Attained Age	Preferred		Standard		Attained Age	Preferred		Standard	
	Female	Male	Female	Male		Female	Male	Female	Male
0-64	6,116	7,034	6,795	7,818	0-64	N/A	N/A	N/A	N/A
65	1,170	1,344	1,299	1,492	65	1,231	1,415	1,367	1,570
66	1,170	1,344	1,299	1,492	66	1,231	1,415	1,367	1,570
67	1,170	1,344	1,299	1,492	67	1,231	1,415	1,367	1,570
68	1,226	1,411	1,363	1,568	68	1,292	1,485	1,434	1,650
69	1,282	1,475	1,424	1,637	69	1,349	1,552	1,498	1,723
70	1,334	1,532	1,481	1,703	70	1,404	1,613	1,559	1,792
71	1,384	1,591	1,538	1,766	71	1,456	1,674	1,618	1,860
72	1,431	1,645	1,591	1,830	72	1,506	1,733	1,674	1,925
73	1,477	1,697	1,641	1,886	73	1,555	1,786	1,727	1,986
74	1,519	1,747	1,688	1,941	74	1,599	1,839	1,777	2,043
75	1,558	1,790	1,730	1,990	75	1,640	1,885	1,822	2,095
76	1,593	1,832	1,771	2,035	76	1,677	1,928	1,864	2,142
77	1,627	1,871	1,808	2,080	77	1,712	1,970	1,902	2,190
78	1,660	1,908	1,843	2,119	78	1,747	2,008	1,940	2,230
79	1,688	1,941	1,875	2,157	79	1,777	2,043	1,974	2,271
80	1,714	1,971	1,906	2,191	80	1,804	2,076	2,006	2,307
81	1,738	2,000	1,933	2,224	81	1,830	2,105	2,034	2,340
82	1,763	2,028	1,959	2,252	82	1,856	2,134	2,063	2,371
83	1,785	2,055	1,985	2,281	83	1,880	2,163	2,090	2,402
84	1,808	2,078	2,008	2,310	84	1,902	2,188	2,114	2,431
85	1,830	2,103	2,032	2,337	85	1,925	2,213	2,139	2,460
86	1,850	2,126	2,056	2,364	86	1,947	2,238	2,164	2,488
87	1,869	2,150	2,076	2,387	87	1,968	2,263	2,186	2,513
88	1,887	2,171	2,097	2,412	88	1,987	2,286	2,208	2,538
89	1,906	2,193	2,117	2,435	89	2,006	2,309	2,228	2,562
90	1,922	2,212	2,137	2,457	90	2,023	2,327	2,249	2,586
91	1,938	2,229	2,153	2,477	91	2,041	2,346	2,266	2,608
92	1,954	2,247	2,170	2,496	92	2,057	2,364	2,285	2,628
93	1,968	2,264	2,186	2,512	93	2,071	2,383	2,301	2,644
94	1,980	2,277	2,200	2,529	94	2,084	2,397	2,316	2,662
95	1,990	2,289	2,213	2,545	95	2,095	2,410	2,329	2,679
96	2,004	2,302	2,226	2,559	96	2,108	2,424	2,342	2,694
97	2,015	2,316	2,239	2,574	97	2,120	2,438	2,357	2,711
98	2,027	2,330	2,251	2,591	98	2,133	2,452	2,370	2,727
99	2,039	2,345	2,265	2,606	99	2,145	2,468	2,385	2,743

Modal Factors: Ann:1.0000 Semi: 0.5200 Qtrly: 0.2650 Mthly: 0.0833

To calculate household discount:

Base rate x area factor=annual premium (round to nearest whole dollar)

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

Modal premium x .95=discounted premium

Texas	1.21
770-773, 775.....	1.15
750-753, 760, 761, 774, 776, 777, 782, 784, 793, 794.....	1.00
Rest of State.....	1.00

The rates above do not include a one time \$20 policy fee.

ANNUAL ATTAINED AGE PREMIUMS

CONTINENTAL LIFE INSURANCE COMPANY OF BRENTWOOD, TENNESSEE

Medicare Supplement Policy
2010 Standardized Plan F

Medicare Supplement Policy
2010 Standardized Plan HF

Attained Age	Preferred		Standard		Attained Age	Preferred		Standard	
	Female	Male	Female	Male		Female	Male	Female	Male
0-64	N/A	N/A	N/A	N/A	0-64	N/A	N/A	N/A	N/A
65	1,429	1,644	1,588	1,827	65	562	647	624	718
66	1,429	1,644	1,588	1,827	66	562	647	624	718
67	1,429	1,644	1,588	1,827	67	562	647	624	718
68	1,500	1,723	1,666	1,917	68	590	677	656	754
69	1,558	1,792	1,733	1,991	69	612	706	682	783
70	1,614	1,858	1,795	2,064	70	636	731	705	811
71	1,672	1,922	1,857	2,136	71	657	756	730	840
72	1,723	1,983	1,914	2,203	72	677	780	754	866
73	1,771	2,035	1,968	2,262	73	697	800	774	890
74	1,814	2,090	2,017	2,320	74	714	822	794	913
75	1,857	2,136	2,064	2,373	75	730	840	811	933
76	1,893	2,176	2,103	2,419	76	745	856	827	951
77	1,925	2,213	2,139	2,460	77	757	871	842	968
78	1,955	2,249	2,173	2,498	78	769	885	855	982
79	1,983	2,281	2,203	2,533	79	780	896	866	996
80	2,007	2,310	2,230	2,565	80	791	908	877	1,010
81	2,033	2,339	2,260	2,599	81	800	920	889	1,023
82	2,060	2,370	2,289	2,631	82	810	931	902	1,035
83	2,084	2,397	2,316	2,664	83	820	942	911	1,048
84	2,108	2,424	2,342	2,694	84	829	954	920	1,060
85	2,132	2,451	2,370	2,724	85	839	965	931	1,072
86	2,154	2,477	2,394	2,752	86	847	975	941	1,082
87	2,176	2,503	2,418	2,778	87	856	984	951	1,093
88	2,197	2,525	2,438	2,805	88	864	994	959	1,103
89	2,213	2,546	2,460	2,830	89	871	1,002	968	1,113
90	2,232	2,566	2,480	2,853	90	878	1,010	975	1,123
91	2,250	2,586	2,498	2,874	91	885	1,017	983	1,130
92	2,264	2,604	2,518	2,892	92	891	1,025	990	1,137
93	2,279	2,620	2,532	2,910	93	896	1,030	996	1,145
94	2,291	2,635	2,546	2,927	94	902	1,036	1,002	1,151
95	2,302	2,648	2,558	2,941	95	906	1,042	1,006	1,157
96	2,315	2,660	2,571	2,958	96	911	1,047	1,012	1,162
97	2,326	2,675	2,584	2,971	97	917	1,052	1,017	1,168
98	2,339	2,689	2,598	2,987	98	920	1,059	1,023	1,175
99	2,349	2,703	2,611	3,002	99	923	1,063	1,027	1,182

Modal Factors: Ann:1.0000 Semi: 0.5200 Qtrly: 0.2650 Mthly: 0.0833

To calculate household discount:

Base rate x area factor=annual premium (round to nearest whole dollar)

Area Factors:

Texas	1.21
770-773, 775.....	1.15
750-753, 760, 761, 774, 776, 777, 782, 784, 793, 794.....	1.00
Rest of State.....	1.00

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

Modal premium x .95=discounted premium

The rates above do not include a one time \$20 policy fee.

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ANNUAL ATTAINED AGE PREMIUMS

CONTINENTAL LIFE INSURANCE COMPANY OF BRENTWOOD, TENNESSEE

Medicare Supplement Policy
2010 Standardized Plan G

Medicare Supplement Policy
2010 Standardized Plan N

Attained Age	Preferred		Standard		Attained Age	Preferred		Standard	
	Female	Male	Female	Male		Female	Male	Female	Male
0-64	N/A	N/A	N/A	N/A	0-64	N/A	N/A	N/A	N/A
65	1,251	1,439	1,391	1,598	65	993	1,142	1,104	1,270
66	1,251	1,439	1,391	1,598	66	993	1,142	1,104	1,270
67	1,251	1,439	1,391	1,598	67	993	1,142	1,104	1,270
68	1,313	1,509	1,459	1,678	68	1,043	1,200	1,160	1,333
69	1,373	1,578	1,526	1,753	69	1,090	1,253	1,212	1,393
70	1,427	1,641	1,583	1,823	70	1,133	1,304	1,260	1,449
71	1,481	1,702	1,645	1,892	71	1,176	1,353	1,307	1,503
72	1,532	1,762	1,702	1,957	72	1,218	1,400	1,353	1,556
73	1,580	1,818	1,757	2,019	73	1,255	1,444	1,395	1,604
74	1,626	1,871	1,807	2,078	74	1,292	1,485	1,436	1,652
75	1,668	1,918	1,853	2,129	75	1,325	1,524	1,470	1,691
76	1,705	1,962	1,894	2,179	76	1,355	1,558	1,505	1,732
77	1,742	2,003	1,936	2,226	77	1,385	1,591	1,540	1,767
78	1,776	2,042	1,973	2,268	78	1,411	1,624	1,567	1,802
79	1,807	2,078	2,007	2,309	79	1,435	1,652	1,593	1,833
80	1,836	2,110	2,041	2,345	80	1,458	1,677	1,622	1,864
81	1,862	2,142	2,069	2,379	81	1,480	1,701	1,644	1,889
82	1,887	2,170	2,097	2,412	82	1,500	1,723	1,667	1,916
83	1,911	2,199	2,124	2,443	83	1,519	1,747	1,687	1,941
84	1,935	2,226	2,151	2,473	84	1,540	1,767	1,708	1,966
85	1,958	2,252	2,176	2,503	85	1,556	1,789	1,728	1,987
86	1,981	2,277	2,201	2,531	86	1,573	1,809	1,748	2,009
87	2,000	2,301	2,223	2,557	87	1,589	1,827	1,766	2,031
88	2,021	2,324	2,247	2,582	88	1,606	1,847	1,783	2,052
89	2,041	2,346	2,266	2,607	89	1,622	1,864	1,800	2,071
90	2,058	2,367	2,287	2,631	90	1,636	1,880	1,816	2,090
91	2,076	2,387	2,307	2,652	91	1,649	1,895	1,831	2,107
92	2,091	2,405	2,323	2,671	92	1,661	1,909	1,846	2,124
93	2,105	2,422	2,340	2,690	93	1,672	1,923	1,859	2,138
94	2,119	2,437	2,354	2,708	94	1,683	1,936	1,872	2,151
95	2,132	2,451	2,369	2,724	95	1,692	1,947	1,884	2,163
96	2,144	2,465	2,383	2,740	96	1,703	1,958	1,892	2,176
97	2,157	2,481	2,396	2,755	97	1,713	1,971	1,902	2,189
98	2,169	2,495	2,410	2,772	98	1,722	1,982	1,914	2,203
99	2,183	2,510	2,425	2,789	99	1,734	1,995	1,926	2,215

Modal Factors: Ann:1.0000 Semi: 0.5200 Qtrly: 0.2650 Mthly: 0.0833

To calculate household discount:

Base rate x area factor=annual premium (round to nearest whole dollar)

Area Factors:

Texas	1.21
770-773, 775.....	1.15
750-753, 760, 761, 774, 776, 777, 782, 784, 793, 794.....	1.00
Rest of State.....	1.00

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

Modal premium x .95=discounted premium

The rates above do not include a one time \$20 policy fee.

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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 annual 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; or (b) 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 2368, Brentwood, Tennessee 37024. 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.

LIMITATIONS AND EXCLUSIONS

This policy does not cover any expenses of the type excluded by Medicare or not covered under the terms of this policy.

Benefits covered by this policy will not duplicate Medicare benefits.

We will not be liable for any loss which was caused by your committing or attempting to commit any felony or from engaging in an illegal occupation.

REFUND OF PREMIUM

The company shall refund any premium paid for the period beyond the end of the policy month in which the death or cancellation occurred. Unearned premium shall be paid in a lump sum to your estate no later than thirty (30) days after receipt of proof of death or cancellation is received by the company.

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) – MEDICAL 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.

**\$0 Indicates your liability for covered charges. You are responsible for all other non-covered charges.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* 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 [\$1184] All but [\$296] a day All but [\$592] a day \$0 \$0	\$0 [\$296] a day [\$592] a day 100% of Medicare Eligible Expenses \$0	[\$1184] (Part A Deductible) \$0** \$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 21st thru 100th day 101st day and after	All approved amounts All but [\$148] a day \$0	\$0 \$0 \$0	\$0** Up to [\$148] a day All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$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 [\$147] 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.

**\$0 Indicates your liability for covered charges. You are responsible for all other non-covered charges.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic test, durable medical equipment First [\$147] of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0 Generally 80%	\$0 Generally 20%	[\$147] (Part B Deductible) \$0**
Part B Excess Charges (Above Medicare-Approved amounts)	\$0	\$0	All costs
BLOOD First 3 pints Next [\$147] of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0 \$0 80%	All costs \$0 20%	\$0** [\$147] (Part B Deductible) \$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 Durable medical equipment	100%	\$0	\$0**
First [\$147] of Medicare Approved amounts*	\$0	\$0	[\$147] (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.

**\$0 Indicates your liability for covered charges. You are responsible for all other non-covered charges.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* 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 [\$1184] All but [\$296] a day All but [\$592] a day \$0 \$0	[\$1184] (Part A Deductible) [\$296] a day [\$592] a day 100% of Medicare Eligible Expenses \$0	\$0** \$0** \$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 21st thru 100th day 101st day and after	All approved amounts All but [\$148] a day \$0	\$0 \$0 \$0	\$0** Up to [\$148] a day All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$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 [\$147] 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.

**\$0 Indicates your liability for covered charges. You are responsible for all other non-covered charges.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic test, durable medical equipment First [\$147] of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0 Generally 80%	\$0 Generally 20%	[\$147] (Part B Deductible) \$0**
Part B Excess Charges (Above Medicare-Approved amounts)	\$0	\$0	All costs
BLOOD First 3 pints Next [\$147] of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0 \$0 80%	All costs \$0 20%	\$0** [\$147] (Part B Deductible) \$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 [\$147] of Medicare Approved amounts*	\$0	\$0	[\$147] (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.

**\$0 Indicates your liability for covered charges. You are responsible for all other non-covered charges.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* 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 [\$1184] All but [\$296] a day All but [\$592] a day \$0 \$0	[\$1184] (Part A Deductible) [\$296] a day [\$592] a day 100% of Medicare Eligible Expenses \$0	\$0** \$0** \$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 21st thru 100th day 101st day and after	All approved amounts All but [\$148] a day \$0	\$0 Up to [\$148] a day \$0	\$0** \$0** All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$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 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 [\$147] 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.

**\$0 Indicates your liability for covered charges. You are responsible for all other non-covered charges.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic test, durable medical equipment First [\$147] of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0 Generally 80%	[\$147] (Part B Deductible) Generally 20%	\$0** \$0**
Part B Excess Charges (Above Medicare-Approved amounts)	\$0	100%	\$0**
BLOOD First 3 pints Next [\$147] of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0 \$0 80%	All costs [\$147] (Part B Deductible) 20%	\$0** \$0** \$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 [\$147] of Medicare Approved amounts*	\$0	[\$147] (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 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 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.

**\$0 Indicates your liability for covered charges. You are responsible for all other non-covered charges.

***This high deductible plan pays the same benefits as Plan F after one has paid a calendar year [\$2110] deductible. Benefits from high deductible Plan F will not begin until out-of-pocket expenses are [\$2110]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY [\$2110] DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO [\$2110] DEDUCTIBLE*** YOU PAY
HOSPITALIZATION* 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 [\$1184] All but [\$296] a day All but [\$592] a day \$0 \$0	[\$1184] (Part A Deductible) [\$296] a day [\$592] a day 100% of Medicare Eligible Expenses \$0	\$0** \$0** \$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 21st thru 100th day 101st day and after	All approved amounts All but [\$148] a day \$0	\$0 Up to [\$148] a day \$0	\$0** \$0** All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0** \$0**

HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0
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(continued)

+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 [\$147] 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.

**\$0 Indicates your liability for covered charges. You are responsible for all other non-covered charges.

**This high deductible plan pays the same benefits as Plan F after one has paid a calendar year [\$2110] deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed [\$2110]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY [\$2110] DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO [\$2110] DEDUCTIBLE*** YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic test, durable medical equipment First [\$147] of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0 Generally 80%	[\$147] (Part B Deductible) Generally 20%	\$0** \$0**
Part B Excess Charges (Above Medicare-Approved amounts)	\$0	100%	\$0**
BLOOD First 3 pints Next [\$147] of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0 \$0 80%	All costs [\$147] (Part B Deductible) 20%	\$0** \$0** \$0**
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0**

HIGH DEDUCTIBLE PLAN F

PARTS A & B

SERVICES	MEDICARE PAYS	AFTER YOU PAY [\$2110] DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO [\$2110] DEDUCTIBLE*** YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	\$0	\$0**
Durable medical equipment First [\$147] of Medicare Approved amounts*	\$0	[\$147] (Part B Deductible)	\$0**
Remainder of Medicare Approved amounts	80%	20%	\$0**

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY [\$2110] DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO [\$2110] 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 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.

**\$0 Indicates your liability for covered charges. You are responsible for all other non-covered charges.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* 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 [\$1184] All but [\$296] a day All but [\$592] a day \$0 \$0	[\$1184] (Part A Deductible) [\$296] a day [\$592] a day 100% of Medicare Eligible Expenses \$0	\$0** \$0** \$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 21st thru 100th day 101st day and after	All approved amounts All but [\$148] a day \$0	\$0 Up to [\$148] a day \$0	\$0** \$0** All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$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 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 [\$147] 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.

**\$0 Indicates your liability for covered charges. You are responsible for all other non-covered charges.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic test, durable medical equipment First [\$147] of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0 Generally 80%	\$0 Generally 20%	[\$147] (Part B Deductible) \$0**
Part B Excess Charges (Above Medicare-Approved amounts)	\$0	100%	\$0**
BLOOD First 3 pints Next [\$147] of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0 \$0 80%	All costs \$0 20%	\$0** [\$147] (Part B Deductible) \$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 Durable medical equipment First [\$147] of Medicare Approved amounts* Remainder of Medicare Approved amounts	100% \$0 80%	\$0 \$0 20%	\$0** [\$147] (Part B Deductible) \$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 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.

**\$0 Indicates your liability for covered charges. You are responsible for all other non-covered charges.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* 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 [\$1184] All but [\$296] a day All but [\$592] a day \$0 \$0	[\$1184] (Part A Deductible) [\$296] a day [\$592] a day 100% of Medicare Eligible Expenses \$0	\$0** \$0** \$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 21st thru 100th day 101st day and after	All approved amounts All but [\$148] a day \$0	\$0 Up to [\$148] a day \$0	\$0** \$0** All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$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 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 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 [\$147] 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.

**\$0 Indicates your liability for covered charges. You are responsible for all other non-covered charges.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<p>MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic test, durable medical equipment</p> <p>First [\$147] of Medicare-Approved amounts*</p> <p>Remainder of Medicare-Approved amounts</p>	<p>\$0</p> <p>Generally 80%</p>	<p>\$0</p> <p>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.</p>	<p>[\$147] (Part B Deductible)</p> <p>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>Part B Excess Charges (Above Medicare-Approved amounts)</p>	<p>\$0</p>	<p>0%</p>	<p>All costs</p>
<p>BLOOD First 3 pints Next [\$147] of Medicare-Approved amounts* Remainder of Medicare-Approved amounts</p>	<p>\$0</p> <p>\$0</p> <p>80%</p>	<p>All costs</p> <p>\$0</p> <p>20%</p>	<p>\$0**</p> <p>[\$147] (Part B Deductible)</p> <p>\$0**</p>
<p>CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES</p>	<p>100%</p>	<p>\$0</p>	<p>\$0**</p>

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 [\$147] of Medicare Approved amounts*	\$0	\$0	[\$147] (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