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# Outline of Coverage

## **Medicare Supplement Insurance**

**BENEFIT PLANS: A, B, C, D, & N**

Underwritten by

An Aetna Company

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

**Vermont**



**CONTINENTAL LIFE INSURANCE COMPANY OF BRENTWOOD, TENNESSEE  
OUTLINE OF MEDICARE SUPPLEMENT COVERAGE COVER PAGE: Page 1 of 2  
BENEFIT PLANS AVAILABLE: A, B, C, D, 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.

**See Outlines of Coverage sections for details about ALL Plans**

**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, copayments 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

<b>A</b>	<b>B</b>	<b>C</b>	<b>D</b>	<b>F/F*</b>	<b>G</b>	<b>K</b>	<b>L</b>	<b>M</b>	<b>N</b>
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	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 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	Foreign Travel Emergency
						Out-of-pocket limit \$5,240; paid at 100% after limit reached	Out-of-pocket limit \$2,620; 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 \$2,240 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed \$2,240. 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 Issue Age Premiums

For Use in ZIP Codes: Entire State

Rates Effective 3/1/2018

Issue Age	Plan A	Plan B	Plan C	Plan D	Plan N
Under 65	2,942	3,698	4,169	3,742	2,692
65+	1,580	1,991	2,239	2,010	1,484

Modal Factors: Annual: 1.0000 Semi-Annual: 0.5200 Quarterly: 0.2650 Monthly: 0.0833

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-annually: 0.5200 Quarterly: 0.2650 Monthly EFT: 0.0833.

## 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. It is not necessary to complete the health history section if you are applying during your open enrollment period or in the case of a guarantee issue situation.

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

**THE FOLLOWING CHARTS DESCRIBE PLANS A, B, C, D 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 \$1,340</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>\$1,340 (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</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 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.

<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 \$1,340</p> <p>All but \$335 a day</p> <p>All but \$670 a day</p> <p>\$0</p> <p>\$0</p>	<p>\$1,340 (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 C**

**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 \$1,340  All but \$335 a day  All but \$670 a day  \$0  \$0	\$1,340 (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.	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 C**

**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	\$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 \$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 C**

**OTHER BENEFITS – NOT COVERED BY MEDICARE**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<p><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</p>	<p>\$0 \$0</p>	<p>\$0 80% to a lifetime                      maximum benefit of                      \$50,000</p>	<p>\$250 20% and amounts                      over the \$50,000                      lifetime maximum</p>

**PLAN D**

**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 \$1,340  All but \$335 a day  All but \$670 a day  \$0  \$0	\$1,340 (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 D**

**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 D**

**OTHER BENEFITS – NOT COVERED BY MEDICARE**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<p><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</p>	<p>\$0                      \$0</p>	<p>\$0                      80% to a lifetime maximum benefit of \$50,000</p>	<p>\$250                      20% and amounts over the \$50,000 lifetime maximum</p>

**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
<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 \$1,340</p> <p>All but \$335 a day</p> <p>All but \$670 a day</p> <p>\$0</p> <p>\$0</p>	<p>\$1,340 (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 services</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 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



