

CONTINENTAL LIFE INSURANCE COMPANY OF BRENTWOOD, TENNESSEE

Outline of Medicare Supplement Coverage - Cover Page: 1 of 2

Benefit Plan(s) A*, B*, C*, D*, E*, F*, G*

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 for Plans A – J: 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 expenses. **Blood:** First three pints of blood each year .

A*	B*	C*	D*	E*	F*/F+	G*	H	I	J/J+
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits
		Skilled Nursing Facility Coinsurance.	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	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	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible
		Part B Deductible			Part B Deductible				Part B Deductible
					Part B Excess (100%)	Part B Excess (80%)		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	Foreign Travel Emergency
			At-Home Recovery			At-Home Recovery		At-Home Recovery	At-Home Recovery
				Preventive Care NOT covered by Medicare					Preventive Care NOT covered by Medicare

*Plans A, B, C, D, E, F and G offered by the Company.

+Plans F and J also have an option called a high deductible plan F and a high deductible plan J. These high deductible plans pay the same or offer the same benefits as Plans F and J after one has paid a calendar year \$1900 deductible. Benefits from high deductible plans F and J will not begin until out-of-pocket expenses are \$1900. 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.

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Basic Benefits for Plans K and L include **similar** services as plans A – J, but cost-sharing for the basic benefits is a different levels.

K**	L**
100% of Part A Hospitalization Coinsurance plus coverage for 365 Days after Medicare Benefits End	100% of Part A Hospitalization Coinsurance plus coverage for 365 Days after Medicare Benefits End
50% Hospice cost-sharing	75% Hospice cost-sharing
50% of Medicare-eligible expenses for the first three pints of blood	75% of Medicare-eligible expenses for the first three pints of blood
50% Part B Coinsurance, except 100% Coinsurance for Part B Preventive Services	75% Part B Coinsurance, except 100% Coinsurance for Part B Preventive Services
50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance
50% Part A Deductible	75% Part A Deductible
\$4440 Out of Pocket Annual Limit***	\$2220 Out of Pocket Annual Limit***

** Plans K and L provide for different cost-sharing for items and services than Plans A – J.

Once you reach the annual limit, the plan pays 100% of the Medicare co-payments, coinsurance, and deductibles for the rest of the calendar year. The out-of-pocket annual limit does NOT include charges from your provider that exceed Medicare-approved amounts, called “Excess Charges”. You will be responsible for paying excess charges.

*** The out-of-pocket annual limit will increase each year for inflation.

See Outlines of Coverage for details and exceptions.

CONTINENTAL LIFE INSURANCE COMPANY OF BRENTWOOD, TENNESSEE
VIRGINIA MEDICARE SUPPLEMENT RATES – ATTAINED AGE RATES – RATES INCREASE EACH YEAR WITH AGE

\$20.00 Fee, payable once with application

Effective August 1, 2007

Mode factors: Semi-Annual - .52 times annual
 Quarterly - .265 times annual
 Bank Service Plan – 1/12 times annual

Area Factors: VIRGINIA:
 All Other Virginia Zip Codes - 1.00 times Rates Shown
 Virginia Zip Codes 220-223, 232-234, 236 1.10 times Rates Shown

Attained Age	Medicare Supplement Plan A			
	Preferred		Standard	
	Female	Male	Female	Male
65-67	891	1,026	991	1,141
68	930	1,069	1,033	1,187
69	967	1,111	1,073	1,236
70	1,003	1,154	1,114	1,281
71	1,045	1,202	1,161	1,336
72	1,074	1,237	1,195	1,374
73	1,110	1,277	1,234	1,419
74	1,139	1,311	1,265	1,455
75	1,172	1,349	1,302	1,497
76	1,200	1,380	1,333	1,534
77	1,222	1,406	1,357	1,561
78	1,246	1,434	1,384	1,594
79	1,267	1,457	1,407	1,621
80	1,284	1,477	1,426	1,640
81	1,295	1,490	1,439	1,657
82	1,313	1,510	1,459	1,678
83	1,328	1,529	1,476	1,697
84	1,342	1,544	1,491	1,715
85	1,357	1,561	1,508	1,736
86	1,371	1,577	1,523	1,753
87	1,386	1,594	1,538	1,771
88	1,401	1,610	1,555	1,788
89	1,414	1,626	1,571	1,807
90	1,430	1,645	1,588	1,828
91	1,443	1,660	1,603	1,844
92	1,451	1,670	1,611	1,854
93	1,473	1,693	1,636	1,881
94	1,486	1,709	1,650	1,899
95	1,499	1,725	1,664	1,917
96	1,511	1,739	1,678	1,932
97	1,529	1,757	1,697	1,955
98	1,538	1,771	1,709	1,968
99	1,620	1,863	1,798	2,070

Attained Age	Medicare Supplement Plan B			
	Preferred		Standard	
	Female	Male	Female	Male
65-67	1,143	1,315	1,270	1,461
68	1,196	1,375	1,327	1,529
69	1,246	1,434	1,384	1,593
70	1,302	1,497	1,445	1,663
71	1,350	1,552	1,497	1,725
72	1,402	1,611	1,556	1,790
73	1,446	1,664	1,607	1,851
74	1,491	1,715	1,657	1,906
75	1,534	1,764	1,703	1,960
76	1,576	1,813	1,752	2,015
77	1,616	1,859	1,795	2,065
78	1,653	1,903	1,837	2,112
79	1,685	1,938	1,871	2,154
80	1,715	1,973	1,905	2,192
81	1,743	2,007	1,937	2,229
82	1,770	2,037	1,966	2,262
83	1,795	2,065	1,994	2,295
84	1,821	2,095	2,022	2,327
85	1,844	2,122	2,048	2,358
86	1,870	2,152	2,077	2,391
87	1,893	2,178	2,102	2,421
88	1,912	2,200	2,124	2,445
89	1,929	2,220	2,143	2,466
90	1,953	2,246	2,169	2,496
91	1,970	2,264	2,188	2,516
92	1,982	2,280	2,202	2,534
93	2,005	2,306	2,226	2,562
94	2,019	2,322	2,241	2,580
95	2,032	2,340	2,258	2,598
96	2,044	2,353	2,271	2,614
97	2,059	2,370	2,286	2,631
98	2,071	2,381	2,297	2,644
99	2,088	2,402	2,320	2,669

CONTINENTAL LIFE INSURANCE COMPANY OF BRENTWOOD, TENNESSEE
VIRGINIA MEDICARE SUPPLEMENT RATES – ATTAINED AGE RATES – RATES INCREASE EACH YEAR WITH AGE

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Effective August 1, 2007

Mode factors: Semi-Annual - .52 times annual
 Quarterly - .265 times annual
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Area Factors: VIRGINIA:
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Attained Age	Medicare Supplement Plan C			
	Preferred		Standard	
	Female	Male	Female	Male
65-67	1,281	1,473	1,422	1,637
68	1,335	1,535	1,480	1,705
69	1,387	1,594	1,541	1,773
70	1,438	1,653	1,595	1,837
71	1,490	1,713	1,653	1,904
72	1,537	1,770	1,708	1,966
73	1,584	1,822	1,760	2,025
74	1,634	1,878	1,813	2,087
75	1,676	1,929	1,863	2,143
76	1,717	1,975	1,907	2,194
77	1,757	2,022	1,953	2,247
78	1,798	2,066	1,996	2,297
79	1,826	2,101	2,028	2,333
80	1,864	2,144	2,071	2,382
81	1,892	2,177	2,102	2,420
82	1,920	2,208	2,131	2,454
83	1,946	2,240	2,163	2,489
84	1,970	2,266	2,188	2,516
85	1,996	2,296	2,216	2,551
86	2,020	2,322	2,243	2,580
87	2,044	2,350	2,270	2,613
88	2,065	2,376	2,295	2,641
89	2,087	2,400	2,319	2,667
90	2,106	2,423	2,340	2,693
91	2,123	2,441	2,358	2,713
92	2,141	2,463	2,378	2,738
93	2,156	2,481	2,395	2,756
94	2,170	2,497	2,410	2,774
95	2,181	2,511	2,424	2,789
96	2,194	2,525	2,437	2,805
97	2,209	2,540	2,453	2,823
98	2,224	2,559	2,470	2,843
99	2,233	2,568	2,479	2,856

Attained Age	Medicare Supplement Plan D			
	Preferred		Standard	
	Female	Male	Female	Male
65-67	1,079	1,241	1,199	1,379
68	1,126	1,295	1,250	1,440
69	1,175	1,352	1,305	1,502
70	1,225	1,409	1,361	1,568
71	1,271	1,462	1,411	1,625
72	1,319	1,518	1,465	1,686
73	1,363	1,570	1,517	1,744
74	1,407	1,620	1,564	1,798
75	1,450	1,668	1,609	1,853
76	1,492	1,717	1,657	1,907
77	1,526	1,756	1,696	1,952
78	1,563	1,797	1,736	1,996
79	1,594	1,835	1,771	2,038
80	1,624	1,869	1,803	2,075
81	1,648	1,895	1,830	2,107
82	1,673	1,925	1,859	2,140
83	1,701	1,957	1,889	2,172
84	1,726	1,986	1,917	2,206
85	1,747	2,010	1,940	2,233
86	1,771	2,037	1,966	2,262
87	1,793	2,062	1,991	2,292
88	1,814	2,087	2,015	2,319
89	1,831	2,108	2,036	2,341
90	1,856	2,136	2,062	2,372
91	1,865	2,145	2,072	2,384
92	1,884	2,166	2,091	2,408
93	1,897	2,182	2,108	2,425
94	1,911	2,198	2,122	2,442
95	1,923	2,212	2,136	2,458
96	1,936	2,227	2,148	2,475
97	1,946	2,239	2,162	2,489
98	1,959	2,255	2,175	2,504
99	1,974	2,271	2,192	2,524

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Attained Age	Medicare Supplement Plan E			
	Preferred		Standard	
	Female	Male	Female	Male
65-67	791	910	879	1,011
68	826	950	918	1,056
69	863	992	958	1,103
70	898	1,034	998	1,149
71	933	1,073	1,037	1,192
72	966	1,110	1,072	1,234
73	1,000	1,150	1,109	1,277
74	1,031	1,186	1,144	1,318
75	1,061	1,222	1,178	1,357
76	1,090	1,254	1,210	1,393
77	1,117	1,284	1,240	1,427
78	1,142	1,313	1,268	1,460
79	1,165	1,340	1,294	1,489
80	1,188	1,367	1,319	1,519
81	1,205	1,386	1,338	1,540
82	1,226	1,410	1,361	1,568
83	1,242	1,428	1,379	1,587
84	1,260	1,451	1,401	1,612
85	1,278	1,471	1,420	1,635
86	1,293	1,488	1,437	1,653
87	1,310	1,507	1,454	1,674
88	1,325	1,524	1,472	1,694
89	1,337	1,538	1,486	1,709
90	1,352	1,555	1,501	1,728
91	1,362	1,568	1,513	1,741
92	1,376	1,583	1,529	1,760
93	1,387	1,595	1,541	1,773
94	1,396	1,606	1,552	1,786
95	1,405	1,616	1,560	1,796
96	1,414	1,626	1,570	1,807
97	1,424	1,637	1,580	1,819
98	1,432	1,646	1,590	1,829
99	1,440	1,657	1,600	1,841

Attained Age	Medicare Supplement Plan F			
	Preferred		Standard	
	Female	Male	Female	Male
65-67	1,380	1,588	1,534	1,764
68	1,434	1,651	1,594	1,834
69	1,492	1,717	1,658	1,907
70	1,547	1,779	1,719	1,979
71	1,605	1,845	1,780	2,051
72	1,655	1,904	1,839	2,114
73	1,708	1,963	1,897	2,182
74	1,756	2,021	1,951	2,245
75	1,805	2,076	2,005	2,307
76	1,852	2,129	2,056	2,365
77	1,892	2,177	2,102	2,420
78	1,930	2,222	2,144	2,468
79	1,970	2,266	2,188	2,516
80	2,005	2,306	2,226	2,561
81	2,031	2,337	2,256	2,595
82	2,064	2,375	2,293	2,640
83	2,088	2,402	2,320	2,669
84	2,119	2,439	2,354	2,709
85	2,147	2,471	2,386	2,745
86	2,169	2,496	2,409	2,773
87	2,195	2,527	2,440	2,809
88	2,221	2,556	2,466	2,839
89	2,240	2,578	2,489	2,863
90	2,263	2,604	2,513	2,892
91	2,280	2,624	2,533	2,914
92	2,301	2,647	2,556	2,941
93	2,319	2,666	2,575	2,963
94	2,332	2,683	2,591	2,982
95	2,347	2,700	2,606	2,999
96	2,360	2,715	2,620	3,016
97	2,375	2,732	2,638	3,035
98	2,387	2,746	2,651	3,052
99	2,400	2,762	2,666	3,068

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Attained Age	Medicare Supplement Plan G			
	Preferred		Standard	
	Female	Male	Female	Male
65-67	1,098	1,261	1,220	1,403
68	1,148	1,319	1,273	1,466
69	1,198	1,376	1,328	1,529
70	1,246	1,433	1,384	1,592
71	1,294	1,489	1,438	1,655
72	1,338	1,541	1,487	1,711
73	1,386	1,594	1,540	1,772
74	1,428	1,644	1,588	1,826
75	1,472	1,693	1,635	1,880
76	1,510	1,739	1,678	1,932
77	1,546	1,779	1,719	1,976
78	1,582	1,820	1,756	2,022
79	1,616	1,859	1,794	2,064
80	1,645	1,893	1,826	2,105
81	1,671	1,922	1,855	2,135
82	1,699	1,955	1,888	2,172
83	1,720	1,978	1,911	2,198
84	1,747	2,009	1,940	2,233
85	1,771	2,037	1,966	2,262
86	1,791	2,061	1,990	2,290
87	1,814	2,087	2,015	2,319
88	1,836	2,111	2,039	2,345
89	1,854	2,132	2,059	2,370
90	1,872	2,155	2,079	2,393
91	1,888	2,170	2,095	2,411
92	1,907	2,193	2,117	2,437
93	1,922	2,210	2,133	2,456
94	1,935	2,224	2,147	2,471
95	1,946	2,239	2,162	2,489
96	1,959	2,255	2,175	2,504
97	1,971	2,267	2,189	2,520
98	1,984	2,282	2,204	2,535
99	1,995	2,295	2,216	2,550

PREMIUM INFORMATION

We guarantee to renew the policy during your lifetime as long as you pay the renewal premiums on time, either in advance or during the grace period.

Your premium will change on the first renewal date that coincides with or follows each anniversary of the effective date. The new premium will be based upon your age at that time. Otherwise we cannot change your premium unless we make the same change for all policies of this type insuring persons in your classification which are in force in the same geographical area of the Commonwealth where you live at the time we change premium. We can make such change on any premium due date. We will provide to you advance notice.

The premiums for other Medicare Supplement policies that are issue age or community rated do not increase due to changes in your age.

While the cost for a Medicare Supplement policy that is based on attained age may be lower than the cost of a Medicare Supplement policy that is issue age or community rated at your present age, it is important to compare the potential cost of these policies over the life of the policy.

DISCLOSURES

Use this outline to compare benefits and premiums 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 Continental Life Insurance Company of Brentwood, Tennessee.

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, 101 Continental Place, Brentwood, Tennessee 37027. If you send the policy back to us within thirty (30) days after you receive it, we will treat the policy as if it had never been issued and return all of 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

This policy may not fully 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 and 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 all 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.

PLAN A
MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies. First 60 days 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 \$1,024 All but \$256 a day All but \$512 a day \$0 \$0	\$0 \$256 a day \$512 a day 100% of Medicare Eligible Expense \$0	\$1,024 (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 \$128 a day \$0	\$0 \$0 \$0	\$0 Up to \$128 a day 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 coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

**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 (Continued)
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed \$135 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.			
First \$135 of Medicare Approved Amounts*	\$0	\$0	\$135 (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD			
First 3 pints	\$0	All Costs	\$0
Next \$135 of Medicare Approved Amounts*	\$0	\$0	\$135 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE			
MEDICARE APPROVED SERVICES			
-Medically necessary skilled care service and medical supplies	100%	\$0	\$0
-Durable medical equipment			
First \$135 of Medicare Approved Amounts*	\$0	\$0	\$135 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

PLAN B
MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 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 \$1,024 All but \$256 a day All but \$512 a day \$0 \$0	\$1,024 (Part A deductible) \$256 a day \$512 a day 100% of Medicare Eligible Expense \$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 \$128 a day \$0	\$0 \$0 \$0	\$0 Up to \$128 a day 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 coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

**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 (Continued)
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed \$135 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT TREATMENT, such as, Physician's services, inpatient and out-patient medical and surgical services and supplies, physical and speech therapy, diagnostic test, durable medical equipment.			
- First \$135 of Medicare Approved Amounts*	\$0	\$0	\$135 (Part B deductible)
- Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
PART B EXCESS CHARGES (Above Medicare Approved Amount)	\$0	\$0	All costs
BLOOD			
- First 3 pints	\$0	All Costs	\$0
- Next \$135 of Medicare Approved Amounts*	\$0	\$0	\$135 (Part B deductible)
- Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
-Medically necessary skilled care service and medical supplies	100%	\$0	\$0
-Durable medical equipment			
First \$135 of Medicare Approved Amounts*	\$0	\$0	\$135 (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.

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 \$1,024 All but \$256 a day All but \$512 a day \$0 \$0	\$1,024 (Part A deductible) \$256 a day \$512 a day 100% of Medicare Eligible Expense \$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 \$128 a day \$0	\$0 Up to \$128 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 coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

**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 C (Continued)
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed \$135 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as, Physician's services, inpatient and out-patient medical and surgical services and supplies, physical and speech therapy, diagnostic test, durable medical equipment. - First \$135 of Medicare Approved Amounts* - Remainder of Medicare Approved Amounts	\$0 Generally 80%	\$135 (Part B deductible) Generally 20%	\$0 \$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD - First 3 pints - Next \$135 of Medicare Approved Amounts* - Remainder of Medicare Approved Amounts	\$0 \$0 80%	All Costs \$135 (Part B deductible) 20%	\$0 \$0 \$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES -Medically necessary skilled care service and medical supplies -Durable medical equipment First \$135 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% \$0 80%	\$0 \$135 (Part B deductible) 20%	\$0 \$0 \$0
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OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care service beginning during the first 60 days of each trip outside of 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 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.

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 \$1,024 All but \$256 a day All but \$512 a day \$0 \$0	\$1,024 (Part A deductible) \$256 a day \$512 a day 100% of Medicare Eligible Expense \$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 \$128 a day \$0	\$0 Up to \$128 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 coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

**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 D (Continued)
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed \$135 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT , such as, Physician's services, inpatient and out-patient medical and surgical services and supplies, physical and speech therapy, diagnostic test, durable medical equipment. - First \$135 of Medicare Approved Amounts* - Remainder of Medicare Approved Amounts	\$0 Generally 80%	\$0 Generally 20%	\$135 (Part B deductible) \$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD - First 3 pints - Next \$135 of Medicare Approved Amounts* - Remainder of Medicare Approved Amounts	\$0 \$0 80%	All Costs \$0 20%	\$0 \$135 (Part B deductible) \$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES -Medically necessary skilled care service and medical supplies -Durable medical equipment First \$135 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$135 (Part B deductible) \$0
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PLAN D (Continued)
MEDICARE (PART A & B) - (CONTINUED)

HOME HEALTH CARE - (cont'd) AT-HOME RECOVERY SERVICES - NOT COVERED BY MEDICARE			
Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Health Care Treatment Plan.			
-Benefit for each visit	\$0	Actual Charges to \$40 a visit.	Balance
-Number of visits covered (must be received within 8 weeks of last Medicare Approved Visit.)	\$0	Up to number of Medicare Approved visits not to exceed 7 per week.	
-Calendar year maximum	\$0	\$1,600	

OTHER BENEFITS - NOT COVERED BY MEDICARE

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

PLAN E
MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies - First 60 days - 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 \$1,024 All but \$256 a day All but \$512 a day \$0 \$0	\$1,024 (Part A deductible) \$256 a day \$512 a day 100% of Medicare Eligible Expense \$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 \$128 a day \$0	\$0 Up to \$128 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 coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

**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 E (Continued)
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed \$135 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT , such as, Physician's services, inpatient and out-patient medical and surgical services and supplies, physical and speech therapy, diagnostic test, durable medical equipment. - First \$135 of Medicare Approved Amounts* - Remainder of Medicare Approved Amounts	\$0 Generally 80%	\$0 Generally 20%	\$135 (Part B deductible) \$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD - First 3 pints - Next \$135 of Medicare Approved Amounts* - Remainder of Medicare Approved Amounts	\$0 \$0 80%	All Costs \$0 20%	\$0 \$135 (Part B deductible) \$0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES -Medically necessary skilled care service and medical supplies -Durable medical equipment First \$135 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$135 (Part B deductible) \$0
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PLAN E (Continued)
OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care service beginning during the first 60 days of each trip outside of 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.
PREVENTIVE MEDICAL CARE BENEFIT - NOT COVERED BY MEDICARE* Some annual physical and preventive tests and services administered or ordered by your doctor when not covered by Medicare First \$120 each calendar year Additional charges	\$0 \$0	\$120 \$0	\$0 All Costs

*Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

PLAN F
MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies. - First 60 days - 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 \$1,024 All but \$256 a day All but \$512 a day \$0 \$0	\$1,024 (Part A deductible) \$256 a day \$512 a day 100% of Medicare Eligible Expense \$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 \$128 a day \$0	\$0 Up to \$128 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 coinsurance for out-patient drugs and in-patient respite care.	\$0	Balance

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

PLAN F (Continued)
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed \$135 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT , such as, Physician's services, inpatient and outpatient medical and surgical services, and supplies, physical and speech therapy, diagnostic tests, durable medical equipment. - First \$135 of Medicare Approved Amounts* - Remainder of Medicare Approved Amounts	\$0 Generally 80%	\$135 (Part B deductible) Generally 20%	\$0 \$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	\$0	100%	\$0
BLOOD - First 3 pints - Next \$135 of Medicare Approved Amounts* - Remainder of Medicare Approved Amounts	\$0 \$0 80%	All Costs \$135 (Part B deductible) 20%	\$0 \$0 \$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES -Medically necessary skilled care service and medical supplies -Durable medical equipment First \$135 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% \$0 80%	\$0 \$135 (Part B deductible) 20%	\$0 \$0 \$0
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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 G
MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies. - First 60 days - 61 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 \$1,024 All but \$256 a day All but \$512 a day \$0 \$0	\$1,024 (Part A deductible) \$256 a day \$512 a day 100% of Medicare Eligible Expense \$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 \$128 a day \$0	\$0 Up to \$128 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 coinsurance for out-patient drugs and in-patient respite care.	\$0	Balance

**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 (Continued)
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed \$135 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT , such as, Physician's services, inpatient and outpatient medical and surgical services, and supplies, physical and speech therapy, diagnostic tests, durable medical equipment. First \$135 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 Generally 80%	\$0 Generally 20%	\$135 (Part B deductible) \$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	\$0	80%	20%
BLOOD - First 3 pints - Next \$135 of Medicare Approved Amounts* - Remainder of Medicare Approved Amounts	\$0 \$0 80%	All Costs \$0 20%	\$0 \$135 (Part B deductible) \$0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES -Medically necessary skilled care service and medical supplies -Durable medical equipment First \$135 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$135 (Part B deductible) \$0
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PLAN G (Continued)
MEDICARE (PART A & B) - (CONTINUED)

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE - (cont'd) AT-HOME RECOVERY SERVICES - NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Health Care Treatment Plan. -Benefit for each visit. -Number of visits covered (must be received within 8 weeks of last Medicare Approved Visit.) -Calendar year maximum	\$0 \$0 \$0	Actual Charges to \$40 a visit. Up to number of Medicare Approved visits not to exceed 7 per week. \$1,600	Balance

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.