CONTINENTAL LIFE INSURANCE COMPANY OF BRENTWOOD, TENNESSEE
800 CRESCENT CENTRE DRIVE, FRANKLIN, TENNESSEE-(800) 264. 4000

OUTLINE OF MEDICARE SUPPLEMENT INSURANCE
OUTLINE OF COVERAGE FOR POLICY FORM CLIMSP10BC

MEDICARE SUPPLEMENT INSURANCE

The Wisconsin Insurance Commissioner has set standards for Medicare Supplement Insurance. This policy meets these standards. It, along with Medicare, may not cover all your medical costs. You should review carefully all policy limitations. For an explanation of these standards and other important information, see *Wisconsin Guide to Health Insurance for People with Medicare,* given to you when you applied for the policy. Do not buy the policy if you did not get this guide.

PREMIUM INFORMATION-We, Continental Life Insurance Company of Brentwood, Tennessee can only raise your premium if we raise the premium for all policies like yours in the same geographic area in this state. Your premium will change each year. The new premium will be based on your age.

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY- This is only an Outline of Coverage describing your policy's most important features. This is not 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 you are not satisfied with your policy, you may return it to Continental Life Insurance Company of Brentwood, Tennessee, 800 Crescent Centre Drive, Franklin, Tennessee 370. 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 of your payments directly to you.

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 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.

CONTINENTAL LIFE INSURANCE COMPANY OF BRENTWOOD, TENNESSEE
OUTLINE OF MEDICARE SUPPLEMENT INSURANCE

BASIC PLAN

MEDICARE SUPPLEMENT PART A-HOSPITAL EXPENSES-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.

Medicare Part A Benefits	Per Benefit Period	Medicare Pays	This Policy Pays	You Pay
HOSPITALIZATION Semiprivate room and board general nursing and miscellaneous hospital services and supplies (Does not include personal items).	First 60 days	All but [$1156] each benefit period.	$0 or [ ] Part A Deductible Rider **	[$1156] or $0
	61st to 90th Day	All but [$289] a day	[$289] a day	$0
	91st day and After while using 60 lifetime reserve days	All but [$578] a day	[$578] a day	$0
	Once lifetime reserve days are used: Additional 365 days	$0	100% of Medicare Eligible Expenses*	$0
	Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital	First 20 days	All approved amounts	$0	$0
	21st through 100th day	All but [$144.50] per day	Up to [$144.50] a day	$0
	101st day and after	[$0]	$0	All Costs

INPATIENT PSYCHIATRIC CARE Inpatient psychiatric care in a participating psychiatric hospital		190 days per lifetime	175 days per lifetime	All charges not covered by policy nor by Medicare
BLOOD	First 3 pints Additional Amounts	$0 100%	First 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 or copayment for outpatient drugs and inpatient respite care	$0	$0

*NOTICE: When your Medicare Part A hospital benefits are exhausted, the issuer stands in the place of Medicare and will pay whatever amount Medicare would have paid as provided in the policy's "Core Benefits."

**These are optional riders. You purchased this benefit if the box is checked and you paid the premium.

BASIC MEDICARE SUPPLEMENT POLICIES-PART B BENEFITS

Once you have been billed [$140] of Medicare approved amounts for covered services, your Medicare Part B deductible will have been met for the calendar year.

Medicare Part B Benefits	Per Calendar Year	Medicare Pays	This Policy Pays	You Pay
MEDICAL EXPENSES Eligible expense for physician's services, in-patient and out-patient medical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment	First [$140] of medicare approved amounts	$0	$0 or [ ] Optional Part B Deductible Rider**	[$140] or $0 or
			[ ] Optional Medicare Copayment Deductible Rider**	Up to [$20] per office visit and up to [$50] per emergency room visit.
	Remainder of Medicare approved amounts	Generally 80%	Generally 20%	Charges in excess of 20% up to the limiting charge
			[ ] Optional Medicare Part B Excess Charges Rider	Balance, if any, or expenses if not covered by Medicare or this policy
BLOOD	First 3 pints	$0	All costs	$0
	Next [$140] of Medicare approved amounts	$0	$0 or [$140] Part B Deductible	Charges not covered by the policy or Medicare
	Remainder of Medicare approved amounts	80%	20%	
CLINICAL LABORATORY SERVICES Tests for diagnostic services		100%	$0	$0

HOME HEALTH CARE		100% of charges for visits considered medically necessary by Medicare	40 visits or [ ] Optional Additional Home Health Care Rider	Charges not covered by policy or Medicare
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	Charges not covered by policy or Medicare

**These are optional riders. You purchased this benefit if the box is checked and you paid the premium.

THE FOLLOWING BENEFITS ARE MANDATED BY YOUR STATE:

Skilled Nursing Facility Benefit-Non-Medicare Eligible Confinement-For confinement in a Wisconsin state licensed nursing facility we will pay the expense incurred for up to 30 days.

Kidney Disease Benefit-We will pay inpatient and outpatient expense for dialysis, transplantation, or donor related services because of kidney disease. We won't pay for expenses paid for under Medicare, nor pay more than $30,000 in any one calendar year. If you have other coverage covering kidney disease expense, we won't pay more than our share.

Chiropractic Benefit-When Medicare Part B does not pay for medically necessary services received from a chiropractor, we will provide payment in full for all usual and customary charges for chiropractor services. Benefits are not payable for any charges paid by Medicare.

Diabetes Benefit-We will provide payment in full for all usual and customary expenses for: (a) the installation or purchase of an insulin infusion pump; (b) non-prescription insulin or any other non-prescription equipment or supplies for the treatment of diabetes, but not including any other outpatient prescription medications; and (c) diabetes self-management education program. Benefits are not payable for any charges paid by Medicare.

Hospital or Ambulatory Dental Benefit-We will provide payment in full for all usual and customary expenses incurred for hospital or ambulatory surgery center charges incurred and anesthetics provided in conjunction with dental care if any of the following applies; (a) the insured person has a chronic health condition; (2) the insured person has a medical condition that requires hospitalization or general anesthesia for dental care. Benefits are not payable for any charges paid by Medicare.

Breast Reconstruction Benefit- We will provide payment in full for all usual and customary expenses incurred, in the manner recommended by the attending physician or oncologist to be appropriate for reconstruction of the affected tissue incident to a mastectomy. Benefits are not payable for any charges paid by Medicare.

EXCEPTIONS, REDUCTIONS AND LIMITATIONS OF THE POLICY-We will not pay benefits for:

(1) expenses deemed unnecessary or unreasonable by Medicare, except in the Benefit provisions and in Optional Riders, if any;
(2) expenses incurred prior to the coverage effective date;
(3) drugs (other than prescription drugs furnished during a hospital or skilled nursing facility stay;
(4) custodial care, dental care (except as provided in the mandated benefits) eye or ear examinations to prescribe or fit eyeglasses or hearing aids, routine immunizations, cosmetic surgery or routine foot care;
(5) services for which a charge is normally not make when there is no insurance;
(6) nursing home care costs (beyond what is covered by Medicare and the Wisconsin 30-day skilled nursing mandated by Wisconsin 632.895(3);
(7) home health care above the number of visits covered by Medicare and the 40-visits mandated by Wisconsin 632.895(2), unless you select the Additional Home Health Care Rider;
(8) care received outside the USA

Benefits will be increased to match any increases in Medicare deductible amounts or co-payment charges. The premium may automatically increase to correspond with these increases.

Renewability of the Policy-We will renew the policy each time you send us the premium. It must be paid on or before the date it is due or during the 31 days that follow.

Your premium will change on the first renewal date that coincides with or follows the anniversary date of the policy.

Material Misrepresentation-in the event of a material misrepresentation, the coverage will be cancelled as of the coverage effective date. A “material misrepresentation” occurs when a condition or combination of conditions you were requested to name on the application was not named and which, if named, would have caused us to deny issuing the coverage. This limitation for material misrepresentation is subject to the Time Limit for Certain defenses provision.

Review and Appeal-In the event of the denial of a claim under the Policy, You may appeal such denial by submitting a written request, which may be in any form and which may include supporting material, for our review. We will provide a description of the review and notification to you regarding the results of the review within 30 days after receiving your request.

Grievance-A grievance may be made by you or on your behalf in writing to us. A grievance is any dissatisfaction with the provision of services or claims practices by us.

IN ADDITION TO THIS OUTLINE OF COVERAGE, CONTINENTAL LIFE INSURANCE COMPANY OF BRENTWOOD, TENNESSEE WILL SEND AN ANNUAL NOTICE TO YOU, 30 DAYS PRIOR TO THE EFFECTIVE DATE OF MEDICARE CHANGES, WHICH WILL DESCRIBE THESE CHANGES AND THE CHANGES IN YOUR MEDICARE SUPPLEMENT COVERAGE.

MEDICARE SUPPLEMENT PREMIUM INFORMATION

ANNUAL PREMIUM

$_____ BASIC MEDICARE SUPPLEMENT COVERAGE

OPTIONAL BENEFITS FOR MEDICARE SUPPLEMENT POLICY-Each of these riders may be purchased separately.

$_____ PART A DEDUCTIBLE RIDER-100% of Part A Deductible

$_____ PART B DEDUCTIBLE RIDER-100% of Part B Deductible

$_____ PART B EXCESS CHARGES RIDER-Difference between what Medicare pays and the amount charged by the provider which shall be no greater than the actual charge or the limiting charge allowed by Medicare, whichever is less.

$_____ ADDITIONAL HOME HEALTH CARE RIDER-An aggregate of 365 visits per year including those covered by Medicare.

$_____ FOREIGN TRAVEL RIDER-After a deductible of not greater than $250, covers at least 80% of expenses associated with emergency medical care received outside the United States during the first 60 days of a trip with a maximum of at least $50,000.

$_____ BASIC PLAN WITH MEDICARE COPAYMENT DEDUCTIBLE RIDER-Pays the Part B coinsurance subject to a copayment or coinsurance of no more than $20 per office visit and no more than $50 per emergency room visit that is in addition to the Medicare Part B medical deductible and in addition to out-of-pocket maximums.

$_____ TOTAL FOR BASIC POLICY, POLICY FEE AND SELECTED OPTIONAL RIDERS

Total Premium, if other than Annual Mode (at time of application), including premium for any Optional Rider selected above:

$_____ EFT $_____ Quarterly $_____ Semi-annual

CONTINENTAL LIFE INSURANCE COMPANY OF BRENTWOOD, TENNESSEE
WISCONSIN-ANNUAL ATTAINED AGE RATES
AREA 1-ALL ZIP CODES EXCEPT 530-534
EFFECTIVE DATE: JUNE 1, 2012

NON TOBACCO

	Female					Male				
Attained Age	Base	Base with Coinsurance	Part A	Home Health	Part B Excess	Base	Base with Coinsurance	Part A	Home Health	Part B Excess
0-64	1,597	1,279	459	109	100	1,837	1,470	528	124	116
65	876	700	261	65	58	1,008	806	300	75	67
66	902	721	273	68	60	1,038	829	314	77	70
67	931	744	285	70	63	1,069	855	327	81	72
68	958	767	298	73	64	1,102	880	343	84	73
69	985	788	311	77	65	1,132	906	359	89	75
70	1,015	812	323	81	68	1,167	934	372	93	77
71	1,045	837	335	82	69	1,203	962	386	95	80
72	1,077	862	347	84	71	1,238	990	399	97	82
73	1,107	886	359	87	73	1,273	1,018	411	100	84
74	1,140	913	369	91	75	1,312	1,051	424	104	86
75	1,176	942	381	93	77	1,353	1,082	438	106	89
76	1,202	961	389	95	79	1,382	1,106	447	109	91
77	1,230	984	399	98	80	1,414	1,131	459	112	92
78	1,254	1,003	408	100	81	1,441	1,152	469	117	93
79	1,281	1,024	418	103	82	1,473	1,178	481	118	94
80	1,309	1,047	423	104	83	1,507	1,204	488	119	95
81	1,336	1,069	433	105	84	1,536	1,228	497	120	97
82	1,365	1,092	440	105	86	1,569	1,256	504	121	99
83	1,392	1,113	445	106	87	1,602	1,281	512	122	100
84	1,422	1,137	450	107	91	1,635	1,308	517	123	104
85	1,450	1,161	454	107	92	1,669	1,335	523	123	105
86	1,482	1,185	456	109	94	1,703	1,363	524	124	108
87	1,510	1,209	457	109	95	1,736	1,389	526	124	109
88	1,537	1,230	459	109	96	1,767	1,414	528	124	110
89	1,567	1,254	459	109	97	1,801	1,441	528	124	111
90+	1,597	1,279	459	109	100	1,837	1,470	528	124	116
Part B Deductible Rider			$140.00	All Ages, All Areas						
Foreign Travel			$37.00	All Ages, All Areas						

To determine premiums other than Annual use the following modal factors:
Semi-annual: 0.5200 Quarterly: 0.2650 Monthly: 0.0833

The above rates do not include a one-time $20 policy fee at time of issue

For Area 2 (Zip Codes 530-534) multiply above Base, Base with Coinsurance Rider, Part A, Home Health and Part B Excess times 1.15

CONTINENTAL LIFE INSURANCE COMPANY OF BRENTWOOD, TENNESSEE
WISCONSIN-ANNUAL ATTAINED AGE RATES
AREA 1-ALL ZIP CODES EXCEPT 530-534
EFFECTIVE DATE: JUNE 1, 2012

TOBACCO

	Female					Male				
Attained Age	Base	Base with Coinsurance	Part A	Home Health	Part B Excess	Base	Base with Coinsurance	Part A	Home Health	Part B Excess
0-64	1,758	1,406	505	120	111	2,022	1,617	582	137	127
65	963	771	287	72	64	1,108	887	330	82	73
66	993	794	300	75	67	1,140	913	347	85	77
67	1,023	819	313	77	69	1,176	942	361	89	80
68	1,054	842	327	81	70	1,212	970	377	93	81
69	1,083	866	342	85	72	1,245	996	394	98	82
70	1,117	894	355	89	75	1,284	1,028	408	103	85
71	1,150	920	368	91	76	1,323	1,058	424	105	87
72	1,185	947	381	93	79	1,362	1,090	440	107	91
73	1,218	974	394	96	81	1,401	1,120	454	111	93
74	1,255	1,004	406	99	82	1,444	1,156	468	114	95
75	1,294	1,035	419	103	85	1,488	1,190	482	117	98
76	1,322	1,057	429	105	86	1,522	1,218	492	120	99
77	1,353	1,082	440	108	87	1,555	1,244	505	124	100
78	1,379	1,104	448	111	89	1,584	1,268	516	129	103
79	1,409	1,128	459	112	91	1,620	1,296	529	130	104
80	1,440	1,151	467	114	92	1,657	1,326	537	131	105
81	1,471	1,176	477	116	93	1,689	1,351	548	132	107
82	1,501	1,201	483	116	95	1,726	1,380	555	133	109
83	1,531	1,225	490	117	96	1,761	1,409	563	134	111
84	1,564	1,251	495	118	99	1,799	1,440	570	135	114
85	1,595	1,275	499	118	100	1,836	1,470	575	135	116
86	1,630	1,304	501	120	104	1,874	1,499	576	137	119
87	1,661	1,328	503	120	105	1,908	1,526	578	137	120
88	1,691	1,353	505	120	106	1,944	1,555	582	137	121
89	1,724	1,379	505	120	107	1,982	1,585	582	137	122
90+	1,758	1,406	505	120	111	2,022	1,617	582	137	127
Part B Deductible Rider			$140.00	All Ages, All Areas						
Foreign Travel			$37.00	All Ages, All Areas						

To determine premiums other than Annual use the following modal factors:
Semi-annual: 0.5200 Quarterly: 0.2650 Monthly: 0.0833

The above rates do not include a one-time $20 policy fee at time of issue

For Area 2 (Zip Codes 530-534) multiply above Base, Base with Coinsurance Rider, Part A, Home Health and Part B Excess times 1.15