

The actual Medicare Supplement Outline of Coverage (92H-200-00C-ALL) MUST be provided with this informational brochure.
This brochure is not a substitute for the Outline of Coverage.

Medicare Supplement **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
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 \$1,100.00 All but \$275.00 a day All but \$550.00 a day \$0.00 \$0.00	\$1,100.00 (Part A deductible) \$275.00 a day \$550.00 a day 100% of Medicare eligible expenses \$0.00	\$0.00 \$0.00 \$0.00 \$0.00** 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 \$137.50 a day \$0.00	\$0.00 Up to \$137.50 a day \$0.00	\$0.00 \$0.00 All costs
BLOOD First 3 pints Additional amounts	\$0.00 100%	3 pints \$0.00	\$0.00 \$0.00
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	\$0.00

**** 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.



Christian Fidelity[®]
Life Insurance Company

PLAN N
— CONTINUED ON OTHER SIDE —

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— CONTINUED —

MEDICARE (PART B) – MEDICARE SERVICES – PER CALENDAR YEAR

* Once you have been billed \$155.00 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 tests, durable medical equipment. First \$155.00 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0.00 Generally 80%	\$0.00 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.	\$155.00 (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.
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	\$0.00	\$0.00	All costs
BLOOD First 3 pints Next \$155.00 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0.00 \$0.00 80%	All costs \$0.00 20%	\$0.00 \$155.00 (Part B deductible) \$0.00
CLINICAL LABORATORY SERVICES TESTS FOR DIAGNOSTIC SERVICES	100%	\$0.00	\$0.00
HOME HEALTH CARE MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies Durable medical equipment First \$155.00 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% \$0.00 80%	\$0.00 \$0.00 20%	\$0.00 \$155.00 (Part B deductible) \$0.00

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	\$0.00 \$0.00	\$0.00 80% to a lifetime maximum benefit of \$50,000	\$250.00 20% and amounts over the \$50,000 lifetime maximum