Continental Life Insurance Company of Brentwood, Tennessee
An Aetna Company

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Outline of Coverage

Medicare Supplement Insurance

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

Underwritten by

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

California

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.

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, 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 $[4970]; paid at 100% after limit reached	Out-of-pocket limit $[2470]; 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 [$2180] deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed [$2180]. 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 Attained Age Premiums

For Use in ZIP Codes: 900-912, 914-916, 918, 926-927

Attained Age	Preferred					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	3,058	3,868	4,496	n/a	n/a	3,184
65	1,607	2,032	2,365	845	2,088	1,589
66	1,670	2,111	2,456	878	2,169	1,654
67	1,734	2,193	2,552	912	2,254	1,722
68	1,803	2,280	2,651	948	2,341	1,792
69	1,873	2,369	2,755	985	2,432	1,865
70	1,945	2,461	2,862	1,023	2,526	1,941
71	2,022	2,558	2,974	1,062	2,626	2,023
72	2,103	2,659	3,091	1,106	2,729	2,111
73	2,184	2,763	3,214	1,147	2,837	2,203
74	2,271	2,873	3,341	1,195	2,948	2,299
75	2,363	2,988	3,473	1,241	3,066	2,395
76	2,429	3,072	3,572	1,277	3,154	2,471
77	2,498	3,159	3,673	1,314	3,243	2,554
78	2,569	3,250	3,777	1,351	3,336	2,636
79	2,641	3,340	3,884	1,389	3,428	2,718
80	2,715	3,433	3,992	1,428	3,524	2,804
81	2,748	3,474	4,042	1,447	3,567	2,841
82	2,781	3,517	4,089	1,465	3,610	2,878
83	2,814	3,558	4,137	1,477	3,652	2,915
84	2,848	3,602	4,188	1,496	3,698	2,954
85	2,881	3,644	4,237	1,517	3,741	2,991
86	2,917	3,689	4,288	1,533	3,787	3,029
87	2,951	3,732	4,340	1,552	3,832	3,067
88	2,987	3,777	4,392	1,570	3,878	3,107
89	3,022	3,822	4,444	1,589	3,924	3,147
90	3,058	3,868	4,496	1,607	3,972	3,184
91	3,093	3,914	4,551	1,626	4,020	3,226
92	3,133	3,962	4,606	1,647	4,066	3,267
93	3,169	4,009	4,662	1,667	4,115	3,307
94	3,207	4,057	4,718	1,688	4,166	3,352
95	3,247	4,106	4,774	1,706	4,215	3,395
96	3,285	4,155	4,832	1,730	4,266	3,440
97	3,325	4,205	4,891	1,749	4,318	3,483
98	3,366	4,257	4,950	1,770	4,370	3,526
99	3,406	4,307	5,009	1,789	4,421	3,572

Attained Age	Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	3,395	4,292	4,991	n/a	n/a	3,535
65	1,785	2,256	2,624	937	2,315	1,763
66	1,855	2,344	2,726	974	2,406	1,836
67	1,926	2,436	2,832	1,012	2,500	1,911
68	2,002	2,530	2,943	1,052	2,598	1,989
69	2,080	2,629	3,056	1,093	2,699	2,070
70	2,160	2,732	3,176	1,136	2,804	2,155
71	2,245	2,840	3,302	1,180	2,915	2,247
72	2,334	2,952	3,432	1,228	3,029	2,344
73	2,426	3,069	3,567	1,273	3,150	2,444
74	2,521	3,189	3,707	1,326	3,273	2,552
75	2,621	3,314	3,854	1,378	3,403	2,658
76	2,696	3,410	3,965	1,417	3,500	2,743
77	2,772	3,504	4,076	1,458	3,599	2,835
78	2,851	3,606	4,192	1,499	3,700	2,925
79	2,932	3,707	4,311	1,543	3,804	3,017
80	3,014	3,811	4,431	1,585	3,913	3,114
81	3,051	3,857	4,485	1,606	3,961	3,154
82	3,087	3,905	4,540	1,625	4,009	3,196
83	3,122	3,951	4,594	1,640	4,055	3,235
84	3,161	3,996	4,648	1,662	4,105	3,278
85	3,199	4,046	4,703	1,682	4,152	3,321
86	3,237	4,096	4,761	1,702	4,205	3,363
87	3,276	4,142	4,817	1,723	4,254	3,404
88	3,314	4,192	4,874	1,743	4,305	3,448
89	3,354	4,243	4,933	1,763	4,355	3,492
90	3,395	4,292	4,991	1,784	4,407	3,535
91	3,435	4,344	5,051	1,807	4,461	3,583
92	3,476	4,396	5,111	1,826	4,514	3,628
93	3,518	4,450	5,173	1,850	4,566	3,673
94	3,561	4,502	5,236	1,874	4,622	3,721
95	3,604	4,557	5,301	1,895	4,680	3,768
96	3,646	4,611	5,364	1,919	4,736	3,820
97	3,692	4,669	5,429	1,941	4,794	3,865
98	3,735	4,725	5,494	1,966	4,850	3,915
99	3,780	4,780	5,558	1,985	4,906	3,966

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

The rates do not include the $20 policy fee.

To calculate household discount:

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

Modal premium x .95 = discounted premium

If appyling during Open Enrollment or GI situation use Preferred rates

Continental Life Insurance Company of Brentwood, Tennessee

Annual Attained Age Premiums

For Use in ZIP Codes: 913, 917, 921, 924, 928

Attained Age	Preferred					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	2,723	3,444	4,004	n/a	n/a	2,835
65	1,431	1,809	2,106	753	1,859	1,415
66	1,487	1,880	2,187	782	1,931	1,473
67	1,545	1,953	2,273	813	2,007	1,534
68	1,606	2,030	2,361	844	2,085	1,596
69	1,668	2,109	2,453	877	2,166	1,660
70	1,732	2,191	2,549	911	2,250	1,729
71	1,801	2,278	2,649	946	2,339	1,802
72	1,873	2,368	2,752	985	2,430	1,880
73	1,945	2,461	2,862	1,021	2,527	1,962
74	2,023	2,558	2,976	1,064	2,625	2,047
75	2,105	2,661	3,093	1,105	2,730	2,133
76	2,163	2,735	3,181	1,137	2,808	2,201
77	2,224	2,813	3,271	1,170	2,888	2,274
78	2,288	2,894	3,364	1,203	2,971	2,347
79	2,352	2,974	3,459	1,237	3,052	2,420
80	2,418	3,057	3,555	1,271	3,138	2,497
81	2,447	3,094	3,599	1,288	3,177	2,530
82	2,477	3,132	3,642	1,304	3,215	2,563
83	2,506	3,168	3,684	1,315	3,253	2,596
84	2,536	3,207	3,730	1,332	3,293	2,630
85	2,566	3,245	3,773	1,351	3,332	2,663
86	2,597	3,285	3,819	1,365	3,372	2,697
87	2,628	3,323	3,865	1,382	3,412	2,732
88	2,660	3,364	3,911	1,398	3,454	2,767
89	2,691	3,404	3,958	1,415	3,494	2,802
90	2,723	3,444	4,004	1,431	3,537	2,835
91	2,755	3,486	4,053	1,448	3,579	2,873
92	2,790	3,528	4,102	1,466	3,621	2,910
93	2,822	3,570	4,152	1,485	3,665	2,945
94	2,856	3,612	4,202	1,503	3,710	2,985
95	2,891	3,656	4,252	1,519	3,754	3,023
96	2,926	3,700	4,303	1,541	3,799	3,063
97	2,961	3,744	4,355	1,558	3,845	3,101
98	2,998	3,791	4,408	1,576	3,892	3,140
99	3,033	3,836	4,460	1,593	3,937	3,181

Attained Age	Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	3,023	3,822	4,444	n/a	n/a	3,148
65	1,590	2,009	2,336	834	2,062	1,570
66	1,652	2,087	2,428	867	2,142	1,635
67	1,715	2,169	2,522	902	2,227	1,702
68	1,782	2,253	2,621	937	2,313	1,771
69	1,852	2,341	2,722	974	2,403	1,843
70	1,924	2,433	2,828	1,011	2,497	1,919
71	2,000	2,529	2,940	1,050	2,596	2,001
72	2,079	2,629	3,056	1,093	2,697	2,087
73	2,161	2,733	3,177	1,133	2,805	2,176
74	2,245	2,840	3,301	1,181	2,915	2,273
75	2,334	2,951	3,432	1,227	3,030	2,367
76	2,401	3,037	3,531	1,261	3,117	2,442
77	2,468	3,121	3,630	1,298	3,205	2,524
78	2,539	3,211	3,733	1,335	3,295	2,605
79	2,611	3,301	3,839	1,374	3,388	2,686
80	2,684	3,394	3,945	1,412	3,484	2,773
81	2,717	3,434	3,994	1,430	3,527	2,808
82	2,749	3,477	4,043	1,447	3,570	2,846
83	2,780	3,518	4,091	1,460	3,611	2,880
84	2,815	3,559	4,139	1,480	3,655	2,919
85	2,849	3,603	4,188	1,498	3,698	2,957
86	2,883	3,648	4,240	1,515	3,744	2,995
87	2,917	3,688	4,290	1,535	3,788	3,032
88	2,951	3,733	4,341	1,552	3,833	3,071
89	2,987	3,778	4,393	1,570	3,878	3,110
90	3,023	3,822	4,444	1,588	3,925	3,148
91	3,059	3,869	4,498	1,609	3,972	3,190
92	3,095	3,915	4,552	1,626	4,020	3,231
93	3,133	3,963	4,607	1,647	4,066	3,271
94	3,171	4,009	4,663	1,669	4,116	3,314
95	3,210	4,058	4,720	1,687	4,168	3,355
96	3,246	4,107	4,776	1,709	4,218	3,401
97	3,288	4,158	4,835	1,729	4,269	3,442
98	3,326	4,208	4,892	1,751	4,319	3,487
99	3,366	4,257	4,950	1,768	4,369	3,532

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

The rates do not include the $20 policy fee.

To calculate household discount:

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

Modal premium x .95 = discounted premium

If appyling during Open Enrollment or GI situation use Preferred rates

Continental Life Insurance Company of Brentwood, Tennessee

Annual Attained Age Premiums

For Use in ZIP Codes: 941, 943, 946-948, 951

Attained Age	Preferred					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	2,611	3,303	3,840	n/a	n/a	2,719
65	1,372	1,735	2,019	722	1,783	1,357
66	1,426	1,803	2,098	750	1,852	1,412
67	1,481	1,873	2,180	779	1,925	1,471
68	1,540	1,947	2,264	810	2,000	1,530
69	1,599	2,023	2,353	841	2,077	1,592
70	1,661	2,101	2,444	874	2,157	1,658
71	1,727	2,184	2,540	907	2,243	1,728
72	1,796	2,271	2,640	944	2,331	1,803
73	1,865	2,360	2,745	979	2,423	1,881
74	1,940	2,453	2,854	1,020	2,518	1,963
75	2,018	2,552	2,966	1,060	2,618	2,045
76	2,074	2,623	3,050	1,090	2,693	2,111
77	2,133	2,698	3,137	1,122	2,769	2,181
78	2,194	2,775	3,226	1,154	2,849	2,251
79	2,256	2,852	3,317	1,186	2,927	2,321
80	2,319	2,932	3,409	1,219	3,009	2,395
81	2,347	2,967	3,452	1,236	3,047	2,427
82	2,375	3,003	3,492	1,251	3,083	2,458
83	2,403	3,038	3,533	1,261	3,119	2,490
84	2,432	3,076	3,577	1,278	3,158	2,523
85	2,461	3,112	3,619	1,295	3,195	2,554
86	2,491	3,151	3,662	1,309	3,234	2,587
87	2,520	3,187	3,707	1,326	3,272	2,620
88	2,551	3,226	3,751	1,341	3,312	2,654
89	2,581	3,264	3,795	1,357	3,351	2,687
90	2,611	3,303	3,840	1,372	3,392	2,719
91	2,642	3,343	3,887	1,389	3,433	2,755
92	2,676	3,384	3,934	1,406	3,473	2,790
93	2,706	3,423	3,982	1,424	3,515	2,824
94	2,739	3,464	4,029	1,441	3,558	2,863
95	2,773	3,506	4,077	1,457	3,600	2,899
96	2,806	3,549	4,127	1,478	3,643	2,938
97	2,840	3,591	4,177	1,494	3,688	2,974
98	2,875	3,635	4,227	1,512	3,732	3,012
99	2,909	3,678	4,278	1,528	3,776	3,050

Attained Age	Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	2,899	3,666	4,262	n/a	n/a	3,019
65	1,525	1,927	2,241	800	1,977	1,506
66	1,584	2,002	2,328	832	2,055	1,568
67	1,645	2,080	2,418	865	2,135	1,632
68	1,709	2,161	2,513	899	2,218	1,699
69	1,776	2,245	2,610	934	2,305	1,768
70	1,845	2,333	2,712	970	2,395	1,840
71	1,918	2,425	2,820	1,007	2,490	1,919
72	1,994	2,521	2,931	1,048	2,587	2,002
73	2,072	2,621	3,047	1,087	2,690	2,087
74	2,153	2,724	3,166	1,133	2,795	2,180
75	2,238	2,830	3,291	1,177	2,906	2,270
76	2,303	2,912	3,386	1,210	2,989	2,342
77	2,367	2,993	3,481	1,245	3,074	2,421
78	2,435	3,079	3,580	1,280	3,160	2,498
79	2,504	3,166	3,682	1,317	3,249	2,576
80	2,574	3,255	3,784	1,354	3,342	2,659
81	2,606	3,294	3,831	1,371	3,382	2,693
82	2,636	3,335	3,877	1,388	3,423	2,730
83	2,666	3,374	3,923	1,400	3,463	2,762
84	2,699	3,413	3,970	1,419	3,505	2,800
85	2,732	3,455	4,017	1,437	3,546	2,836
86	2,765	3,498	4,066	1,453	3,591	2,872
87	2,797	3,537	4,114	1,472	3,633	2,907
88	2,830	3,580	4,163	1,488	3,676	2,945
89	2,864	3,623	4,213	1,506	3,719	2,982
90	2,899	3,666	4,262	1,523	3,764	3,019
91	2,933	3,710	4,314	1,543	3,810	3,060
92	2,968	3,755	4,365	1,560	3,855	3,098
93	3,005	3,800	4,418	1,580	3,900	3,137
94	3,041	3,845	4,472	1,601	3,948	3,178
95	3,078	3,891	4,527	1,618	3,997	3,218
96	3,113	3,938	4,581	1,639	4,045	3,262
97	3,153	3,987	4,637	1,658	4,094	3,301
98	3,189	4,035	4,692	1,679	4,142	3,344
99	3,228	4,082	4,747	1,695	4,190	3,387

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

The rates do not include the $20 policy fee.

To calculate household discount:

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

Modal premium x .95 = discounted premium

If appyling during Open Enrollment or GI situation use Preferred rates

Continental Life Insurance Company of Brentwood, Tennessee

Annual Attained Age Premiums

For Use in ZIP Codes: 919, 925, 933, 942

Attained Age	Preferred					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	2,455	3,105	3,610	n/a	n/a	2,556
65	1,290	1,631	1,899	679	1,676	1,276
66	1,341	1,695	1,972	705	1,741	1,328
67	1,393	1,761	2,049	733	1,810	1,383
68	1,448	1,830	2,129	761	1,880	1,439
69	1,504	1,902	2,212	791	1,953	1,497
70	1,562	1,976	2,298	822	2,028	1,559
71	1,624	2,054	2,388	853	2,109	1,625
72	1,689	2,135	2,482	888	2,191	1,695
73	1,753	2,219	2,581	921	2,278	1,769
74	1,824	2,307	2,683	959	2,367	1,846
75	1,898	2,399	2,789	997	2,462	1,923
76	1,950	2,466	2,868	1,025	2,532	1,984
77	2,005	2,537	2,949	1,055	2,604	2,050
78	2,063	2,609	3,033	1,085	2,679	2,116
79	2,121	2,682	3,119	1,115	2,752	2,182
80	2,180	2,757	3,205	1,146	2,829	2,252
81	2,207	2,790	3,245	1,162	2,864	2,281
82	2,233	2,824	3,284	1,176	2,899	2,311
83	2,259	2,857	3,322	1,186	2,933	2,341
84	2,287	2,892	3,363	1,201	2,969	2,372
85	2,313	2,926	3,402	1,218	3,004	2,401
86	2,342	2,962	3,443	1,231	3,040	2,432
87	2,369	2,996	3,485	1,246	3,077	2,463
88	2,398	3,033	3,527	1,261	3,114	2,495
89	2,427	3,069	3,568	1,276	3,150	2,527
90	2,455	3,105	3,610	1,290	3,189	2,556
91	2,484	3,143	3,654	1,306	3,227	2,591
92	2,516	3,181	3,698	1,322	3,265	2,624
93	2,544	3,219	3,743	1,339	3,304	2,655
94	2,575	3,257	3,788	1,355	3,345	2,692
95	2,607	3,297	3,834	1,370	3,385	2,726
96	2,638	3,336	3,880	1,389	3,425	2,762
97	2,670	3,376	3,927	1,405	3,467	2,796
98	2,703	3,418	3,974	1,421	3,509	2,831
99	2,735	3,458	4,022	1,437	3,550	2,868

Attained Age	Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	2,726	3,446	4,007	n/a	n/a	2,838
65	1,433	1,812	2,107	752	1,859	1,416
66	1,489	1,882	2,189	782	1,932	1,474
67	1,547	1,956	2,274	813	2,008	1,535
68	1,607	2,032	2,363	845	2,086	1,597
69	1,670	2,111	2,454	878	2,167	1,662
70	1,735	2,193	2,550	912	2,252	1,730
71	1,803	2,280	2,651	947	2,341	1,804
72	1,874	2,371	2,756	986	2,432	1,882
73	1,948	2,464	2,864	1,022	2,529	1,962
74	2,024	2,561	2,977	1,065	2,628	2,049
75	2,104	2,661	3,094	1,107	2,732	2,134
76	2,165	2,738	3,183	1,137	2,811	2,202
77	2,225	2,814	3,273	1,170	2,890	2,276
78	2,289	2,895	3,366	1,203	2,971	2,349
79	2,354	2,977	3,462	1,239	3,055	2,422
80	2,420	3,060	3,557	1,273	3,142	2,500
81	2,450	3,097	3,601	1,289	3,180	2,532
82	2,478	3,135	3,645	1,305	3,219	2,566
83	2,507	3,172	3,688	1,317	3,256	2,597
84	2,538	3,209	3,732	1,334	3,296	2,632
85	2,569	3,248	3,776	1,351	3,334	2,666
86	2,599	3,289	3,823	1,366	3,376	2,701
87	2,630	3,325	3,868	1,384	3,416	2,734
88	2,661	3,366	3,914	1,399	3,456	2,769
89	2,693	3,407	3,961	1,416	3,497	2,804
90	2,726	3,446	4,007	1,432	3,539	2,838
91	2,758	3,488	4,056	1,451	3,582	2,877
92	2,791	3,530	4,104	1,466	3,625	2,913
93	2,825	3,573	4,154	1,485	3,666	2,949
94	2,859	3,615	4,204	1,505	3,711	2,988
95	2,894	3,659	4,256	1,521	3,758	3,025
96	2,927	3,703	4,307	1,541	3,803	3,067
97	2,965	3,749	4,359	1,559	3,849	3,103
98	2,999	3,794	4,411	1,579	3,894	3,144
99	3,035	3,838	4,463	1,594	3,939	3,185

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

The rates do not include the $20 policy fee.

To calculate household discount:

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

Modal premium x .95 = discounted premium

If appyling during Open Enrollment or GI situation use Preferred rates

Continental Life Insurance Company of Brentwood, Tennessee

Annual Attained Age Premiums

For Use in ZIP Codes: 920, 922, 930-931, 937-938, 944, 958

Attained Age	Preferred					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	2,232	2,823	3,282	n/a	n/a	2,324
65	1,173	1,483	1,726	617	1,524	1,160
66	1,219	1,541	1,793	641	1,583	1,207
67	1,266	1,601	1,863	666	1,645	1,257
68	1,316	1,664	1,935	692	1,709	1,308
69	1,367	1,729	2,011	719	1,775	1,361
70	1,420	1,796	2,089	747	1,844	1,417
71	1,476	1,867	2,171	775	1,917	1,477
72	1,535	1,941	2,256	807	1,992	1,541
73	1,594	2,017	2,346	837	2,071	1,608
74	1,658	2,097	2,439	872	2,152	1,678
75	1,725	2,181	2,535	906	2,238	1,748
76	1,773	2,242	2,607	932	2,302	1,804
77	1,823	2,306	2,681	959	2,367	1,864
78	1,875	2,372	2,757	986	2,435	1,924
79	1,928	2,438	2,835	1,014	2,502	1,984
80	1,982	2,506	2,914	1,042	2,572	2,047
81	2,006	2,536	2,950	1,056	2,604	2,074
82	2,030	2,567	2,985	1,069	2,635	2,101
83	2,054	2,597	3,020	1,078	2,666	2,128
84	2,079	2,629	3,057	1,092	2,699	2,156
85	2,103	2,660	3,093	1,107	2,731	2,183
86	2,129	2,693	3,130	1,119	2,764	2,211
87	2,154	2,724	3,168	1,133	2,797	2,239
88	2,180	2,757	3,206	1,146	2,831	2,268
89	2,206	2,790	3,244	1,160	2,864	2,297
90	2,232	2,823	3,282	1,173	2,899	2,324
91	2,258	2,857	3,322	1,187	2,934	2,355
92	2,287	2,892	3,362	1,202	2,968	2,385
93	2,313	2,926	3,403	1,217	3,004	2,414
94	2,341	2,961	3,444	1,232	3,041	2,447
95	2,370	2,997	3,485	1,245	3,077	2,478
96	2,398	3,033	3,527	1,263	3,114	2,511
97	2,427	3,069	3,570	1,277	3,152	2,542
98	2,457	3,107	3,613	1,292	3,190	2,574
99	2,486	3,144	3,656	1,306	3,227	2,607

Attained Age	Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	2,478	3,133	3,643	n/a	n/a	2,580
65	1,303	1,647	1,915	684	1,690	1,287
66	1,354	1,711	1,990	711	1,756	1,340
67	1,406	1,778	2,067	739	1,825	1,395
68	1,461	1,847	2,148	768	1,896	1,452
69	1,518	1,919	2,231	798	1,970	1,511
70	1,577	1,994	2,318	829	2,047	1,573
71	1,639	2,073	2,410	861	2,128	1,640
72	1,704	2,155	2,505	896	2,211	1,711
73	1,771	2,240	2,604	929	2,299	1,784
74	1,840	2,328	2,706	968	2,389	1,863
75	1,913	2,419	2,813	1,006	2,484	1,940
76	1,968	2,489	2,894	1,034	2,555	2,002
77	2,023	2,558	2,975	1,064	2,627	2,069
78	2,081	2,632	3,060	1,094	2,701	2,135
79	2,140	2,706	3,147	1,126	2,777	2,202
80	2,200	2,782	3,234	1,157	2,856	2,273
81	2,227	2,815	3,274	1,172	2,891	2,302
82	2,253	2,850	3,314	1,186	2,926	2,333
83	2,279	2,884	3,353	1,197	2,960	2,361
84	2,307	2,917	3,393	1,213	2,996	2,393
85	2,335	2,953	3,433	1,228	3,031	2,424
86	2,363	2,990	3,475	1,242	3,069	2,455
87	2,391	3,023	3,516	1,258	3,105	2,485
88	2,419	3,060	3,558	1,272	3,142	2,517
89	2,448	3,097	3,601	1,287	3,179	2,549
90	2,478	3,133	3,643	1,302	3,217	2,580
91	2,507	3,171	3,687	1,319	3,256	2,615
92	2,537	3,209	3,731	1,333	3,295	2,648
93	2,568	3,248	3,776	1,350	3,333	2,681
94	2,599	3,286	3,822	1,368	3,374	2,716
95	2,631	3,326	3,869	1,383	3,416	2,750
96	2,661	3,366	3,915	1,401	3,457	2,788
97	2,695	3,408	3,963	1,417	3,499	2,821
98	2,726	3,449	4,010	1,435	3,540	2,858
99	2,759	3,489	4,057	1,449	3,581	2,895

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

The rates do not include the $20 policy fee.

To calculate household discount:

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

Modal premium x .95 = discounted premium

If appyling during Open Enrollment or GI situation use Preferred rates

Continental Life Insurance Company of Brentwood, Tennessee

Annual Attained Age Premiums

For Use in ZIP Codes: Rest of State

Attained Age	Preferred					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	2,120	2,682	3,118	n/a	n/a	2,208
65	1,114	1,409	1,640	586	1,448	1,102
66	1,158	1,464	1,703	609	1,504	1,147
67	1,203	1,521	1,770	633	1,563	1,194
68	1,250	1,581	1,838	657	1,624	1,243
69	1,299	1,643	1,910	683	1,686	1,293
70	1,349	1,706	1,985	710	1,752	1,346
71	1,402	1,774	2,062	736	1,821	1,403
72	1,458	1,844	2,143	767	1,892	1,464
73	1,514	1,916	2,229	795	1,967	1,528
74	1,575	1,992	2,317	828	2,044	1,594
75	1,639	2,072	2,408	861	2,126	1,661
76	1,684	2,130	2,477	885	2,187	1,714
77	1,732	2,191	2,547	911	2,249	1,771
78	1,781	2,253	2,619	937	2,313	1,828
79	1,832	2,316	2,693	963	2,377	1,885
80	1,883	2,381	2,768	990	2,443	1,945
81	1,906	2,409	2,803	1,003	2,474	1,970
82	1,929	2,439	2,836	1,016	2,503	1,996
83	1,951	2,467	2,869	1,024	2,533	2,022
84	1,975	2,498	2,904	1,037	2,564	2,048
85	1,998	2,527	2,938	1,052	2,594	2,074
86	2,023	2,558	2,974	1,063	2,626	2,100
87	2,046	2,588	3,010	1,076	2,657	2,127
88	2,071	2,619	3,046	1,089	2,689	2,155
89	2,096	2,651	3,082	1,102	2,721	2,182
90	2,120	2,682	3,118	1,114	2,754	2,208
91	2,145	2,714	3,156	1,128	2,787	2,237
92	2,173	2,747	3,194	1,142	2,820	2,266
93	2,197	2,780	3,233	1,156	2,854	2,293
94	2,224	2,813	3,272	1,170	2,889	2,325
95	2,252	2,847	3,311	1,183	2,923	2,354
96	2,278	2,881	3,351	1,200	2,958	2,385
97	2,306	2,916	3,392	1,213	2,994	2,415
98	2,334	2,952	3,432	1,227	3,031	2,445
99	2,362	2,987	3,473	1,241	3,066	2,477

Attained Age	Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	2,354	2,976	3,461	n/a	n/a	2,451
65	1,238	1,565	1,819	650	1,606	1,223
66	1,286	1,625	1,891	675	1,668	1,273
67	1,336	1,689	1,964	702	1,734	1,325
68	1,388	1,755	2,041	730	1,801	1,379
69	1,442	1,823	2,119	758	1,872	1,435
70	1,498	1,894	2,202	788	1,945	1,494
71	1,557	1,969	2,290	818	2,022	1,558
72	1,619	2,047	2,380	851	2,100	1,625
73	1,682	2,128	2,474	883	2,184	1,695
74	1,748	2,212	2,571	920	2,270	1,770
75	1,817	2,298	2,672	956	2,360	1,843
76	1,870	2,365	2,749	982	2,427	1,902
77	1,922	2,430	2,826	1,011	2,496	1,966
78	1,977	2,500	2,907	1,039	2,566	2,028
79	2,033	2,571	2,990	1,070	2,638	2,092
80	2,090	2,643	3,072	1,099	2,713	2,159
81	2,116	2,674	3,110	1,113	2,746	2,187
82	2,140	2,708	3,148	1,127	2,780	2,216
83	2,165	2,740	3,185	1,137	2,812	2,243
84	2,192	2,771	3,223	1,152	2,846	2,273
85	2,218	2,805	3,261	1,167	2,879	2,303
86	2,245	2,841	3,301	1,180	2,916	2,332
87	2,271	2,872	3,340	1,195	2,950	2,361
88	2,298	2,907	3,380	1,208	2,985	2,391
89	2,326	2,942	3,421	1,223	3,020	2,422
90	2,354	2,976	3,461	1,237	3,056	2,451
91	2,382	3,012	3,503	1,253	3,093	2,484
92	2,410	3,049	3,544	1,266	3,130	2,516
93	2,440	3,086	3,587	1,283	3,166	2,547
94	2,469	3,122	3,631	1,300	3,205	2,580
95	2,499	3,160	3,676	1,314	3,245	2,613
96	2,528	3,198	3,719	1,331	3,284	2,649
97	2,560	3,238	3,765	1,346	3,324	2,680
98	2,590	3,277	3,810	1,363	3,363	2,715
99	2,621	3,315	3,854	1,377	3,402	2,750

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

The rates do not include the $20 policy fee.

To calculate household discount:

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

Modal premium x .95 = discounted premium

If appyling during Open Enrollment or GI situation 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 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.

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; (b) be someone with whom you are in a civil union partnership; or (c) 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.

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) – HOSPITAL SERVICES – PER CALENDAR YEAR

*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	All but [$1260]	$0	[$1260] (Part A Deductible)
61st thru 90th day	All but [$315] a day	[$315] a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but[$630] a day	[$630] 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 thru 100th day	All but [$157.50] a day	$0	Up to[$157.50] a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$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.

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*	$0	$0	[$147] (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 [$147] of Medicare-Approved amounts*	$0	$0	[$147] (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 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 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	All but [$1260]	[$1260] (Part A Deductible)	$0
61st thru 90th day	All but [$315] a day	[$315] a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but [$630] a day	[$630] 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 thru 100th day	All but [$157.50] a day	$0	Up to [$157.50] a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$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 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.

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*	$0	$0	[$147] (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 [$147] of Medicare-Approved amounts*	$0	$0	[$147] (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 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.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [$1260]	[$1260] (Part A Deductible)	$0
61st thru 90th day	All but $315 a day	[$315] a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but [$630] a day	[$630] 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 thru 100th day	All but[$157.50] a day	Up to [$157.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$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 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.

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*	$0	[$147] (Part B Deductible)	$0
Remainder of Medicare-Approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-Approved amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next [$147] of Medicare-Approved amounts*	$0	[$147] (Part B Deductible)	$0
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 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	$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

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.

*****This high deductible plan pays the same benefits as Plan F after one has paid a calendar year [$2180] deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses are [$2180]. 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.**

SERVICES	MEDICARE PAYS	AFTER YOU PAY [$2180] DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO [$2180] DEDUCTIBLE*** YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but [$1260]	[$1260] (Part A Deductible)	$0
61st thru 90th day	All but [$315] a day	[$315] a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but [$630] a day	[$630] 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 thru 100th day	All but [$157.50] a day	Up to [$157.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$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 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.

*****This high deductible plan pays the same benefits as Plan F after one has paid a calendar year [$2180] deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses are [$2180]. 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.**

SERVICES	MEDICARE PAYS	AFTER YOU PAY [$2180] DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO [$2180] 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*	$0	[$147] (Part B Deductible)	$0
Remainder of Medicare-Approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-Approved amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next [$147] of Medicare-Approved amounts*	$0	[$147] (Part B Deductible)	$0
Remainder of Medicare-Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

HIGH DEDUCTIBLE PLAN F

PARTS A & B

SERVICES	MEDICARE PAYS	AFTER YOU PAY [$2180] DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO [$2180] 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 [$2180] DEDUCTIBLE** PLAN PAYS	IN ADDITION TO [$2180] 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	$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 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	All but [$1260]	[$1260] (Part A Deductible)	$0
61st thru 90th day	All but [$315] a day	[$315] a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but [$630] a day	[$630] 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 thru 100th day	All but [$157.50] a day	Up to [$157.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$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 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.

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*	$0	$0	[$147] (Part B Deductible)
Remainder of Medicare-Approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-Approved amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next [$147] of Medicare-Approved amounts*	$0	$0	[$147] (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 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 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	$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 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	All but [$1260]	[$1260] (Part A Deductible)	$0
61st thru 90th day	All but [$315] a day	[$315] a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but [$630] a day	[$630] 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 thru 100th day	All but [$157.50] a day	Up to [$157.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$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 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 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.

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*	$0	$0	[$147] (Part B Deductible)
Remainder of Medicare-Approved amounts	Generally 80%	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.	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	0%	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next [$147] of Medicare-Approved amounts*	$0	$0	[$147] (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

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