800 Crescent Centre Dr.
Suite 200
Franklin, TN 37067
800 264.4000
aetnaseniorproducts.com

Outline of Coverage

Medicare Supplement Insurance

BENEFIT PLANS A, B, F, HF, G, & N

Underwritten by

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

Pennsylvania

CLIMS03889PA

Rates Effective: 02/2018 A

CONTINENTAL LIFE INSURANCE COMPANY OF BRENTWOOD, TENNESSEE

OUTLINE OF MEDICARE SUPPLEMENT COVERAGE COVER PAGE

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" and "B" and "C" or "F". 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 fo 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 $5240; paid at 100% after limit reached	Out-of-pocket limit $2620; paid at 100% after limit reached		

*Plan F also has an option called a high deductible plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2240 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed $2240. 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 Premiums

For Use in ZIP Codes: 150-154 and 156

Female Rates

Rates Effective 2/1/2018

Attained	Preferred					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	1,224	1,319	1,702	680	1,460	1,092
65	1,224	1,319	1,702	680	1,460	1,092
66	1,224	1,319	1,702	680	1,460	1,116
67	1,224	1,319	1,702	680	1,460	1,142
68	1,238	1,335	1,722	689	1,478	1,182
69	1,266	1,363	1,759	704	1,510	1,235
70	1,300	1,399	1,806	722	1,549	1,294
71	1,338	1,442	1,860	744	1,596	1,333
72	1,380	1,486	1,918	767	1,645	1,375
73	1,425	1,535	1,980	792	1,700	1,420
74	1,475	1,589	2,050	820	1,759	1,470
75	1,529	1,646	2,124	850	1,824	1,522
76	1,582	1,704	2,199	879	1,887	1,576
77	1,635	1,762	2,274	910	1,950	1,629
78	1,688	1,819	2,347	939	2,015	1,683
79	1,744	1,878	2,424	970	2,080	1,738
80	1,799	1,938	2,501	1,000	2,146	1,792
81	1,855	1,999	2,579	1,032	2,214	1,849
82	1,913	2,061	2,659	1,063	2,283	1,906
83	1,973	2,124	2,741	1,096	2,353	1,965
84	2,033	2,190	2,825	1,130	2,425	2,025
85	2,104	2,266	2,923	1,170	2,510	2,095
86	2,164	2,331	3,007	1,203	2,581	2,156
87	2,225	2,397	3,093	1,237	2,654	2,217
88	2,287	2,463	3,180	1,271	2,729	2,280
89	2,352	2,532	3,268	1,307	2,805	2,342
90	2,416	2,602	3,357	1,344	2,882	2,407
91	2,481	2,672	3,449	1,380	2,959	2,472
92	2,548	2,745	3,541	1,417	3,040	2,539
93	2,616	2,818	3,636	1,454	3,121	2,607
94	2,686	2,893	3,732	1,493	3,204	2,675
95	2,756	2,969	3,830	1,532	3,287	2,746
96	2,827	3,044	3,929	1,572	3,372	2,817
97	2,900	3,122	4,030	1,611	3,458	2,888
98	2,972	3,201	4,131	1,652	3,545	2,961
99+	3,046	3,282	4,234	1,694	3,634	3,036

Attained	Standard					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	1,359	1,466	1,890	756	1,623	1,214
65	1,359	1,466	1,890	756	1,623	1,214
66	1,359	1,466	1,890	756	1,623	1,241
67	1,359	1,466	1,890	756	1,623	1,270
68	1,376	1,483	1,913	766	1,642	1,314
69	1,406	1,514	1,955	782	1,677	1,373
70	1,444	1,555	2,007	802	1,721	1,438
71	1,487	1,602	2,067	826	1,773	1,483
72	1,533	1,651	2,131	852	1,828	1,529
73	1,583	1,705	2,200	880	1,888	1,577
74	1,639	1,765	2,278	912	1,955	1,633
75	1,698	1,829	2,361	945	2,026	1,692
76	1,758	1,894	2,443	976	2,097	1,752
77	1,817	1,957	2,527	1,010	2,167	1,810
78	1,876	2,022	2,608	1,043	2,239	1,869
79	1,937	2,087	2,693	1,077	2,312	1,932
80	1,999	2,154	2,779	1,111	2,384	1,992
81	2,061	2,222	2,866	1,146	2,460	2,054
82	2,126	2,291	2,954	1,182	2,536	2,119
83	2,192	2,361	3,046	1,218	2,614	2,183
84	2,259	2,433	3,139	1,255	2,694	2,250
85	2,338	2,518	3,248	1,300	2,789	2,328
86	2,405	2,590	3,341	1,337	2,868	2,397
87	2,472	2,663	3,436	1,375	2,949	2,465
88	2,541	2,737	3,534	1,413	3,032	2,533
89	2,613	2,814	3,631	1,453	3,117	2,602
90	2,685	2,892	3,730	1,493	3,201	2,674
91	2,757	2,970	3,832	1,533	3,288	2,747
92	2,832	3,050	3,935	1,574	3,378	2,822
93	2,906	3,131	4,041	1,616	3,468	2,896
94	2,984	3,214	4,147	1,659	3,560	2,973
95	3,062	3,298	4,256	1,703	3,652	3,051
96	3,141	3,382	4,365	1,747	3,747	3,130
97	3,222	3,469	4,477	1,790	3,842	3,209
98	3,302	3,557	4,590	1,835	3,939	3,289
99+	3,385	3,647	4,704	1,883	4,037	3,374

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

The above rates do not include the $20 one-time policy fee.

To calculate a Household discount:

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

Modal premium x .93 = discounted premium

If applying during Open Enrollment or Guaranteed Issue Period, use Preferred rates.

Continental Life Insurance Company of Brentwood, Tennessee

Annual Premiums

For Use in ZIP Codes: 150-154 and 156

Male Rates

Rates Effective 2/1/2018

Attained Age	Preferred					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	1,407	1,516	1,957	782	1,679	1,255
65	1,407	1,516	1,957	782	1,679	1,255
66	1,407	1,516	1,957	782	1,679	1,285
67	1,407	1,516	1,957	782	1,679	1,314
68	1,424	1,535	1,981	793	1,700	1,361
69	1,455	1,567	2,024	809	1,736	1,420
70	1,495	1,609	2,077	831	1,782	1,488
71	1,539	1,658	2,139	855	1,835	1,535
72	1,587	1,709	2,206	883	1,892	1,581
73	1,639	1,765	2,277	911	1,955	1,633
74	1,696	1,827	2,357	944	2,024	1,689
75	1,758	1,894	2,443	977	2,097	1,750
76	1,819	1,959	2,529	1,011	2,171	1,813
77	1,880	2,026	2,615	1,046	2,243	1,875
78	1,941	2,093	2,700	1,080	2,317	1,936
79	2,005	2,159	2,788	1,115	2,392	1,999
80	2,069	2,228	2,876	1,150	2,468	2,061
81	2,133	2,298	2,965	1,187	2,546	2,127
82	2,200	2,371	3,058	1,223	2,625	2,192
83	2,269	2,443	3,153	1,261	2,705	2,260
84	2,338	2,519	3,249	1,300	2,789	2,329
85	2,419	2,606	3,362	1,345	2,886	2,410
86	2,488	2,680	3,458	1,384	2,969	2,480
87	2,558	2,756	3,557	1,423	3,052	2,550
88	2,631	2,833	3,657	1,462	3,138	2,623
89	2,704	2,912	3,758	1,504	3,225	2,694
90	2,779	2,992	3,861	1,545	3,314	2,767
91	2,853	3,074	3,966	1,587	3,404	2,843
92	2,930	3,156	4,073	1,629	3,496	2,920
93	3,008	3,241	4,182	1,672	3,589	2,998
94	3,089	3,327	4,292	1,716	3,684	3,076
95	3,170	3,414	4,404	1,762	3,780	3,157
96	3,251	3,501	4,519	1,808	3,878	3,240
97	3,335	3,590	4,634	1,853	3,976	3,322
98	3,418	3,682	4,751	1,900	4,077	3,405
99+	3,503	3,774	4,869	1,948	4,179	3,492

Attained Age	Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	1,563	1,686	2,174	869	1,866	1,394
65	1,563	1,686	2,174	869	1,866	1,394
66	1,563	1,686	2,174	869	1,866	1,427
67	1,563	1,686	2,174	869	1,866	1,461
68	1,583	1,705	2,200	881	1,888	1,512
69	1,617	1,741	2,249	899	1,929	1,579
70	1,661	1,788	2,307	923	1,979	1,654
71	1,710	1,843	2,376	950	2,039	1,705
72	1,764	1,898	2,451	980	2,103	1,758
73	1,820	1,961	2,530	1,012	2,172	1,814
74	1,885	2,029	2,619	1,049	2,249	1,879
75	1,953	2,104	2,714	1,086	2,330	1,946
76	2,022	2,178	2,809	1,123	2,411	2,015
77	2,089	2,251	2,905	1,162	2,493	2,083
78	2,157	2,324	2,999	1,199	2,574	2,149
79	2,227	2,400	3,096	1,238	2,659	2,222
80	2,298	2,477	3,196	1,277	2,743	2,291
81	2,371	2,555	3,295	1,318	2,830	2,362
82	2,444	2,634	3,397	1,359	2,917	2,436
83	2,521	2,714	3,503	1,401	3,006	2,511
84	2,598	2,798	3,610	1,444	3,098	2,588
85	2,688	2,895	3,735	1,495	3,207	2,677
86	2,765	2,979	3,843	1,537	3,298	2,756
87	2,843	3,063	3,952	1,582	3,392	2,834
88	2,922	3,147	4,063	1,625	3,486	2,914
89	3,005	3,236	4,175	1,671	3,584	2,993
90	3,087	3,326	4,289	1,716	3,682	3,075
91	3,171	3,415	4,407	1,764	3,782	3,158
92	3,257	3,508	4,525	1,810	3,884	3,244
93	3,343	3,601	4,647	1,859	3,988	3,331
94	3,432	3,696	4,770	1,907	4,094	3,418
95	3,522	3,793	4,894	1,958	4,200	3,509
96	3,613	3,889	5,019	2,009	4,309	3,599
97	3,705	3,990	5,148	2,059	4,418	3,691
98	3,797	4,091	5,278	2,111	4,530	3,783
99+	3,893	4,193	5,409	2,165	4,643	3,879

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

The above rates do not include the $20 one-time policy fee.

To calculate a Household discount:

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

Modal premium x .93 = discounted premium

If applying during Open Enrollment or Guaranteed Issue Period, use Preferred rates.

Continental Life Insurance Company of Brentwood, Tennessee

Annual Premiums

For Use in ZIP Codes: 189-194

Female Rates

Rates Effective 2/1/2018

Attained	Preferred					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	1,365	1,470	1,898	759	1,628	1,217
65	1,365	1,470	1,898	759	1,628	1,217
66	1,365	1,470	1,898	759	1,628	1,245
67	1,365	1,470	1,898	759	1,628	1,274
68	1,381	1,488	1,920	769	1,648	1,318
69	1,411	1,520	1,962	785	1,683	1,377
70	1,449	1,560	2,013	805	1,727	1,443
71	1,492	1,608	2,074	829	1,779	1,487
72	1,538	1,657	2,138	856	1,835	1,533
73	1,589	1,711	2,208	883	1,895	1,584
74	1,644	1,772	2,286	915	1,962	1,639
75	1,705	1,836	2,369	948	2,034	1,697
76	1,764	1,900	2,452	980	2,104	1,758
77	1,823	1,964	2,535	1,014	2,175	1,817
78	1,882	2,029	2,617	1,047	2,247	1,876
79	1,944	2,094	2,703	1,081	2,320	1,938
80	2,006	2,161	2,788	1,115	2,393	1,998
81	2,069	2,229	2,875	1,150	2,468	2,061
82	2,133	2,298	2,965	1,186	2,545	2,126
83	2,200	2,369	3,057	1,222	2,623	2,191
84	2,267	2,442	3,150	1,260	2,704	2,258
85	2,346	2,526	3,260	1,304	2,798	2,336
86	2,413	2,599	3,353	1,342	2,878	2,404
87	2,481	2,672	3,449	1,380	2,960	2,472
88	2,550	2,747	3,546	1,418	3,043	2,543
89	2,622	2,824	3,644	1,458	3,127	2,612
90	2,694	2,902	3,743	1,498	3,213	2,684
91	2,767	2,980	3,846	1,538	3,300	2,757
92	2,841	3,061	3,949	1,580	3,389	2,831
93	2,917	3,142	4,055	1,622	3,480	2,907
94	2,995	3,226	4,162	1,664	3,572	2,982
95	3,073	3,310	4,270	1,709	3,665	3,062
96	3,153	3,394	4,381	1,753	3,760	3,141
97	3,233	3,481	4,493	1,797	3,856	3,221
98	3,314	3,570	4,607	1,842	3,953	3,301
99+	3,397	3,659	4,721	1,889	4,052	3,386

Attained	Standard					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	1,516	1,634	2,108	843	1,809	1,353
65	1,516	1,634	2,108	843	1,809	1,353
66	1,516	1,634	2,108	843	1,809	1,383
67	1,516	1,634	2,108	843	1,809	1,416
68	1,535	1,653	2,133	854	1,831	1,465
69	1,567	1,688	2,180	872	1,870	1,531
70	1,610	1,734	2,238	895	1,919	1,604
71	1,658	1,787	2,305	921	1,977	1,653
72	1,710	1,841	2,376	950	2,039	1,705
73	1,765	1,901	2,453	982	2,105	1,759
74	1,827	1,968	2,540	1,017	2,180	1,821
75	1,894	2,040	2,632	1,053	2,259	1,886
76	1,961	2,112	2,724	1,089	2,339	1,953
77	2,026	2,182	2,817	1,126	2,417	2,019
78	2,092	2,254	2,908	1,163	2,496	2,084
79	2,160	2,327	3,003	1,201	2,578	2,155
80	2,229	2,402	3,098	1,239	2,659	2,221
81	2,298	2,477	3,195	1,278	2,743	2,291
82	2,370	2,554	3,294	1,318	2,827	2,363
83	2,444	2,632	3,397	1,358	2,914	2,434
84	2,519	2,713	3,500	1,400	3,004	2,509
85	2,607	2,807	3,621	1,449	3,110	2,596
86	2,681	2,888	3,726	1,491	3,198	2,672
87	2,757	2,970	3,832	1,533	3,289	2,748
88	2,834	3,052	3,940	1,575	3,381	2,825
89	2,913	3,137	4,048	1,620	3,475	2,902
90	2,994	3,224	4,159	1,664	3,570	2,981
91	3,074	3,311	4,273	1,710	3,667	3,063
92	3,158	3,401	4,387	1,755	3,766	3,146
93	3,241	3,491	4,506	1,802	3,867	3,229
94	3,328	3,583	4,624	1,850	3,969	3,315
95	3,415	3,678	4,745	1,899	4,072	3,402
96	3,503	3,771	4,867	1,948	4,178	3,490
97	3,592	3,868	4,992	1,996	4,284	3,578
98	3,682	3,966	5,118	2,046	4,392	3,668
99+	3,775	4,066	5,245	2,099	4,502	3,762

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

The above rates do not include the $20 one-time policy fee.

To calculate a Household discount:

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

Modal premium x .93 = discounted premium

If applying during Open Enrollment or Guaranteed Issue Period, use Preferred rates.

Continental Life Insurance Company of Brentwood, Tennessee

Annual Premiums

For Use in ZIP Codes: 189-194

Male Rates

Rates Effective 2/1/2018

Attained Age	Preferred					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	1,569	1,691	2,182	872	1,872	1,400
65	1,569	1,691	2,182	872	1,872	1,400
66	1,569	1,691	2,182	872	1,872	1,433
67	1,569	1,691	2,182	872	1,872	1,465
68	1,588	1,711	2,209	885	1,895	1,517
69	1,623	1,748	2,257	902	1,935	1,584
70	1,667	1,794	2,316	926	1,987	1,659
71	1,716	1,848	2,385	954	2,046	1,711
72	1,769	1,905	2,460	984	2,109	1,763
73	1,827	1,968	2,539	1,016	2,180	1,821
74	1,891	2,037	2,628	1,052	2,257	1,884
75	1,961	2,112	2,724	1,090	2,339	1,952
76	2,029	2,185	2,820	1,128	2,420	2,021
77	2,097	2,259	2,916	1,167	2,501	2,090
78	2,165	2,334	3,010	1,205	2,583	2,158
79	2,235	2,408	3,108	1,244	2,667	2,229
80	2,307	2,485	3,207	1,283	2,752	2,298
81	2,379	2,563	3,306	1,323	2,839	2,371
82	2,453	2,643	3,410	1,363	2,927	2,444
83	2,530	2,724	3,515	1,406	3,016	2,520
84	2,607	2,809	3,623	1,449	3,110	2,597
85	2,698	2,906	3,749	1,499	3,218	2,688
86	2,775	2,989	3,856	1,544	3,310	2,766
87	2,853	3,073	3,966	1,586	3,403	2,844
88	2,933	3,159	4,077	1,630	3,499	2,924
89	3,015	3,247	4,191	1,677	3,596	3,004
90	3,098	3,336	4,305	1,722	3,696	3,086
91	3,182	3,427	4,423	1,769	3,795	3,170
92	3,267	3,519	4,541	1,817	3,898	3,256
93	3,354	3,614	4,663	1,865	4,002	3,343
94	3,445	3,709	4,785	1,914	4,108	3,430
95	3,534	3,806	4,910	1,964	4,215	3,520
96	3,625	3,903	5,039	2,016	4,324	3,612
97	3,718	4,003	5,167	2,066	4,434	3,704
98	3,812	4,105	5,297	2,118	4,546	3,796
99+	3,906	4,208	5,429	2,172	4,659	3,893

Attained Age	Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	1,743	1,880	2,424	969	2,080	1,555
65	1,743	1,880	2,424	969	2,080	1,555
66	1,743	1,880	2,424	969	2,080	1,591
67	1,743	1,880	2,424	969	2,080	1,629
68	1,765	1,901	2,453	983	2,105	1,686
69	1,803	1,942	2,507	1,003	2,151	1,760
70	1,852	1,993	2,573	1,029	2,206	1,845
71	1,906	2,055	2,650	1,060	2,273	1,901
72	1,967	2,117	2,733	1,092	2,345	1,961
73	2,030	2,186	2,821	1,129	2,422	2,022
74	2,102	2,263	2,921	1,169	2,507	2,095
75	2,177	2,346	3,027	1,211	2,598	2,170
76	2,254	2,428	3,132	1,252	2,689	2,247
77	2,330	2,510	3,239	1,295	2,780	2,322
78	2,405	2,592	3,344	1,337	2,870	2,397
79	2,483	2,676	3,452	1,381	2,965	2,477
80	2,563	2,762	3,563	1,424	3,058	2,554
81	2,643	2,849	3,674	1,469	3,155	2,633
82	2,725	2,937	3,788	1,516	3,252	2,717
83	2,811	3,027	3,906	1,562	3,352	2,800
84	2,897	3,120	4,026	1,610	3,455	2,885
85	2,998	3,228	4,164	1,667	3,576	2,985
86	3,083	3,321	4,285	1,714	3,678	3,073
87	3,170	3,416	4,406	1,764	3,783	3,160
88	3,258	3,509	4,531	1,812	3,887	3,250
89	3,350	3,609	4,656	1,864	3,997	3,338
90	3,442	3,708	4,783	1,914	4,105	3,428
91	3,536	3,808	4,914	1,967	4,217	3,522
92	3,631	3,911	5,045	2,019	4,331	3,617
93	3,727	4,016	5,181	2,073	4,447	3,714
94	3,827	4,121	5,318	2,127	4,565	3,812
95	3,927	4,230	5,457	2,184	4,683	3,912
96	4,028	4,337	5,597	2,240	4,804	4,013
97	4,132	4,449	5,741	2,296	4,927	4,115
98	4,234	4,561	5,885	2,354	5,051	4,218
99+	4,341	4,676	6,032	2,414	5,177	4,326

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

The above rates do not include the $20 one-time policy fee.

To calculate a Household discount:

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

Modal premium x .93 = discounted premium

If applying during Open Enrollment or Guaranteed Issue Period, use Preferred rates.

Continental Life Insurance Company of Brentwood, Tennessee

Annual Premiums

For Use in: Rest of State

Female Rates

Rates Effective 2/1/2018

Attained Age	Preferred					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	1,083	1,167	1,506	602	1,292	966
65	1,083	1,167	1,506	602	1,292	966
66	1,083	1,167	1,506	602	1,292	988
67	1,083	1,167	1,506	602	1,292	1,011
68	1,096	1,181	1,524	610	1,308	1,046
69	1,120	1,206	1,557	623	1,336	1,093
70	1,150	1,238	1,598	639	1,371	1,145
71	1,184	1,276	1,646	658	1,412	1,180
72	1,221	1,315	1,697	679	1,456	1,217
73	1,261	1,358	1,752	701	1,504	1,257
74	1,305	1,406	1,814	726	1,557	1,301
75	1,353	1,457	1,880	752	1,614	1,347
76	1,400	1,508	1,946	778	1,670	1,395
77	1,447	1,559	2,012	805	1,726	1,442
78	1,494	1,610	2,077	831	1,783	1,489
79	1,543	1,662	2,145	858	1,841	1,538
80	1,592	1,715	2,213	885	1,899	1,586
81	1,642	1,769	2,282	913	1,959	1,636
82	1,693	1,824	2,353	941	2,020	1,687
83	1,746	1,880	2,426	970	2,082	1,739
84	1,799	1,938	2,500	1,000	2,146	1,792
85	1,862	2,005	2,587	1,035	2,221	1,854
86	1,915	2,063	2,661	1,065	2,284	1,908
87	1,969	2,121	2,737	1,095	2,349	1,962
88	2,024	2,180	2,814	1,125	2,415	2,018
89	2,081	2,241	2,892	1,157	2,482	2,073
90	2,138	2,303	2,971	1,189	2,550	2,130
91	2,196	2,365	3,052	1,221	2,619	2,188
92	2,255	2,429	3,134	1,254	2,690	2,247
93	2,315	2,494	3,218	1,287	2,762	2,307
94	2,377	2,560	3,303	1,321	2,835	2,367
95	2,439	2,627	3,389	1,356	2,909	2,430
96	2,502	2,694	3,477	1,391	2,984	2,493
97	2,566	2,763	3,566	1,426	3,060	2,556
98	2,630	2,833	3,656	1,462	3,137	2,620
99+	2,696	2,904	3,747	1,499	3,216	2,687

Attained Age	Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	1,203	1,297	1,673	669	1,436	1,074
65	1,203	1,297	1,673	669	1,436	1,074
66	1,203	1,297	1,673	669	1,436	1,098
67	1,203	1,297	1,673	669	1,436	1,124
68	1,218	1,312	1,693	678	1,453	1,163
69	1,244	1,340	1,730	692	1,484	1,215
70	1,278	1,376	1,776	710	1,523	1,273
71	1,316	1,418	1,829	731	1,569	1,312
72	1,357	1,461	1,886	754	1,618	1,353
73	1,401	1,509	1,947	779	1,671	1,396
74	1,450	1,562	2,016	807	1,730	1,445
75	1,503	1,619	2,089	836	1,793	1,497
76	1,556	1,676	2,162	864	1,856	1,550
77	1,608	1,732	2,236	894	1,918	1,602
78	1,660	1,789	2,308	923	1,981	1,654
79	1,714	1,847	2,383	953	2,046	1,710
80	1,769	1,906	2,459	983	2,110	1,763
81	1,824	1,966	2,536	1,014	2,177	1,818
82	1,881	2,027	2,614	1,046	2,244	1,875
83	1,940	2,089	2,696	1,078	2,313	1,932
84	1,999	2,153	2,778	1,111	2,384	1,991
85	2,069	2,228	2,874	1,150	2,468	2,060
86	2,128	2,292	2,957	1,183	2,538	2,121
87	2,188	2,357	3,041	1,217	2,610	2,181
88	2,249	2,422	3,127	1,250	2,683	2,242
89	2,312	2,490	3,213	1,286	2,758	2,303
90	2,376	2,559	3,301	1,321	2,833	2,366
91	2,440	2,628	3,391	1,357	2,910	2,431
92	2,506	2,699	3,482	1,393	2,989	2,497
93	2,572	2,771	3,576	1,430	3,069	2,563
94	2,641	2,844	3,670	1,468	3,150	2,631
95	2,710	2,919	3,766	1,507	3,232	2,700
96	2,780	2,993	3,863	1,546	3,316	2,770
97	2,851	3,070	3,962	1,584	3,400	2,840
98	2,922	3,148	4,062	1,624	3,486	2,911
99+	2,996	3,227	4,163	1,666	3,573	2,986

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

The above rates do not include the $20 one-time policy fee.

To calculate a Household discount:

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

Modal premium x .93 = discounted premium

If applying during Open Enrollment or Guaranteed Issue Period, use Preferred rates.

Continental Life Insurance Company of Brentwood, Tennessee

Annual Premiums

For Use in: Rest of State

Male Rates

Rates Effective 2/1/2018

Attained Age	Preferred					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	1,245	1,342	1,732	692	1,486	1,111
65	1,245	1,342	1,732	692	1,486	1,111
66	1,245	1,342	1,732	692	1,486	1,137
67	1,245	1,342	1,732	692	1,486	1,163
68	1,260	1,358	1,753	702	1,504	1,204
69	1,288	1,387	1,791	716	1,536	1,257
70	1,323	1,424	1,838	735	1,577	1,317
71	1,362	1,467	1,893	757	1,624	1,358
72	1,404	1,512	1,952	781	1,674	1,399
73	1,450	1,562	2,015	806	1,730	1,445
74	1,501	1,617	2,086	835	1,791	1,495
75	1,556	1,676	2,162	865	1,856	1,549
76	1,610	1,734	2,238	895	1,921	1,604
77	1,664	1,793	2,314	926	1,985	1,659
78	1,718	1,852	2,389	956	2,050	1,713
79	1,774	1,911	2,467	987	2,117	1,769
80	1,831	1,972	2,545	1,018	2,184	1,824
81	1,888	2,034	2,624	1,050	2,253	1,882
82	1,947	2,098	2,706	1,082	2,323	1,940
83	2,008	2,162	2,790	1,116	2,394	2,000
84	2,069	2,229	2,875	1,150	2,468	2,061
85	2,141	2,306	2,975	1,190	2,554	2,133
86	2,202	2,372	3,060	1,225	2,627	2,195
87	2,264	2,439	3,148	1,259	2,701	2,257
88	2,328	2,507	3,236	1,294	2,777	2,321
89	2,393	2,577	3,326	1,331	2,854	2,384
90	2,459	2,648	3,417	1,367	2,933	2,449
91	2,525	2,720	3,510	1,404	3,012	2,516
92	2,593	2,793	3,604	1,442	3,094	2,584
93	2,662	2,868	3,701	1,480	3,176	2,653
94	2,734	2,944	3,798	1,519	3,260	2,722
95	2,805	3,021	3,897	1,559	3,345	2,794
96	2,877	3,098	3,999	1,600	3,432	2,867
97	2,951	3,177	4,101	1,640	3,519	2,940
98	3,025	3,258	4,204	1,681	3,608	3,013
99+	3,100	3,340	4,309	1,724	3,698	3,090

Attained Age	Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	1,383	1,492	1,924	769	1,651	1,234
65	1,383	1,492	1,924	769	1,651	1,234
66	1,383	1,492	1,924	769	1,651	1,263
67	1,383	1,492	1,924	769	1,651	1,293
68	1,401	1,509	1,947	780	1,671	1,338
69	1,431	1,541	1,990	796	1,707	1,397
70	1,470	1,582	2,042	817	1,751	1,464
71	1,513	1,631	2,103	841	1,804	1,509
72	1,561	1,680	2,169	867	1,861	1,556
73	1,611	1,735	2,239	896	1,922	1,605
74	1,668	1,796	2,318	928	1,990	1,663
75	1,728	1,862	2,402	961	2,062	1,722
76	1,789	1,927	2,486	994	2,134	1,783
77	1,849	1,992	2,571	1,028	2,206	1,843
78	1,909	2,057	2,654	1,061	2,278	1,902
79	1,971	2,124	2,740	1,096	2,353	1,966
80	2,034	2,192	2,828	1,130	2,427	2,027
81	2,098	2,261	2,916	1,166	2,504	2,090
82	2,163	2,331	3,006	1,203	2,581	2,156
83	2,231	2,402	3,100	1,240	2,660	2,222
84	2,299	2,476	3,195	1,278	2,742	2,290
85	2,379	2,562	3,305	1,323	2,838	2,369
86	2,447	2,636	3,401	1,360	2,919	2,439
87	2,516	2,711	3,497	1,400	3,002	2,508
88	2,586	2,785	3,596	1,438	3,085	2,579
89	2,659	2,864	3,695	1,479	3,172	2,649
90	2,732	2,943	3,796	1,519	3,258	2,721
91	2,806	3,022	3,900	1,561	3,347	2,795
92	2,882	3,104	4,004	1,602	3,437	2,871
93	2,958	3,187	4,112	1,645	3,529	2,948
94	3,037	3,271	4,221	1,688	3,623	3,025
95	3,117	3,357	4,331	1,733	3,717	3,105
96	3,197	3,442	4,442	1,778	3,813	3,185
97	3,279	3,531	4,556	1,822	3,910	3,266
98	3,360	3,620	4,671	1,868	4,009	3,348
99+	3,445	3,711	4,787	1,916	4,109	3,433

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

The above rates do not include the $20 one-time policy fee.

To calculate a Household discount:

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

Modal premium x .93 = discounted premium

If applying during Open Enrollment or Guaranteed Issue Period, use Preferred rates.

PREMIUM INFORMATION

Continental Life Insurance Company of Brentwood, Tennessee can only raise your premium if we raise the premium for all policies like yours in this state. Premiums for this policy will increase annually 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.

Premiums payable other than annual will be determined according to the following factors:

Semi-annual: 0.5200 Quarterly: 0.2650 Monthly EFT: 0.0833.

HOUSEHOLD DISCOUNT

In order to be eligible for the Household discount under an 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 Company 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; and (c) be someone with whom you have continuously resided for the past 12 months. The household discount will only be applicable if a policy for each applicant is issued. The discounted rate will be 7 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 14770, Lexington, KY 40512-4770. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all your payments.

POLICY REPLACEMENT

If you are replacing another health insurance policy, do **NOT** cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE

The policy may not cover all of your medical costs. Neither Continental Life Insurance Company of Brentwood, Tennessee nor its agents are connected with Medicare. This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult *Medicare & You* for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT

When you fill out the application for the new policy, be sure to answer truthfully and completely any questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information.

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) – MEDICAL 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 $1340	$0	$1340 (Part A Deductible)
61st thru 90th day	All but $335 a day	$335 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $670 a day	$670 a day	$0
•Once lifetime reserve days are used:			$0**
•Additional 365 days	$0	100% of Medicare Eligible Expenses	All costs
•Beyond the Additional 365 days	$0	$0	
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 $167.50 a day	$0	Up to $167.50 a day
101st day and after	$0	$0	All costs
BLOOD First 3 pints Additional amounts	$0 100%	3 pints $0	$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 $183 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

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 $183 of Medicare-Approved amounts*	$0	$0	$183 (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 $183 of Medicare-Approved amounts*	$0	$0	$183 (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 $183of Medicare Approved amounts*	$0	$0	$183 (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 $1340	$1340 (Part A Deductible)	$0
61st thru 90th day	All but $335 a day	$335 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $670 a day	$670 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 $167.50 a day	$0	Up to $167.50 a day
101st day and after	$0	$0	All costs
BLOOD First 3 pints Additional amounts	$0 100%	3 pints $0	$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 $183 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

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 $183 of Medicare-Approved amounts*	$0	$0	$183 (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 $183 of Medicare-Approved amounts*	$0	$0	$183 (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 $183 of Medicare Approved amounts*	$0	$0	$183 (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 $1340	$1340 (Part A Deductible)	$0
61st thru 90th day	All but $335 a day	$335 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $670 a day	$670 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 $167.50 a day	Up to $167.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD First 3 pints Additional amounts	$0 100%	3 pints $0	$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 $183 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

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 $183 of Medicare-Approved amounts*	$0	$183 (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 $183 of Medicare-Approved amounts*	$0	$183 (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 $183 of Medicare Approved amounts*	$0	$183 (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 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.

*****This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2240 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses are $2240. 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 $2240 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2240 DEDUCTIBLE*** YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1340	$1340 (Part A Deductible)	$0
61st thru 90th day	All but $335 a day	$335 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $670 a day	$670 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 $167.50 a day	Up to $167.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD First 3 pints Additional amounts	$0 100%	3 pints $0	$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 $183 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

*****This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2240 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses are $2240. 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 $2240 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2240 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 tests, durable medical equipment			
First $183 of Medicare-Approved amounts*	$0	$183 (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 $183 of Medicare-Approved amounts*	$0	$183 (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 $2240 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2240 DEDUCTIBLE*** YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
•Medically necessary skilled care services and medical supplies	100%	$0	$0
•Durable medical equipment			
•First $183 of Medicare Approved amounts*	$0	$183 (Part B Deductible)	$0
•Remainder of Medicare Approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2240 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2240 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 $1340	$1340 (Part A Deductible)	$0
61st thru 90th day	All but $335 a day	$335 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $670 a day	$670 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 $167.50 a day	Up to $167.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD First 3 pints Additional amounts	$0 100%	3 pints $0	$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 $183 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

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 $183 of Medicare-Approved amounts*	$0	$0	$183 (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 $183 of Medicare-Approved amounts*	$0	$0	$183 (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 $183 of Medicare Approved amounts*	$0	$0	$183 (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 $1340	$1340 (Part A Deductible)	$0
61st thru 90th day	All but $335 a day	$335 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $670 a day	$670 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 $167.50 a day	Up to $167.50 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 $183 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

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 $183 of Medicare-Approved amounts*	$0	$0	$183 (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 $183 of Medicare-Approved amounts*	$0	$0	$183 (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 $183 of Medicare Approved amounts*	$0	$0	$183 (Part B Deductible)
•Remainder of Medicare Approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

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