Outline of coverage

Medicare Supplement Insurance

Benefit Plans A, B, F, High Deductible F, G, N

California

Underwritten by

Continental Life Insurance Company of Brentwood, Tennessee

An Aetna Company

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CLIMS05024CA

Rates effective: 09/2023 B

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

This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plan "A" available. Some plans may not be available. Only applicants **first** eligible for Medicare before 2020 may purchase Plans C, F, and High Deductible F.

Note: A ✓ means 100% of the benefit is paid.

Benefits	Plans Available to All Applicants								Medicare first eligible before 2020 only	
	A	B	D	G[1]	K	L	M	N	C	F[1]
Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Medicare Part B coinsurance or copayment	✓	✓	✓	✓	50%	75%	✓	✓ copays apply[3]	✓	✓
Blood (first three pints)	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Part A hospice care coinsurance or copayment	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Skilled nursing facility coinsurance			✓	✓	50%	75%	✓	✓	✓	✓
Medicare Part A deductible		✓	✓	✓	50%	75%	50%	✓	✓	✓
Medicare Part B deductible									✓	✓
Medicare Part B excess charges				✓						✓
Foreign travel emergency (up to plan limits)			✓	✓			✓	✓	✓	✓
Out-of-pocket limit in 2024[2]					**$7,060[2]**	**$3,530[2]**				

[1] Plans F and G also have a high deductible option, which require first paying a plan deductible of **$2,800** before the plan begins to pay. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High deductible plan G does not cover the Medicare Part B deductible. However, high deductible plans F and G count your payment of the Medicare Part B deductible toward meeting the plan deductible.

[2] Plans K and L pay 100% of covered services for the rest of the calendar year once you meet the out-of-pocket yearly limit.

[3] Plan N pays 100% of the Part B coinsurance, except for a copayment of up to $20 for some office visits and up to a $50 copayment for emergency room visits that do not result in an inpatient admission.

Continental Life Insurance Company of Brentwood, Tennessee

Annual premiums

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

Rates effective 9/1/2023

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	4,462	5,642	7,904	n/a	5,905	4,462
65	2,343	2,965	4,155	777	3,103	2,226
66	2,436	3,080	4,314	808	3,225	2,318
67	2,530	3,200	4,484	838	3,350	2,413
68	2,630	3,325	4,659	870	3,480	2,513
69	2,733	3,455	4,843	907	3,617	2,613
70	2,839	3,589	5,028	943	3,755	2,719
71	2,947	3,733	5,229	975	3,903	2,835
72	3,067	3,880	5,431	1,017	4,057	2,958
73	3,185	4,032	5,647	1,054	4,218	3,087
74	3,313	4,194	5,872	1,097	4,383	3,221
75	3,450	4,361	6,103	1,141	4,559	3,355
76	3,543	4,480	6,276	1,174	4,688	3,463
77	3,643	4,606	6,454	1,207	4,822	3,578
78	3,746	4,742	6,639	1,241	4,958	3,695
79	3,854	4,873	6,825	1,277	5,095	3,809
80	3,962	5,007	7,016	1,314	5,238	3,932
81	4,009	5,068	7,102	1,329	5,303	3,981
82	4,058	5,132	7,188	1,347	5,365	4,033
83	4,106	5,190	7,272	1,358	5,431	4,085
84	4,155	5,255	7,362	1,374	5,495	4,139
85	4,202	5,316	7,446	1,393	5,564	4,191
86	4,254	5,384	7,534	1,410	5,629	4,246
87	4,305	5,443	7,625	1,426	5,695	4,300
88	4,357	5,512	7,717	1,444	5,765	4,352
89	4,407	5,576	7,812	1,462	5,831	4,411
90	4,462	5,642	7,904	1,475	5,905	4,462
91	4,514	5,712	7,998	1,496	5,975	4,521
92	4,572	5,780	8,095	1,514	6,044	4,580
93	4,624	5,847	8,191	1,532	6,117	4,635
94	4,679	5,917	8,293	1,552	6,194	4,698
95	4,737	5,990	8,393	1,569	6,265	4,758
96	4,794	6,062	8,490	1,591	6,343	4,821
97	4,851	6,133	8,595	1,607	6,421	4,880
98	4,910	6,207	8,697	1,628	6,497	4,943
99	4,968	6,281	8,801	1,645	6,572	5,003

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	4,951	6,260	8,769	n/a	6,551	4,955
65	2,604	3,289	4,609	862	3,441	2,470
66	2,708	3,420	4,787	895	3,576	2,574
67	2,810	3,554	4,977	930	3,718	2,680
68	2,918	3,689	5,173	969	3,861	2,789
69	3,033	3,833	5,369	1,004	4,013	2,903
70	3,152	3,987	5,577	1,045	4,169	3,018
71	3,277	4,143	5,802	1,085	4,333	3,148
72	3,404	4,306	6,031	1,128	4,503	3,287
73	3,539	4,477	6,269	1,171	4,684	3,425
74	3,680	4,653	6,512	1,219	4,864	3,577
75	3,824	4,833	6,773	1,267	5,059	3,726
76	3,933	4,974	6,969	1,302	5,206	3,841
77	4,044	5,113	7,164	1,340	5,353	3,973
78	4,159	5,259	7,368	1,377	5,499	4,099
79	4,277	5,409	7,576	1,418	5,655	4,226
80	4,396	5,559	7,787	1,458	5,817	4,365
81	4,451	5,627	7,882	1,474	5,886	4,418
82	4,503	5,698	7,978	1,495	5,960	4,480
83	4,554	5,764	8,073	1,507	6,028	4,532
84	4,609	5,829	8,167	1,526	6,101	4,594
85	4,666	5,902	8,265	1,548	6,172	4,654
86	4,721	5,976	8,365	1,563	6,250	4,713
87	4,777	6,043	8,464	1,584	6,323	4,770
88	4,833	6,117	8,568	1,603	6,399	4,833
89	4,894	6,191	8,668	1,621	6,475	4,894
90	4,951	6,260	8,769	1,640	6,551	4,955
91	5,010	6,335	8,876	1,660	6,632	5,022
92	5,070	6,414	8,980	1,678	6,713	5,084
93	5,133	6,491	9,091	1,700	6,787	5,147
94	5,194	6,566	9,202	1,723	6,871	5,214
95	5,258	6,649	9,319	1,743	6,955	5,281
96	5,317	6,728	9,426	1,763	7,042	5,354
97	5,387	6,813	9,541	1,785	7,127	5,416
98	5,447	6,892	9,656	1,807	7,209	5,487
99	5,514	6,972	9,768	1,825	7,295	5,558

The above rates do not include the $20 application fee.

To calculate a household discount:

Annual premium **x** modal factor **= modal premium** (round to nearest whole cent)
Modal premium **x** .95 **= discounted premium**

If applying during Open Enrollment or Guaranteed Issue periods, use preferred rates.

Modal factors

Semi-annual 0.5200
Quarterly 0.2650
Monthly 0.0833

Continental Life Insurance Company of Brentwood, Tennessee

Annual premiums

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

Rates effective 9/1/2023

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	3,974	5,024	7,038	n/a	5,258	3,974
65	2,086	2,640	3,700	692	2,763	1,983
66	2,169	2,743	3,842	720	2,872	2,064
67	2,253	2,850	3,993	747	2,983	2,148
68	2,342	2,961	4,149	775	3,099	2,237
69	2,434	3,077	4,313	808	3,221	2,327
70	2,528	3,196	4,477	839	3,344	2,422
71	2,624	3,325	4,657	869	3,476	2,524
72	2,732	3,455	4,836	905	3,612	2,634
73	2,837	3,590	5,029	938	3,756	2,749
74	2,950	3,734	5,229	977	3,903	2,868
75	3,072	3,883	5,435	1,016	4,060	2,988
76	3,155	3,989	5,589	1,046	4,175	3,084
77	3,244	4,102	5,747	1,075	4,294	3,187
78	3,335	4,222	5,912	1,105	4,415	3,290
79	3,432	4,340	6,078	1,137	4,537	3,392
80	3,528	4,459	6,248	1,170	4,664	3,501
81	3,570	4,513	6,324	1,183	4,723	3,545
82	3,614	4,570	6,401	1,199	4,778	3,592
83	3,656	4,621	6,476	1,209	4,836	3,638
84	3,700	4,680	6,556	1,224	4,893	3,686
85	3,742	4,734	6,631	1,241	4,954	3,732
86	3,788	4,795	6,709	1,255	5,013	3,781
87	3,833	4,847	6,791	1,270	5,072	3,830
88	3,880	4,908	6,872	1,286	5,134	3,876
89	3,925	4,965	6,956	1,302	5,192	3,928
90	3,974	5,024	7,038	1,314	5,258	3,974
91	4,020	5,086	7,122	1,332	5,320	4,026
92	4,071	5,147	7,209	1,348	5,383	4,078
93	4,118	5,207	7,294	1,364	5,447	4,127
94	4,166	5,269	7,385	1,382	5,516	4,183
95	4,219	5,334	7,474	1,397	5,579	4,237
96	4,269	5,399	7,560	1,416	5,649	4,293
97	4,320	5,462	7,654	1,431	5,718	4,346
98	4,372	5,528	7,745	1,449	5,785	4,402
99	4,424	5,594	7,837	1,465	5,852	4,455

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	4,409	5,574	7,809	n/a	5,834	4,413
65	2,319	2,929	4,104	767	3,065	2,200
66	2,412	3,045	4,263	797	3,184	2,292
67	2,502	3,165	4,432	828	3,311	2,386
68	2,599	3,285	4,607	863	3,438	2,484
69	2,701	3,414	4,781	894	3,573	2,585
70	2,807	3,550	4,967	931	3,712	2,688
71	2,918	3,689	5,167	966	3,859	2,804
72	3,032	3,834	5,370	1,004	4,010	2,927
73	3,151	3,987	5,583	1,043	4,171	3,050
74	3,277	4,143	5,799	1,086	4,331	3,185
75	3,405	4,304	6,032	1,129	4,505	3,318
76	3,503	4,430	6,206	1,159	4,636	3,421
77	3,601	4,553	6,379	1,193	4,767	3,538
78	3,704	4,684	6,561	1,226	4,897	3,650
79	3,809	4,817	6,747	1,263	5,036	3,764
80	3,915	4,951	6,934	1,298	5,180	3,887
81	3,964	5,011	7,019	1,313	5,241	3,935
82	4,010	5,074	7,104	1,331	5,307	3,989
83	4,055	5,133	7,189	1,342	5,368	4,036
84	4,104	5,191	7,272	1,359	5,433	4,091
85	4,155	5,256	7,360	1,379	5,496	4,144
86	4,204	5,322	7,449	1,392	5,566	4,197
87	4,254	5,381	7,537	1,410	5,630	4,248
88	4,304	5,447	7,630	1,427	5,699	4,304
89	4,358	5,513	7,719	1,443	5,766	4,358
90	4,409	5,574	7,809	1,460	5,834	4,413
91	4,462	5,641	7,904	1,479	5,906	4,473
92	4,515	5,712	7,997	1,495	5,978	4,527
93	4,571	5,780	8,096	1,514	6,044	4,584
94	4,625	5,847	8,195	1,535	6,118	4,643
95	4,682	5,921	8,298	1,552	6,194	4,703
96	4,735	5,991	8,394	1,570	6,271	4,768
97	4,797	6,067	8,496	1,590	6,346	4,823
98	4,851	6,138	8,599	1,609	6,420	4,886
99	4,911	6,209	8,699	1,625	6,497	4,950

The above rates do not include the $20 application fee.

To calculate a household discount:

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

Modal premium **x** .95 **= discounted premium**

If applying during Open Enrollment or Guaranteed Issue periods, use preferred rates.

Modal factors

Semi-annual	0.5200
Quarterly	0.2650
Monthly	0.0833

Continental Life Insurance Company of Brentwood, Tennessee

Annual premiums

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

Rates effective 9/1/2023

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	3,811	4,818	6,750	n/a	5,043	3,811
65	2,001	2,532	3,549	663	2,650	1,901
66	2,080	2,630	3,684	690	2,754	1,980
67	2,161	2,733	3,829	716	2,861	2,060
68	2,246	2,840	3,979	743	2,972	2,146
69	2,334	2,951	4,136	775	3,089	2,231
70	2,424	3,065	4,294	805	3,207	2,322
71	2,517	3,188	4,466	833	3,333	2,421
72	2,620	3,313	4,638	868	3,464	2,526
73	2,720	3,443	4,823	900	3,602	2,636
74	2,829	3,581	5,015	937	3,743	2,751
75	2,946	3,724	5,212	975	3,894	2,865
76	3,026	3,826	5,360	1,003	4,004	2,958
77	3,111	3,934	5,512	1,031	4,118	3,056
78	3,199	4,049	5,670	1,060	4,234	3,155
79	3,291	4,162	5,829	1,090	4,351	3,253
80	3,384	4,276	5,992	1,122	4,473	3,358
81	3,423	4,328	6,065	1,135	4,529	3,400
82	3,466	4,383	6,139	1,150	4,582	3,444
83	3,506	4,432	6,210	1,159	4,638	3,489
84	3,549	4,488	6,288	1,174	4,693	3,535
85	3,588	4,540	6,359	1,190	4,751	3,579
86	3,633	4,598	6,434	1,204	4,808	3,626
87	3,676	4,648	6,512	1,218	4,864	3,673
88	3,721	4,707	6,591	1,233	4,923	3,717
89	3,764	4,762	6,671	1,248	4,980	3,767
90	3,811	4,818	6,750	1,260	5,043	3,811
91	3,855	4,878	6,830	1,278	5,102	3,861
92	3,904	4,936	6,914	1,293	5,162	3,911
93	3,949	4,994	6,995	1,308	5,224	3,958
94	3,996	5,053	7,082	1,326	5,290	4,012
95	4,046	5,115	7,167	1,340	5,350	4,063
96	4,094	5,177	7,250	1,358	5,417	4,117
97	4,143	5,238	7,341	1,372	5,484	4,168
98	4,193	5,301	7,427	1,390	5,548	4,221
99	4,242	5,364	7,516	1,405	5,612	4,273

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	4,228	5,346	7,489	n/a	5,595	4,232
65	2,224	2,809	3,936	736	2,939	2,110
66	2,313	2,920	4,088	764	3,054	2,198
67	2,400	3,035	4,251	794	3,175	2,289
68	2,492	3,151	4,418	827	3,297	2,382
69	2,590	3,274	4,585	858	3,427	2,479
70	2,692	3,405	4,763	893	3,560	2,578
71	2,799	3,538	4,955	927	3,701	2,689
72	2,907	3,677	5,150	963	3,846	2,807
73	3,022	3,824	5,354	1,000	4,000	2,925
74	3,143	3,973	5,561	1,041	4,154	3,055
75	3,265	4,128	5,784	1,082	4,321	3,182
76	3,359	4,248	5,952	1,112	4,446	3,281
77	3,454	4,366	6,118	1,144	4,571	3,393
78	3,552	4,492	6,292	1,176	4,696	3,501
79	3,653	4,619	6,470	1,211	4,830	3,609
80	3,755	4,748	6,650	1,245	4,968	3,728
81	3,801	4,805	6,731	1,259	5,026	3,773
82	3,846	4,866	6,813	1,276	5,090	3,826
83	3,889	4,922	6,895	1,287	5,148	3,870
84	3,936	4,978	6,974	1,303	5,210	3,923
85	3,985	5,040	7,059	1,322	5,271	3,974
86	4,032	5,104	7,144	1,335	5,338	4,025
87	4,080	5,161	7,228	1,353	5,400	4,074
88	4,128	5,224	7,317	1,369	5,465	4,128
89	4,179	5,287	7,403	1,384	5,529	4,179
90	4,228	5,346	7,489	1,400	5,595	4,232
91	4,279	5,410	7,580	1,418	5,664	4,289
92	4,330	5,478	7,669	1,433	5,733	4,342
93	4,384	5,543	7,764	1,452	5,796	4,396
94	4,435	5,608	7,859	1,472	5,868	4,453
95	4,490	5,678	7,958	1,488	5,940	4,510
96	4,541	5,746	8,050	1,506	6,014	4,572
97	4,600	5,818	8,148	1,525	6,086	4,625
98	4,652	5,886	8,246	1,543	6,157	4,686
99	4,709	5,954	8,342	1,558	6,230	4,747

The above rates do not include the $20 application fee.

To calculate a household discount:

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

Modal premium **x** .95 **= discounted premium**

If applying during Open Enrollment or Guaranteed Issue periods, use preferred rates.

Modal factors

Semi-annual	0.5200
Quarterly	0.2650
Monthly	0.0833

Continental Life Insurance Company of Brentwood, Tennessee

Annual premiums

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

Rates effective 9/1/2023

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	3,583	4,530	6,346	n/a	4,741	3,583
65	1,881	2,380	3,336	624	2,492	1,788
66	1,956	2,473	3,464	649	2,589	1,861
67	2,032	2,570	3,600	673	2,690	1,937
68	2,112	2,670	3,741	699	2,794	2,017
69	2,195	2,774	3,889	728	2,904	2,098
70	2,279	2,882	4,037	757	3,015	2,184
71	2,366	2,998	4,199	783	3,134	2,276
72	2,463	3,115	4,360	816	3,257	2,375
73	2,558	3,237	4,534	846	3,387	2,478
74	2,660	3,367	4,715	881	3,519	2,586
75	2,770	3,501	4,901	916	3,661	2,694
76	2,845	3,597	5,039	943	3,764	2,781
77	2,925	3,698	5,182	969	3,872	2,873
78	3,007	3,807	5,331	997	3,981	2,967
79	3,094	3,913	5,480	1,025	4,091	3,058
80	3,181	4,021	5,633	1,055	4,205	3,157
81	3,219	4,069	5,702	1,067	4,258	3,197
82	3,258	4,121	5,772	1,081	4,308	3,238
83	3,297	4,167	5,839	1,090	4,360	3,280
84	3,336	4,220	5,911	1,103	4,412	3,323
85	3,374	4,268	5,979	1,119	4,467	3,365
86	3,416	4,323	6,049	1,132	4,520	3,409
87	3,456	4,370	6,123	1,145	4,573	3,453
88	3,498	4,425	6,196	1,159	4,629	3,495
89	3,539	4,477	6,272	1,174	4,682	3,542
90	3,583	4,530	6,346	1,185	4,741	3,583
91	3,625	4,586	6,422	1,201	4,797	3,630
92	3,671	4,641	6,500	1,216	4,853	3,677
93	3,713	4,695	6,577	1,230	4,912	3,721
94	3,757	4,751	6,658	1,246	4,973	3,772
95	3,804	4,809	6,739	1,260	5,030	3,820
96	3,849	4,868	6,817	1,277	5,093	3,871
97	3,895	4,925	6,901	1,290	5,156	3,918
98	3,942	4,984	6,983	1,307	5,216	3,969
99	3,989	5,044	7,066	1,321	5,277	4,017

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	3,975	5,026	7,041	n/a	5,260	3,979
65	2,091	2,641	3,700	692	2,763	1,983
66	2,175	2,746	3,843	718	2,871	2,067
67	2,256	2,853	3,996	747	2,985	2,152
68	2,343	2,962	4,154	778	3,100	2,240
69	2,435	3,078	4,311	806	3,222	2,331
70	2,531	3,201	4,478	839	3,347	2,423
71	2,631	3,326	4,659	871	3,479	2,528
72	2,734	3,457	4,842	905	3,616	2,639
73	2,841	3,595	5,034	941	3,761	2,750
74	2,955	3,736	5,228	979	3,905	2,872
75	3,070	3,881	5,438	1,018	4,062	2,992
76	3,158	3,994	5,596	1,045	4,180	3,084
77	3,247	4,105	5,752	1,076	4,298	3,190
78	3,340	4,223	5,916	1,106	4,415	3,291
79	3,434	4,343	6,083	1,139	4,541	3,394
80	3,530	4,464	6,252	1,170	4,671	3,505
81	3,574	4,518	6,328	1,184	4,726	3,548
82	3,616	4,575	6,405	1,200	4,785	3,597
83	3,656	4,628	6,482	1,210	4,840	3,639
84	3,700	4,681	6,557	1,225	4,898	3,688
85	3,747	4,739	6,636	1,243	4,956	3,737
86	3,791	4,798	6,717	1,255	5,018	3,784
87	3,836	4,852	6,796	1,272	5,077	3,830
88	3,881	4,912	6,879	1,287	5,138	3,881
89	3,929	4,971	6,960	1,301	5,199	3,929
90	3,975	5,026	7,041	1,317	5,260	3,979
91	4,023	5,086	7,127	1,333	5,325	4,033
92	4,071	5,150	7,211	1,348	5,390	4,082
93	4,122	5,212	7,300	1,365	5,449	4,133
94	4,170	5,272	7,389	1,384	5,517	4,187
95	4,222	5,338	7,482	1,399	5,585	4,241
96	4,269	5,402	7,568	1,416	5,654	4,299
97	4,325	5,470	7,660	1,433	5,722	4,348
98	4,374	5,534	7,753	1,451	5,788	4,406
99	4,428	5,598	7,843	1,465	5,858	4,463

The above rates do not include the $20 application fee.

To calculate a household discount:

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

Modal premium **x** .95 **= discounted premium**

If applying during Open Enrollment or Guaranteed Issue periods, use preferred rates.

Modal factors

Semi-annual	0.5200
Quarterly	0.2650
Monthly	0.0833

Continental Life Insurance Company of Brentwood, Tennessee

Annual premiums

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

Rates effective 9/1/2023

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	3,257	4,118	5,769	n/a	4,310	3,257
65	1,710	2,164	3,033	567	2,265	1,625
66	1,778	2,248	3,149	590	2,354	1,692
67	1,847	2,336	3,273	612	2,445	1,761
68	1,920	2,427	3,401	635	2,540	1,834
69	1,995	2,522	3,535	662	2,640	1,907
70	2,072	2,620	3,670	688	2,741	1,985
71	2,151	2,725	3,817	712	2,849	2,069
72	2,239	2,832	3,964	742	2,961	2,159
73	2,325	2,943	4,122	769	3,079	2,253
74	2,418	3,061	4,286	801	3,199	2,351
75	2,518	3,183	4,455	833	3,328	2,449
76	2,586	3,270	4,581	857	3,422	2,528
77	2,659	3,362	4,711	881	3,520	2,612
78	2,734	3,461	4,846	906	3,619	2,697
79	2,813	3,557	4,982	932	3,719	2,780
80	2,892	3,655	5,121	959	3,823	2,870
81	2,926	3,699	5,184	970	3,871	2,906
82	2,962	3,746	5,247	983	3,916	2,944
83	2,997	3,788	5,308	991	3,964	2,982
84	3,033	3,836	5,374	1,003	4,011	3,021
85	3,067	3,880	5,435	1,017	4,061	3,059
86	3,105	3,930	5,499	1,029	4,109	3,099
87	3,142	3,973	5,566	1,041	4,157	3,139
88	3,180	4,023	5,633	1,054	4,208	3,177
89	3,217	4,070	5,702	1,067	4,256	3,220
90	3,257	4,118	5,769	1,077	4,310	3,257
91	3,295	4,169	5,838	1,092	4,361	3,300
92	3,337	4,219	5,909	1,105	4,412	3,343
93	3,375	4,268	5,979	1,118	4,465	3,383
94	3,415	4,319	6,053	1,133	4,521	3,429
95	3,458	4,372	6,126	1,145	4,573	3,473
96	3,499	4,425	6,197	1,161	4,630	3,519
97	3,541	4,477	6,274	1,173	4,687	3,562
98	3,584	4,531	6,348	1,188	4,742	3,608
99	3,626	4,585	6,424	1,201	4,797	3,652

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	3,614	4,569	6,401	n/a	4,782	3,617
65	1,901	2,401	3,364	629	2,512	1,803
66	1,977	2,496	3,494	653	2,610	1,879
67	2,051	2,594	3,633	679	2,714	1,956
68	2,130	2,693	3,776	707	2,818	2,036
69	2,214	2,798	3,919	733	2,929	2,119
70	2,301	2,910	4,071	763	3,043	2,203
71	2,392	3,024	4,235	792	3,163	2,298
72	2,485	3,143	4,402	823	3,287	2,399
73	2,583	3,268	4,576	855	3,419	2,500
74	2,686	3,396	4,753	890	3,550	2,611
75	2,791	3,528	4,944	925	3,693	2,720
76	2,871	3,631	5,087	950	3,800	2,804
77	2,952	3,732	5,229	978	3,907	2,900
78	3,036	3,839	5,378	1,005	4,014	2,992
79	3,122	3,948	5,530	1,035	4,128	3,085
80	3,209	4,058	5,684	1,064	4,246	3,186
81	3,249	4,107	5,753	1,076	4,296	3,225
82	3,287	4,159	5,823	1,091	4,350	3,270
83	3,324	4,207	5,893	1,100	4,400	3,308
84	3,364	4,255	5,961	1,114	4,453	3,353
85	3,406	4,308	6,033	1,130	4,505	3,397
86	3,446	4,362	6,106	1,141	4,562	3,440
87	3,487	4,411	6,178	1,156	4,615	3,482
88	3,528	4,465	6,254	1,170	4,671	3,528
89	3,572	4,519	6,327	1,183	4,726	3,572
90	3,614	4,569	6,401	1,197	4,782	3,617
91	3,657	4,624	6,479	1,212	4,841	3,666
92	3,701	4,682	6,555	1,225	4,900	3,711
93	3,747	4,738	6,636	1,241	4,954	3,757
94	3,791	4,793	6,717	1,258	5,015	3,806
95	3,838	4,853	6,802	1,272	5,077	3,855
96	3,881	4,911	6,880	1,287	5,140	3,908
97	3,932	4,973	6,964	1,303	5,202	3,953
98	3,976	5,031	7,048	1,319	5,262	4,005
99	4,025	5,089	7,130	1,332	5,325	4,057

The above rates do not include the $20 application fee.

To calculate a household discount:

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

Modal premium **x** .95 **= discounted premium**

If applying during Open Enrollment or Guaranteed Issue periods, use preferred rates.

Modal factors

Semi-annual 0.5200

Quarterly 0.2650

Monthly 0.0833

Continental Life Insurance Company of Brentwood, Tennessee

Annual premiums

For Use in ZIP Codes: Rest of State

Rates effective 9/1/2023

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	3,094	3,912	5,481	n/a	4,095	3,094
65	1,625	2,056	2,881	539	2,152	1,544
66	1,689	2,136	2,992	561	2,236	1,607
67	1,755	2,219	3,109	581	2,323	1,673
68	1,824	2,306	3,231	603	2,413	1,742
69	1,895	2,396	3,358	629	2,508	1,812
70	1,968	2,489	3,487	654	2,604	1,886
71	2,043	2,589	3,626	676	2,707	1,966
72	2,127	2,690	3,766	705	2,813	2,051
73	2,209	2,796	3,916	731	2,925	2,140
74	2,297	2,908	4,072	761	3,039	2,233
75	2,392	3,024	4,232	791	3,162	2,327
76	2,457	3,107	4,352	814	3,251	2,402
77	2,526	3,194	4,475	837	3,344	2,481
78	2,597	3,288	4,604	861	3,438	2,562
79	2,672	3,379	4,733	885	3,533	2,641
80	2,747	3,472	4,865	911	3,632	2,727
81	2,780	3,514	4,925	922	3,677	2,761
82	2,814	3,559	4,985	934	3,720	2,797
83	2,847	3,599	5,043	941	3,766	2,833
84	2,881	3,644	5,105	953	3,810	2,870
85	2,914	3,686	5,163	966	3,858	2,906
86	2,950	3,734	5,224	978	3,904	2,944
87	2,985	3,774	5,288	989	3,949	2,982
88	3,021	3,822	5,351	1,001	3,998	3,018
89	3,056	3,867	5,417	1,014	4,043	3,059
90	3,094	3,912	5,481	1,023	4,095	3,094
91	3,130	3,961	5,546	1,037	4,143	3,135
92	3,170	4,008	5,614	1,050	4,191	3,176
93	3,206	4,055	5,680	1,062	4,242	3,214
94	3,244	4,103	5,750	1,076	4,295	3,258
95	3,285	4,153	5,820	1,088	4,344	3,299
96	3,324	4,204	5,887	1,103	4,399	3,343
97	3,364	4,253	5,960	1,114	4,453	3,384
98	3,405	4,304	6,031	1,129	4,505	3,428
99	3,445	4,356	6,103	1,141	4,557	3,469

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	3,433	4,341	6,081	n/a	4,543	3,436
65	1,806	2,281	3,196	598	2,386	1,713
66	1,878	2,371	3,319	620	2,480	1,785
67	1,948	2,464	3,451	645	2,578	1,858
68	2,024	2,558	3,587	672	2,677	1,934
69	2,103	2,658	3,723	696	2,783	2,013
70	2,186	2,765	3,867	725	2,891	2,093
71	2,272	2,873	4,023	752	3,005	2,183
72	2,361	2,986	4,182	782	3,123	2,279
73	2,454	3,105	4,347	812	3,248	2,375
74	2,552	3,226	4,515	846	3,373	2,480
75	2,651	3,352	4,697	879	3,508	2,584
76	2,727	3,449	4,833	903	3,610	2,664
77	2,804	3,545	4,968	929	3,712	2,755
78	2,884	3,647	5,109	955	3,813	2,842
79	2,966	3,751	5,254	983	3,922	2,931
80	3,049	3,855	5,400	1,011	4,034	3,027
81	3,087	3,902	5,465	1,022	4,081	3,064
82	3,123	3,951	5,532	1,036	4,133	3,107
83	3,158	3,997	5,598	1,045	4,180	3,143
84	3,196	4,042	5,663	1,058	4,230	3,185
85	3,236	4,093	5,731	1,074	4,280	3,227
86	3,274	4,144	5,801	1,084	4,334	3,268
87	3,313	4,190	5,869	1,098	4,384	3,308
88	3,352	4,242	5,941	1,112	4,437	3,352
89	3,393	4,293	6,011	1,124	4,490	3,393
90	3,433	4,341	6,081	1,137	4,543	3,436
91	3,474	4,393	6,155	1,151	4,599	3,483
92	3,516	4,448	6,227	1,164	4,655	3,525
93	3,560	4,501	6,304	1,179	4,706	3,569
94	3,601	4,553	6,381	1,195	4,764	3,616
95	3,646	4,610	6,462	1,208	4,823	3,662
96	3,687	4,665	6,536	1,223	4,883	3,713
97	3,735	4,724	6,616	1,238	4,942	3,755
98	3,777	4,779	6,696	1,253	4,999	3,805
99	3,824	4,835	6,774	1,265	5,059	3,854

The above rates do not include the $20 application fee.

To calculate a household discount:

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

Modal premium **x** .95 **= discounted premium**

If applying during Open Enrollment or Guaranteed Issue periods, use preferred rates.

Modal factors

Semi-annual 0.5200

Quarterly 0.2650

Monthly 0.0833

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.

Premiums payable other than annually 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 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 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) – 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 $1,632	$0	$1,632 (Part A Deductible)
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after While using 60 lifetime reserve days	All but $816 a day	$816 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 $204 a day	$0	Up to $204 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 $240 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 $240 of Medicare-Approved amounts*	$0	$0	$240 (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 $240 of Medicare-Approved amounts*	$0	$0	$240 (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 $240 of Medicare-Approved amounts*	$0	$0	$240 (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 $1,632	$1,632 (Part A Deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after While using 60 lifetime reserve days	All but $816 a day	$816 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 $204 a day	$0	Up to $204 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 B

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

*Once you have been billed $240 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 $240 of Medicare-Approved amounts*	$0	$0	$240 (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 $240 of Medicare-Approved amounts*	$0	$0	$240 (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 $240 of Medicare-Approved amounts*	$0	$0	$240 (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 $1,632	$1,632 (Part A Deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after While using 60 lifetime reserve days	All but $816 a day	$816 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 $204 a day	Up to $204 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 an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN F

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

*Once you have been billed $240 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 $240 of Medicare-Approved amounts*	$0	$240 (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 $240 of Medicare-Approved amounts*	$0	$240 (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 $240 of Medicare-Approved amounts*	$0	$240 (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 $2,800 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses are $2,800. 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 $2,800 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2,800 DEDUCTIBLE*** YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,632	$1,632 (Part A Deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after While using 60 lifetime reserve days	All but $816 a day	$816 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 $204 a day	Up to $204 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 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.

HIGH DEDUCTIBLE PLAN F

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

*Once you have been billed $240 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 $2,800 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses are $2,800. 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 $2,800 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2,800 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 $240 of Medicare-Approved amounts*	$0	$240 (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 $240 of Medicare-Approved amounts*	$0	$240 (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 $2,800 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2,800 DEDUCTIBLE** YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
First $240 of Medicare-Approved amounts*	$0	$240 (Part B Deductible)	$0
Remainder of Medicare-Approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,800 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2,800 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 $1,632	$1,632 (Part A Deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after While using 60 lifetime reserve days	All but $816 a day	$816 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 $204 a day	Up to $204 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 an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN G

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

*Once you have been billed $240 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 $240 of Medicare-Approved amounts*	$0	$0	$240 (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 $240 of Medicare-Approved amounts*	$0	$0	$240 (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 $240 of Medicare-Approved amounts*	$0	$0	$240 (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 $1,632	$1,632 (Part A Deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after While using 60 lifetime reserve days	All but $816 a day	$816 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 $204 a day	Up to $204 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 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 N

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

*Once you have been billed $240 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 $240 of Medicare-Approved amounts*	$0	$0	$240 (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 $240 of Medicare-Approved amounts*	$0	$0	$240 (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 $240 of Medicare-Approved amounts*	$0	$0	$240 (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