Outline of coverage

Medicare Supplement Insurance

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

Nevada

Underwritten by

Continental Life Insurance Company of Brentwood, Tennessee

An Aetna Company

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Rates effective: 03/2024 A

CONTINENTAL LIFE INSURANCE COMPANY OF BRENTWOOD, TENNESSEE
OUTLINE OF MEDICARE SUPPLEMENT COVERAGE COVER PAGE
BENEFIT PLANS AVAILABLE: A, B, F, G, HIGH DEDUCTIBLE G, N

This chart shows the benefits included in each of the standard Medicare supplement plans. 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: 889-891
Female rates

Rates effective 3/1/2024

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
65	1,826	1,935	2,331	1,861	646	1,403
66	1,826	1,935	2,331	1,861	646	1,403
67	1,826	1,935	2,331	1,861	646	1,403
68	1,845	1,955	2,354	1,881	653	1,453
69	1,886	1,999	2,408	1,923	667	1,513
70	1,938	2,054	2,473	1,975	685	1,571
71	1,996	2,115	2,547	2,036	706	1,625
72	2,056	2,182	2,627	2,097	728	1,682
73	2,124	2,252	2,712	2,166	753	1,737
74	2,199	2,332	2,807	2,242	778	1,797
75	2,276	2,412	2,905	2,320	806	1,854
76	2,354	2,497	3,007	2,403	834	1,914
77	2,436	2,584	3,113	2,486	863	1,976
78	2,522	2,672	3,217	2,573	892	2,043
79	2,601	2,756	3,320	2,651	920	2,109
80	2,681	2,843	3,423	2,735	949	2,181
81	2,767	2,932	3,531	2,822	980	2,250
82	2,848	3,020	3,635	2,905	1,008	2,316
83	2,938	3,113	3,749	2,994	1,039	2,386
84	3,022	3,204	3,859	3,083	1,070	2,457
85	3,130	3,321	3,999	3,194	1,108	2,546
86	3,221	3,414	4,112	3,285	1,139	2,619
87	3,311	3,511	4,228	3,379	1,173	2,692
88	3,404	3,609	4,347	3,474	1,205	2,768
89	3,498	3,711	4,468	3,570	1,239	2,846
90	3,596	3,811	4,590	3,668	1,272	2,922
91	3,693	3,916	4,716	3,768	1,307	3,003
92	3,794	4,021	4,844	3,869	1,342	3,084
93	3,894	4,130	4,972	3,972	1,378	3,165
94	3,999	4,238	5,103	4,079	1,415	3,249
95	4,100	4,348	5,237	4,184	1,452	3,335
96	4,208	4,461	5,372	4,292	1,489	3,419
97	4,316	4,576	5,509	4,402	1,527	3,508
98	4,423	4,692	5,648	4,513	1,566	3,596
99+	4,534	4,809	5,789	4,627	1,605	3,687

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
65	2,027	2,149	2,589	2,069	718	1,560
66	2,027	2,149	2,589	2,069	718	1,560
67	2,027	2,149	2,589	2,069	718	1,560
68	2,050	2,172	2,617	2,091	727	1,615
69	2,095	2,222	2,676	2,139	742	1,682
70	2,152	2,283	2,748	2,196	761	1,745
71	2,214	2,351	2,830	2,262	785	1,807
72	2,285	2,424	2,919	2,332	809	1,868
73	2,359	2,502	3,013	2,406	836	1,930
74	2,444	2,591	3,118	2,490	864	1,997
75	2,527	2,681	3,229	2,578	894	2,061
76	2,617	2,775	3,340	2,670	927	2,128
77	2,709	2,872	3,460	2,763	958	2,197
78	2,800	2,969	3,575	2,857	991	2,270
79	2,889	3,063	3,687	2,946	1,023	2,345
80	2,978	3,160	3,803	3,038	1,055	2,421
81	3,073	3,258	3,924	3,135	1,088	2,499
82	3,163	3,356	4,039	3,228	1,120	2,573
83	3,262	3,460	4,167	3,326	1,155	2,651
84	3,357	3,561	4,287	3,426	1,189	2,730
85	3,479	3,689	4,440	3,548	1,231	2,829
86	3,578	3,794	4,567	3,651	1,267	2,910
87	3,681	3,902	4,698	3,754	1,304	2,992
88	3,783	4,011	4,831	3,860	1,339	3,076
89	3,889	4,123	4,963	3,967	1,376	3,161
90	3,998	4,237	5,101	4,074	1,414	3,248
91	4,103	4,351	5,240	4,186	1,452	3,336
92	4,215	4,468	5,384	4,298	1,491	3,428
93	4,326	4,589	5,524	4,413	1,531	3,518
94	4,440	4,709	5,671	4,531	1,572	3,610
95	4,557	4,832	5,819	4,650	1,612	3,705
96	4,674	4,957	5,969	4,769	1,656	3,801
97	4,793	5,086	6,121	4,891	1,697	3,898
98	4,915	5,213	6,276	5,014	1,740	3,995
99+	5,038	5,344	6,434	5,139	1,782	4,096

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

To calculate the 7% 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 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: 889-891
Male rates

Rates effective 3/1/2024

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
65	2,097	2,224	2,681	2,142	743	1,614
66	2,097	2,224	2,681	2,142	743	1,614
67	2,097	2,224	2,681	2,142	743	1,614
68	2,120	2,250	2,708	2,163	751	1,671
69	2,169	2,299	2,769	2,212	768	1,739
70	2,227	2,362	2,844	2,272	787	1,807
71	2,293	2,432	2,929	2,339	812	1,871
72	2,365	2,509	3,020	2,414	837	1,934
73	2,444	2,591	3,120	2,493	865	1,998
74	2,527	2,681	3,227	2,578	894	2,066
75	2,617	2,775	3,340	2,670	927	2,132
76	2,708	2,872	3,458	2,764	958	2,200
77	2,803	2,973	3,579	2,861	993	2,273
78	2,899	3,074	3,701	2,957	1,026	2,350
79	2,991	3,169	3,818	3,050	1,058	2,425
80	3,083	3,270	3,937	3,145	1,091	2,508
81	3,181	3,373	4,062	3,244	1,126	2,588
82	3,275	3,473	4,180	3,340	1,159	2,663
83	3,375	3,580	4,311	3,444	1,194	2,745
84	3,477	3,685	4,437	3,546	1,230	2,825
85	3,601	3,818	4,599	3,673	1,273	2,928
86	3,704	3,927	4,729	3,779	1,310	3,010
87	3,809	4,038	4,863	3,885	1,348	3,096
88	3,914	4,152	5,000	3,995	1,387	3,182
89	4,024	4,267	5,139	4,105	1,425	3,272
90	4,135	4,385	5,279	4,217	1,463	3,362
91	4,248	4,504	5,424	4,333	1,503	3,453
92	4,361	4,625	5,570	4,450	1,543	3,547
93	4,478	4,749	5,718	4,567	1,585	3,641
94	4,599	4,874	5,870	4,690	1,626	3,738
95	4,716	5,001	6,022	4,811	1,670	3,834
96	4,838	5,130	6,177	4,937	1,713	3,934
97	4,960	5,262	6,335	5,063	1,756	4,034
98	5,087	5,394	6,496	5,190	1,801	4,135
99+	5,216	5,531	6,657	5,320	1,845	4,240

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
65	2,331	2,472	2,978	2,380	826	1,793
66	2,331	2,472	2,978	2,380	826	1,793
67	2,331	2,472	2,978	2,380	826	1,793
68	2,355	2,498	3,008	2,403	836	1,857
69	2,411	2,553	3,077	2,459	853	1,934
70	2,475	2,625	3,160	2,525	876	2,007
71	2,547	2,703	3,255	2,602	903	2,078
72	2,628	2,786	3,357	2,682	930	2,147
73	2,715	2,878	3,465	2,768	962	2,220
74	2,809	2,979	3,586	2,864	994	2,296
75	2,906	3,082	3,713	2,967	1,029	2,368
76	3,008	3,190	3,842	3,070	1,065	2,445
77	3,116	3,304	3,978	3,177	1,102	2,526
78	3,221	3,414	4,112	3,285	1,139	2,610
79	3,323	3,522	4,241	3,388	1,176	2,696
80	3,426	3,634	4,373	3,495	1,213	2,785
81	3,534	3,747	4,511	3,605	1,252	2,874
82	3,637	3,859	4,645	3,713	1,287	2,957
83	3,753	3,978	4,789	3,826	1,328	3,050
84	3,860	4,093	4,930	3,938	1,368	3,140
85	4,001	4,242	5,108	4,081	1,416	3,254
86	4,116	4,364	5,254	4,199	1,456	3,347
87	4,233	4,487	5,403	4,318	1,499	3,440
88	4,352	4,612	5,557	4,439	1,541	3,537
89	4,471	4,743	5,710	4,562	1,582	3,635
90	4,596	4,873	5,865	4,686	1,625	3,737
91	4,719	5,005	6,025	4,814	1,670	3,838
92	4,849	5,139	6,188	4,944	1,715	3,941
93	4,976	5,277	6,355	5,075	1,761	4,046
94	5,108	5,416	6,522	5,211	1,808	4,154
95	5,240	5,558	6,693	5,347	1,855	4,262
96	5,374	5,701	6,864	5,484	1,904	4,371
97	5,512	5,847	7,039	5,625	1,950	4,483
98	5,653	5,993	7,218	5,767	2,001	4,595
99+	5,795	6,145	7,396	5,910	2,050	4,709

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

To calculate the 7% 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 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: Rest of State
Female rates

Rates effective 3/1/2024

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
65	1,691	1,792	2,158	1,723	598	1,299
66	1,691	1,792	2,158	1,723	598	1,299
67	1,691	1,792	2,158	1,723	598	1,299
68	1,708	1,810	2,180	1,742	605	1,345
69	1,746	1,851	2,230	1,781	618	1,401
70	1,794	1,902	2,290	1,829	634	1,455
71	1,848	1,958	2,358	1,885	654	1,505
72	1,904	2,020	2,432	1,942	674	1,557
73	1,967	2,085	2,511	2,006	697	1,608
74	2,036	2,159	2,599	2,076	720	1,664
75	2,107	2,233	2,690	2,148	746	1,717
76	2,180	2,312	2,784	2,225	772	1,772
77	2,256	2,393	2,882	2,302	799	1,830
78	2,335	2,474	2,979	2,382	826	1,892
79	2,408	2,552	3,074	2,455	852	1,953
80	2,482	2,632	3,169	2,532	879	2,019
81	2,562	2,715	3,269	2,613	907	2,083
82	2,637	2,796	3,366	2,690	933	2,144
83	2,720	2,882	3,471	2,772	962	2,209
84	2,798	2,967	3,573	2,855	991	2,275
85	2,898	3,075	3,703	2,957	1,026	2,357
86	2,982	3,161	3,807	3,042	1,055	2,425
87	3,066	3,251	3,915	3,129	1,086	2,493
88	3,152	3,342	4,025	3,217	1,116	2,563
89	3,239	3,436	4,137	3,306	1,147	2,635
90	3,330	3,529	4,250	3,396	1,178	2,706
91	3,419	3,626	4,367	3,489	1,210	2,781
92	3,513	3,723	4,485	3,582	1,243	2,856
93	3,606	3,824	4,604	3,678	1,276	2,931
94	3,703	3,924	4,725	3,777	1,310	3,008
95	3,796	4,026	4,849	3,874	1,344	3,088
96	3,896	4,131	4,974	3,974	1,379	3,166
97	3,996	4,237	5,101	4,076	1,414	3,248
98	4,095	4,344	5,230	4,179	1,450	3,330
99+	4,198	4,453	5,360	4,284	1,486	3,414

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
65	1,877	1,990	2,397	1,916	665	1,444
66	1,877	1,990	2,397	1,916	665	1,444
67	1,877	1,990	2,397	1,916	665	1,444
68	1,898	2,011	2,423	1,936	673	1,495
69	1,940	2,057	2,478	1,981	687	1,557
70	1,993	2,114	2,544	2,033	705	1,616
71	2,050	2,177	2,620	2,094	727	1,673
72	2,116	2,244	2,703	2,159	749	1,730
73	2,184	2,317	2,790	2,228	774	1,787
74	2,263	2,399	2,887	2,306	800	1,849
75	2,340	2,482	2,990	2,387	828	1,908
76	2,423	2,569	3,093	2,472	858	1,970
77	2,508	2,659	3,204	2,558	887	2,034
78	2,593	2,749	3,310	2,645	918	2,102
79	2,675	2,836	3,414	2,728	947	2,171
80	2,757	2,926	3,521	2,813	977	2,242
81	2,845	3,017	3,633	2,903	1,007	2,314
82	2,929	3,107	3,740	2,989	1,037	2,382
83	3,020	3,204	3,858	3,080	1,069	2,455
84	3,108	3,297	3,969	3,172	1,101	2,528
85	3,221	3,416	4,111	3,285	1,140	2,619
86	3,313	3,513	4,229	3,381	1,173	2,694
87	3,408	3,613	4,350	3,476	1,207	2,770
88	3,503	3,714	4,473	3,574	1,240	2,848
89	3,601	3,818	4,595	3,673	1,274	2,927
90	3,702	3,923	4,723	3,772	1,309	3,007
91	3,799	4,029	4,852	3,876	1,344	3,089
92	3,903	4,137	4,985	3,980	1,381	3,174
93	4,006	4,249	5,115	4,086	1,418	3,257
94	4,111	4,360	5,251	4,195	1,456	3,343
95	4,219	4,474	5,388	4,306	1,493	3,431
96	4,328	4,590	5,527	4,416	1,533	3,519
97	4,438	4,709	5,668	4,529	1,571	3,609
98	4,551	4,827	5,811	4,643	1,611	3,699
99+	4,665	4,948	5,957	4,758	1,650	3,793

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

To calculate the 7% 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 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: Rest of State

Male rates

Rates effective 3/1/2024

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
65	1,942	2,059	2,482	1,983	688	1,494
66	1,942	2,059	2,482	1,983	688	1,494
67	1,942	2,059	2,482	1,983	688	1,494
68	1,963	2,083	2,507	2,003	695	1,547
69	2,008	2,129	2,564	2,048	711	1,610
70	2,062	2,187	2,633	2,104	729	1,673
71	2,123	2,252	2,712	2,166	752	1,732
72	2,190	2,323	2,796	2,235	775	1,791
73	2,263	2,399	2,889	2,308	801	1,850
74	2,340	2,482	2,988	2,387	828	1,913
75	2,423	2,569	3,093	2,472	858	1,974
76	2,507	2,659	3,202	2,559	887	2,037
77	2,595	2,753	3,314	2,649	919	2,105
78	2,684	2,846	3,427	2,738	950	2,176
79	2,769	2,934	3,535	2,824	980	2,245
80	2,855	3,028	3,645	2,912	1,010	2,322
81	2,945	3,123	3,761	3,004	1,043	2,396
82	3,032	3,216	3,870	3,093	1,073	2,466
83	3,125	3,315	3,992	3,189	1,106	2,542
84	3,219	3,412	4,108	3,283	1,139	2,616
85	3,334	3,535	4,258	3,401	1,179	2,711
86	3,430	3,636	4,379	3,499	1,213	2,787
87	3,527	3,739	4,503	3,597	1,248	2,867
88	3,624	3,844	4,630	3,699	1,284	2,946
89	3,726	3,951	4,758	3,801	1,319	3,030
90	3,829	4,060	4,888	3,905	1,355	3,113
91	3,933	4,170	5,022	4,012	1,392	3,197
92	4,038	4,282	5,157	4,120	1,429	3,284
93	4,146	4,397	5,294	4,229	1,468	3,371
94	4,258	4,513	5,435	4,343	1,506	3,461
95	4,367	4,631	5,576	4,455	1,546	3,550
96	4,480	4,750	5,719	4,571	1,586	3,643
97	4,593	4,872	5,866	4,688	1,626	3,735
98	4,710	4,994	6,015	4,806	1,668	3,829
99+	4,830	5,121	6,164	4,926	1,708	3,926

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
65	2,158	2,289	2,757	2,204	765	1,660
66	2,158	2,289	2,757	2,204	765	1,660
67	2,158	2,289	2,757	2,204	765	1,660
68	2,181	2,313	2,785	2,225	774	1,719
69	2,232	2,364	2,849	2,277	790	1,791
70	2,292	2,431	2,926	2,338	811	1,858
71	2,358	2,503	3,014	2,409	836	1,924
72	2,433	2,580	3,108	2,483	861	1,988
73	2,514	2,665	3,208	2,563	891	2,056
74	2,601	2,758	3,320	2,652	920	2,126
75	2,691	2,854	3,438	2,747	953	2,193
76	2,785	2,954	3,557	2,843	986	2,264
77	2,885	3,059	3,683	2,942	1,020	2,339
78	2,982	3,161	3,807	3,042	1,055	2,417
79	3,077	3,261	3,927	3,137	1,089	2,496
80	3,172	3,365	4,049	3,236	1,123	2,579
81	3,272	3,469	4,177	3,338	1,159	2,661
82	3,368	3,573	4,301	3,438	1,192	2,738
83	3,475	3,683	4,434	3,543	1,230	2,824
84	3,574	3,790	4,565	3,646	1,267	2,907
85	3,705	3,928	4,730	3,779	1,311	3,013
86	3,811	4,041	4,865	3,888	1,348	3,099
87	3,919	4,155	5,003	3,998	1,388	3,185
88	4,030	4,270	5,145	4,110	1,427	3,275
89	4,140	4,392	5,287	4,224	1,465	3,366
90	4,256	4,512	5,431	4,339	1,505	3,460
91	4,369	4,634	5,579	4,457	1,546	3,554
92	4,490	4,758	5,730	4,578	1,588	3,649
93	4,607	4,886	5,884	4,699	1,631	3,746
94	4,730	5,015	6,039	4,825	1,674	3,846
95	4,852	5,146	6,197	4,951	1,718	3,946
96	4,976	5,279	6,356	5,078	1,763	4,047
97	5,104	5,414	6,518	5,208	1,806	4,151
98	5,234	5,549	6,683	5,340	1,853	4,255
99+	5,366	5,690	6,848	5,472	1,898	4,360

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

To calculate the 7% 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 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 have a Medicare supplement policy with an Aetna company. The Medicare eligible adult must be either (a) your spouse or someone with whom you are in a civil union partnership; and (b) 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 rates 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, G, HIGH DEDUCTIBLE 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

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

HIGH DEDUCTIBLE 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.

*****This high deductible plan pays the same benefits as Plan G after one has paid a calendar year $2,800 deductible. Benefits from high deductible plan G will not begin until out-of-pocket expenses are $2,800. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the policy. This does 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 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.

*****This high deductible plan pays the same benefits as Plan G after one has paid a calendar year $2,800 deductible. Benefits from high deductible plan G will not begin until out-of-pocket expenses are $2,800. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the policy. This does 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	$0	$240 (Unless Part B Deductible has been met)
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 (Unless Part B Deductible has been met)
Remainder of Medicare-Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

HIGH DEDUCTIBLE PLAN G

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	$0	$240 (Unless Part B Deductible has been met)
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 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