Outline of coverage

Medicare Supplement Insurance

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

Ohio

Underwritten by

Continental Life Insurance Company of Brentwood, Tennessee

An Aetna Company

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CLIMS04882OH

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Rates effective: 04/2024 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: 436 and 440-445
Female rates

Rates effective 4/1/2024

ATTAINED AGE	PREFERRED						ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N		Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
65	1,541	1,817	2,100	1,672	704	1,103	65	1,712	2,019	2,335	1,858	781	1,227
66	1,541	1,817	2,100	1,672	704	1,103	66	1,712	2,019	2,335	1,858	781	1,227
67	1,541	1,817	2,100	1,672	704	1,103	67	1,712	2,019	2,335	1,858	781	1,227
68	1,556	1,837	2,125	1,689	713	1,143	68	1,729	2,041	2,360	1,878	791	1,271
69	1,592	1,880	2,172	1,729	728	1,190	69	1,770	2,089	2,414	1,921	808	1,322
70	1,635	1,928	2,230	1,774	748	1,235	70	1,816	2,143	2,478	1,972	831	1,373
71	1,683	1,987	2,297	1,827	768	1,279	71	1,870	2,207	2,553	2,030	855	1,421
72	1,737	2,049	2,368	1,885	794	1,323	72	1,928	2,276	2,632	2,095	882	1,470
73	1,792	2,115	2,445	1,946	819	1,368	73	1,991	2,351	2,716	2,162	910	1,518
74	1,855	2,189	2,531	2,014	848	1,414	74	2,060	2,432	2,813	2,237	941	1,571
75	1,920	2,267	2,620	2,085	878	1,460	75	2,133	2,517	2,909	2,315	977	1,622
76	1,988	2,347	2,712	2,157	909	1,506	76	2,208	2,607	3,014	2,398	1,010	1,674
77	2,057	2,429	2,808	2,232	940	1,556	77	2,285	2,698	3,119	2,481	1,045	1,728
78	2,127	2,511	2,903	2,310	972	1,607	78	2,364	2,788	3,226	2,566	1,081	1,786
79	2,193	2,591	2,994	2,380	1,003	1,659	79	2,438	2,876	3,324	2,646	1,116	1,844
80	2,261	2,671	3,088	2,458	1,036	1,715	80	2,514	2,968	3,430	2,729	1,150	1,905
81	2,333	2,755	3,183	2,535	1,067	1,768	81	2,593	3,061	3,540	2,815	1,185	1,965
82	2,403	2,837	3,280	2,610	1,099	1,822	82	2,670	3,151	3,644	2,900	1,221	2,025
83	2,476	2,925	3,380	2,691	1,132	1,878	83	2,753	3,249	3,756	2,988	1,259	2,087
84	2,550	3,010	3,481	2,768	1,167	1,933	84	2,833	3,346	3,866	3,077	1,294	2,147
85	2,641	3,119	3,606	2,869	1,208	2,002	85	2,934	3,467	4,008	3,188	1,343	2,224
86	2,716	3,209	3,709	2,951	1,242	2,059	86	3,019	3,565	4,121	3,280	1,381	2,288
87	2,794	3,298	3,814	3,035	1,278	2,118	87	3,106	3,665	4,237	3,372	1,421	2,353
88	2,873	3,391	3,922	3,119	1,314	2,177	88	3,190	3,768	4,357	3,468	1,461	2,420
89	2,951	3,485	4,030	3,208	1,350	2,238	89	3,280	3,872	4,479	3,563	1,501	2,486
90	3,034	3,580	4,141	3,294	1,388	2,300	90	3,371	3,980	4,600	3,660	1,542	2,555
91	3,117	3,680	4,252	3,384	1,425	2,361	91	3,463	4,088	4,724	3,762	1,584	2,624
92	3,200	3,778	4,369	3,477	1,464	2,425	92	3,558	4,197	4,853	3,862	1,626	2,695
93	3,284	3,881	4,486	3,566	1,504	2,490	93	3,649	4,311	4,983	3,965	1,671	2,766
94	3,372	3,982	4,601	3,662	1,543	2,556	94	3,747	4,424	5,114	4,071	1,715	2,840
95	3,460	4,086	4,722	3,760	1,583	2,623	95	3,845	4,539	5,247	4,176	1,758	2,914
96	3,551	4,190	4,845	3,855	1,624	2,690	96	3,944	4,655	5,382	4,283	1,804	2,988
97	3,641	4,298	4,969	3,954	1,666	2,758	97	4,045	4,775	5,521	4,393	1,850	3,066
98	3,734	4,408	5,096	4,054	1,706	2,828	98	4,148	4,896	5,661	4,503	1,896	3,144
99+	3,827	4,342	5,221	4,156	1,749	2,899	99+	4,251	4,825	5,800	4,616	1,945	3,221

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

To calculate a 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: 436 and 440-445
Male rates

Rates effective 4/1/2024

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
65	1,773	2,091	2,416	1,923	809	1,269
66	1,773	2,091	2,416	1,923	809	1,269
67	1,773	2,091	2,416	1,923	809	1,269
68	1,790	2,112	2,442	1,944	819	1,314
69	1,830	2,162	2,498	1,989	837	1,369
70	1,878	2,218	2,564	2,040	860	1,421
71	1,934	2,284	2,640	2,100	884	1,471
72	1,997	2,355	2,725	2,167	912	1,521
73	2,061	2,432	2,812	2,237	941	1,572
74	2,133	2,517	2,909	2,315	976	1,626
75	2,207	2,607	3,013	2,399	1,010	1,678
76	2,285	2,700	3,119	2,482	1,045	1,732
77	2,365	2,793	3,228	2,567	1,081	1,789
78	2,445	2,887	3,339	2,657	1,119	1,848
79	2,523	2,977	3,442	2,739	1,154	1,909
80	2,600	3,072	3,551	2,825	1,191	1,972
81	2,683	3,168	3,662	2,915	1,227	2,034
82	2,764	3,262	3,772	3,001	1,263	2,095
83	2,848	3,363	3,887	3,094	1,303	2,160
84	2,930	3,461	4,000	3,183	1,342	2,222
85	3,037	3,589	4,146	3,299	1,389	2,303
86	3,124	3,691	4,265	3,393	1,427	2,369
87	3,213	3,794	4,386	3,490	1,469	2,436
88	3,302	3,902	4,509	3,588	1,510	2,503
89	3,395	4,008	4,634	3,689	1,554	2,573
90	3,488	4,118	4,762	3,787	1,596	2,644
91	3,586	4,232	4,892	3,893	1,639	2,716
92	3,681	4,347	5,025	3,997	1,684	2,789
93	3,778	4,461	5,158	4,103	1,729	2,863
94	3,881	4,579	5,292	4,211	1,775	2,939
95	3,979	4,700	5,432	4,321	1,819	3,016
96	4,085	4,819	5,571	4,434	1,867	3,094
97	4,187	4,943	5,714	4,547	1,915	3,172
98	4,292	5,068	5,860	4,661	1,962	3,253
99+	4,399	4,993	6,005	4,777	2,012	3,334

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
65	1,967	2,321	2,685	2,137	899	1,411
66	1,967	2,321	2,685	2,137	899	1,411
67	1,967	2,321	2,685	2,137	899	1,411
68	1,989	2,348	2,713	2,159	910	1,462
69	2,034	2,403	2,774	2,209	929	1,520
70	2,089	2,464	2,849	2,269	956	1,580
71	2,150	2,539	2,936	2,334	982	1,634
72	2,218	2,618	3,027	2,409	1,013	1,691
73	2,290	2,704	3,124	2,486	1,047	1,746
74	2,370	2,797	3,235	2,572	1,083	1,807
75	2,452	2,895	3,346	2,664	1,123	1,865
76	2,540	2,998	3,467	2,756	1,161	1,925
77	2,627	3,102	3,588	2,853	1,201	1,987
78	2,717	3,208	3,709	2,951	1,244	2,054
79	2,804	3,308	3,824	3,043	1,283	2,120
80	2,890	3,411	3,944	3,138	1,322	2,190
81	2,981	3,521	4,070	3,238	1,363	2,260
82	3,070	3,625	4,190	3,336	1,404	2,329
83	3,165	3,736	4,320	3,438	1,447	2,400
84	3,257	3,847	4,446	3,538	1,490	2,469
85	3,373	3,985	4,610	3,667	1,544	2,559
86	3,472	4,100	4,740	3,772	1,587	2,631
87	3,571	4,216	4,874	3,879	1,635	2,706
88	3,669	4,333	5,012	3,987	1,679	2,782
89	3,772	4,452	5,149	4,098	1,726	2,859
90	3,876	4,575	5,291	4,209	1,773	2,938
91	3,983	4,702	5,435	4,325	1,820	3,017
92	4,089	4,827	5,581	4,441	1,870	3,099
93	4,197	4,958	5,731	4,559	1,921	3,180
94	4,311	5,087	5,880	4,682	1,972	3,267
95	4,422	5,219	6,035	4,802	2,021	3,351
96	4,535	5,352	6,193	4,925	2,075	3,437
97	4,653	5,493	6,348	5,053	2,127	3,525
98	4,771	5,631	6,511	5,178	2,181	3,615
99+	4,891	5,550	6,670	5,309	2,236	3,705

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

To calculate a 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: 450-454 and 459
Female rates

Rates effective 4/1/2024

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
65	1,444	1,702	1,968	1,566	659	1,034
66	1,444	1,702	1,968	1,566	659	1,034
67	1,444	1,702	1,968	1,566	659	1,034
68	1,458	1,721	1,991	1,583	668	1,071
69	1,491	1,762	2,035	1,620	682	1,115
70	1,532	1,806	2,089	1,662	701	1,158
71	1,577	1,862	2,152	1,712	720	1,198
72	1,628	1,920	2,218	1,766	744	1,240
73	1,679	1,981	2,291	1,823	768	1,281
74	1,738	2,051	2,371	1,887	795	1,325
75	1,799	2,124	2,454	1,953	823	1,368
76	1,863	2,199	2,541	2,021	852	1,411
77	1,927	2,276	2,631	2,091	881	1,458
78	1,993	2,352	2,720	2,164	911	1,506
79	2,055	2,427	2,805	2,230	940	1,555
80	2,118	2,502	2,893	2,303	970	1,607
81	2,186	2,581	2,983	2,375	999	1,657
82	2,252	2,658	3,073	2,445	1,030	1,707
83	2,320	2,740	3,167	2,521	1,061	1,760
84	2,389	2,820	3,261	2,594	1,093	1,811
85	2,474	2,922	3,379	2,688	1,132	1,876
86	2,545	3,007	3,475	2,765	1,164	1,929
87	2,618	3,090	3,573	2,843	1,197	1,984
88	2,692	3,177	3,674	2,922	1,231	2,039
89	2,765	3,266	3,776	3,006	1,265	2,097
90	2,842	3,354	3,880	3,087	1,300	2,155
91	2,920	3,448	3,984	3,171	1,335	2,212
92	2,998	3,540	4,093	3,257	1,372	2,272
93	3,077	3,636	4,203	3,342	1,409	2,333
94	3,160	3,730	4,311	3,431	1,446	2,395
95	3,242	3,828	4,424	3,522	1,483	2,458
96	3,327	3,926	4,540	3,612	1,522	2,520
97	3,411	4,027	4,656	3,704	1,561	2,584
98	3,499	4,130	4,775	3,798	1,598	2,650
99+	3,586	4,068	4,892	3,894	1,639	2,716

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
65	1,604	1,892	2,188	1,741	732	1,149
66	1,604	1,892	2,188	1,741	732	1,149
67	1,604	1,892	2,188	1,741	732	1,149
68	1,620	1,913	2,211	1,760	742	1,191
69	1,659	1,957	2,262	1,800	757	1,239
70	1,701	2,008	2,321	1,848	779	1,286
71	1,752	2,068	2,392	1,902	801	1,331
72	1,806	2,132	2,466	1,962	827	1,377
73	1,866	2,203	2,545	2,026	853	1,423
74	1,930	2,279	2,635	2,096	882	1,472
75	1,999	2,359	2,726	2,169	915	1,519
76	2,069	2,443	2,824	2,246	946	1,568
77	2,141	2,528	2,922	2,324	979	1,619
78	2,215	2,612	3,022	2,404	1,013	1,673
79	2,284	2,695	3,115	2,479	1,045	1,727
80	2,356	2,781	3,214	2,557	1,077	1,785
81	2,429	2,868	3,317	2,637	1,111	1,841
82	2,501	2,953	3,414	2,718	1,144	1,897
83	2,579	3,044	3,519	2,800	1,179	1,955
84	2,654	3,135	3,622	2,883	1,213	2,011
85	2,749	3,248	3,755	2,987	1,258	2,084
86	2,829	3,340	3,862	3,073	1,294	2,143
87	2,910	3,434	3,970	3,160	1,331	2,205
88	2,989	3,531	4,082	3,249	1,369	2,267
89	3,073	3,628	4,196	3,338	1,406	2,330
90	3,158	3,729	4,310	3,429	1,445	2,394
91	3,245	3,830	4,426	3,525	1,484	2,459
92	3,333	3,932	4,547	3,618	1,524	2,525
93	3,418	4,039	4,669	3,715	1,565	2,592
94	3,511	4,145	4,791	3,815	1,607	2,661
95	3,603	4,253	4,916	3,912	1,647	2,730
96	3,695	4,362	5,043	4,013	1,690	2,800
97	3,790	4,474	5,173	4,116	1,734	2,872
98	3,886	4,587	5,304	4,219	1,776	2,945
99+	3,983	4,521	5,434	4,325	1,822	3,018

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

To calculate a 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: 450-454 and 459

Male rates

Rates effective 4/1/2024

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
65	1,661	1,959	2,264	1,801	758	1,189
66	1,661	1,959	2,264	1,801	758	1,189
67	1,661	1,959	2,264	1,801	758	1,189
68	1,678	1,979	2,288	1,821	768	1,231
69	1,715	2,026	2,340	1,864	784	1,282
70	1,760	2,078	2,402	1,912	806	1,331
71	1,812	2,140	2,473	1,968	828	1,378
72	1,871	2,207	2,553	2,030	855	1,425
73	1,931	2,279	2,634	2,096	882	1,473
74	1,999	2,359	2,726	2,169	914	1,524
75	2,068	2,443	2,823	2,247	946	1,572
76	2,141	2,529	2,922	2,325	979	1,622
77	2,216	2,617	3,024	2,406	1,013	1,676
78	2,291	2,705	3,128	2,490	1,048	1,732
79	2,364	2,789	3,225	2,567	1,082	1,789
80	2,436	2,879	3,327	2,647	1,116	1,848
81	2,514	2,968	3,431	2,731	1,149	1,905
82	2,590	3,057	3,534	2,812	1,184	1,962
83	2,669	3,151	3,642	2,898	1,221	2,024
84	2,746	3,243	3,748	2,983	1,257	2,082
85	2,845	3,362	3,884	3,091	1,301	2,158
86	2,927	3,458	3,996	3,179	1,337	2,219
87	3,011	3,555	4,109	3,270	1,376	2,283
88	3,094	3,656	4,224	3,361	1,414	2,345
89	3,181	3,755	4,342	3,456	1,456	2,411
90	3,268	3,858	4,462	3,548	1,496	2,477
91	3,360	3,966	4,583	3,647	1,536	2,545
92	3,449	4,073	4,708	3,745	1,578	2,614
93	3,540	4,180	4,833	3,844	1,620	2,682
94	3,636	4,290	4,959	3,946	1,663	2,754
95	3,728	4,403	5,090	4,049	1,705	2,826
96	3,827	4,515	5,220	4,155	1,749	2,898
97	3,923	4,631	5,354	4,260	1,794	2,972
98	4,022	4,749	5,490	4,367	1,839	3,048
99+	4,122	4,678	5,626	4,476	1,886	3,124

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
65	1,843	2,175	2,516	2,002	842	1,322
66	1,843	2,175	2,516	2,002	842	1,322
67	1,843	2,175	2,516	2,002	842	1,322
68	1,864	2,200	2,542	2,023	853	1,370
69	1,905	2,252	2,599	2,070	870	1,424
70	1,957	2,309	2,670	2,126	895	1,480
71	2,014	2,378	2,751	2,187	920	1,531
72	2,078	2,453	2,836	2,257	950	1,584
73	2,146	2,533	2,927	2,330	981	1,636
74	2,220	2,621	3,031	2,410	1,015	1,693
75	2,297	2,712	3,135	2,496	1,052	1,747
76	2,380	2,809	3,248	2,582	1,088	1,803
77	2,462	2,907	3,361	2,673	1,125	1,862
78	2,546	3,006	3,475	2,765	1,166	1,924
79	2,627	3,099	3,583	2,851	1,202	1,986
80	2,708	3,196	3,695	2,940	1,239	2,052
81	2,793	3,299	3,814	3,034	1,277	2,117
82	2,877	3,397	3,926	3,125	1,316	2,182
83	2,965	3,501	4,048	3,221	1,356	2,248
84	3,051	3,605	4,165	3,314	1,396	2,313
85	3,161	3,734	4,319	3,436	1,447	2,397
86	3,253	3,842	4,441	3,534	1,487	2,465
87	3,346	3,950	4,567	3,635	1,532	2,536
88	3,437	4,060	4,696	3,736	1,574	2,606
89	3,534	4,171	4,825	3,840	1,617	2,679
90	3,632	4,287	4,958	3,944	1,661	2,753
91	3,732	4,405	5,092	4,052	1,706	2,827
92	3,831	4,523	5,229	4,161	1,752	2,904
93	3,932	4,646	5,370	4,271	1,800	2,980
94	4,039	4,766	5,509	4,387	1,848	3,061
95	4,143	4,890	5,654	4,499	1,894	3,140
96	4,249	5,015	5,802	4,614	1,944	3,220
97	4,360	5,147	5,948	4,734	1,993	3,303
98	4,470	5,276	6,101	4,852	2,044	3,387
99+	4,582	5,200	6,249	4,974	2,095	3,472

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

To calculate a 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 4/1/2024

ATTAINED AGE	PREFERRED						STANDARD					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
65	1,388	1,637	1,892	1,506	634	994	1,542	1,819	2,104	1,674	704	1,105
66	1,388	1,637	1,892	1,506	634	994	1,542	1,819	2,104	1,674	704	1,105
67	1,388	1,637	1,892	1,506	634	994	1,542	1,819	2,104	1,674	704	1,105
68	1,402	1,655	1,914	1,522	642	1,030	1,558	1,839	2,126	1,692	713	1,145
69	1,434	1,694	1,957	1,558	656	1,072	1,595	1,882	2,175	1,731	728	1,191
70	1,473	1,737	2,009	1,598	674	1,113	1,636	1,931	2,232	1,777	749	1,237
71	1,516	1,790	2,069	1,646	692	1,152	1,685	1,988	2,300	1,829	770	1,280
72	1,565	1,846	2,133	1,698	715	1,192	1,737	2,050	2,371	1,887	795	1,324
73	1,614	1,905	2,203	1,753	738	1,232	1,794	2,118	2,447	1,948	820	1,368
74	1,671	1,972	2,280	1,814	764	1,274	1,856	2,191	2,534	2,015	848	1,415
75	1,730	2,042	2,360	1,878	791	1,315	1,922	2,268	2,621	2,086	880	1,461
76	1,791	2,114	2,443	1,943	819	1,357	1,989	2,349	2,715	2,160	910	1,508
77	1,853	2,188	2,530	2,011	847	1,402	2,059	2,431	2,810	2,235	941	1,557
78	1,916	2,262	2,615	2,081	876	1,448	2,130	2,512	2,906	2,312	974	1,609
79	1,976	2,334	2,697	2,144	904	1,495	2,196	2,591	2,995	2,384	1,005	1,661
80	2,037	2,406	2,782	2,214	933	1,545	2,265	2,674	3,090	2,459	1,036	1,716
81	2,102	2,482	2,868	2,284	961	1,593	2,336	2,758	3,189	2,536	1,068	1,770
82	2,165	2,556	2,955	2,351	990	1,641	2,405	2,839	3,283	2,613	1,100	1,824
83	2,231	2,635	3,045	2,424	1,020	1,692	2,480	2,927	3,384	2,692	1,134	1,880
84	2,297	2,712	3,136	2,494	1,051	1,741	2,552	3,014	3,483	2,772	1,166	1,934
85	2,379	2,810	3,249	2,585	1,088	1,804	2,643	3,123	3,611	2,872	1,210	2,004
86	2,447	2,891	3,341	2,659	1,119	1,855	2,720	3,212	3,713	2,955	1,244	2,061
87	2,517	2,971	3,436	2,734	1,151	1,908	2,798	3,302	3,817	3,038	1,280	2,120
88	2,588	3,055	3,533	2,810	1,184	1,961	2,874	3,395	3,925	3,124	1,316	2,180
89	2,659	3,140	3,631	2,890	1,216	2,016	2,955	3,488	4,035	3,210	1,352	2,240
90	2,733	3,225	3,731	2,968	1,250	2,072	3,037	3,586	4,144	3,297	1,389	2,302
91	2,808	3,315	3,831	3,049	1,284	2,127	3,120	3,683	4,256	3,389	1,427	2,364
92	2,883	3,404	3,936	3,132	1,319	2,185	3,205	3,781	4,372	3,479	1,465	2,428
93	2,959	3,496	4,041	3,213	1,355	2,243	3,287	3,884	4,489	3,572	1,505	2,492
94	3,038	3,587	4,145	3,299	1,390	2,303	3,376	3,986	4,607	3,668	1,545	2,559
95	3,117	3,681	4,254	3,387	1,426	2,363	3,464	4,089	4,727	3,762	1,584	2,625
96	3,199	3,775	4,365	3,473	1,463	2,423	3,553	4,194	4,849	3,859	1,625	2,692
97	3,280	3,872	4,477	3,562	1,501	2,485	3,644	4,302	4,974	3,958	1,667	2,762
98	3,364	3,971	4,591	3,652	1,537	2,548	3,737	4,411	5,100	4,057	1,708	2,832
99+	3,448	3,912	4,704	3,744	1,576	2,612	3,830	4,347	5,225	4,159	1,752	2,902

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

To calculate a 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 4/1/2024

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
65	1,597	1,884	2,177	1,732	729	1,143
66	1,597	1,884	2,177	1,732	729	1,143
67	1,597	1,884	2,177	1,732	729	1,143
68	1,613	1,903	2,200	1,751	738	1,184
69	1,649	1,948	2,250	1,792	754	1,233
70	1,692	1,998	2,310	1,838	775	1,280
71	1,742	2,058	2,378	1,892	796	1,325
72	1,799	2,122	2,455	1,952	822	1,370
73	1,857	2,191	2,533	2,015	848	1,416
74	1,922	2,268	2,621	2,086	879	1,465
75	1,988	2,349	2,714	2,161	910	1,512
76	2,059	2,432	2,810	2,236	941	1,560
77	2,131	2,516	2,908	2,313	974	1,612
78	2,203	2,601	3,008	2,394	1,008	1,665
79	2,273	2,682	3,101	2,468	1,040	1,720
80	2,342	2,768	3,199	2,545	1,073	1,777
81	2,417	2,854	3,299	2,626	1,105	1,832
82	2,490	2,939	3,398	2,704	1,138	1,887
83	2,566	3,030	3,502	2,787	1,174	1,946
84	2,640	3,118	3,604	2,868	1,209	2,002
85	2,736	3,233	3,735	2,972	1,251	2,075
86	2,814	3,325	3,842	3,057	1,286	2,134
87	2,895	3,418	3,951	3,144	1,323	2,195
88	2,975	3,515	4,062	3,232	1,360	2,255
89	3,059	3,611	4,175	3,323	1,400	2,318
90	3,142	3,710	4,290	3,412	1,438	2,382
91	3,231	3,813	4,407	3,507	1,477	2,447
92	3,316	3,916	4,527	3,601	1,517	2,513
93	3,404	4,019	4,647	3,696	1,558	2,579
94	3,496	4,125	4,768	3,794	1,599	2,648
95	3,585	4,234	4,894	3,893	1,639	2,717
96	3,680	4,341	5,019	3,995	1,682	2,787
97	3,772	4,453	5,148	4,096	1,725	2,858
98	3,867	4,566	5,279	4,199	1,768	2,931
99+	3,963	4,498	5,410	4,304	1,813	3,004

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
65	1,772	2,091	2,419	1,925	810	1,271
66	1,772	2,091	2,419	1,925	810	1,271
67	1,772	2,091	2,419	1,925	810	1,271
68	1,792	2,115	2,444	1,945	820	1,317
69	1,832	2,165	2,499	1,990	837	1,369
70	1,882	2,220	2,567	2,044	861	1,423
71	1,937	2,287	2,645	2,103	885	1,472
72	1,998	2,359	2,727	2,170	913	1,523
73	2,063	2,436	2,814	2,240	943	1,573
74	2,135	2,520	2,914	2,317	976	1,628
75	2,209	2,608	3,014	2,400	1,012	1,680
76	2,288	2,701	3,123	2,483	1,046	1,734
77	2,367	2,795	3,232	2,570	1,082	1,790
78	2,448	2,890	3,341	2,659	1,121	1,850
79	2,526	2,980	3,445	2,741	1,156	1,910
80	2,604	3,073	3,553	2,827	1,191	1,973
81	2,686	3,172	3,667	2,917	1,228	2,036
82	2,766	3,266	3,775	3,005	1,265	2,098
83	2,851	3,366	3,892	3,097	1,304	2,162
84	2,934	3,466	4,005	3,187	1,342	2,224
85	3,039	3,590	4,153	3,304	1,391	2,305
86	3,128	3,694	4,270	3,398	1,430	2,370
87	3,217	3,798	4,391	3,495	1,473	2,438
88	3,305	3,904	4,515	3,592	1,513	2,506
89	3,398	4,011	4,639	3,692	1,555	2,576
90	3,492	4,122	4,767	3,792	1,597	2,647
91	3,588	4,236	4,896	3,896	1,640	2,718
92	3,684	4,349	5,028	4,001	1,685	2,792
93	3,781	4,467	5,163	4,107	1,731	2,865
94	3,884	4,583	5,297	4,218	1,777	2,943
95	3,984	4,702	5,437	4,326	1,821	3,019
96	4,086	4,822	5,579	4,437	1,869	3,096
97	4,192	4,949	5,719	4,552	1,916	3,176
98	4,298	5,073	5,866	4,665	1,965	3,257
99+	4,406	5,000	6,009	4,783	2,014	3,338

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

To calculate a 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. The household discount will be discontinued in the event of: 1) divorce or death of the spouse; 2) termination of your civil union partnership, or; 3) you or the other insured person no longer permanently reside at the same address.

PREFERRED / STANDARD RATES

For tobacco users applying outside of Open Enrollment or Guarantee Issue periods, the Standard rates will apply. Preferred rates will apply for all other individuals.

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.

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