Outline of coverage

Medicare Supplement Insurance

Benefit plans: A, B, F, G, High Deductible G, N

Tennessee

Underwritten by

Continental Life Insurance Company of Brentwood, Tennessee

An Aetna Company

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Rates effective: 03/2022 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 2022[2]					**$6,620[2]**	**$3,310[2]**				

[1] Plans F and G also have a high deductible option, which require first paying a plan deductible of $2,490 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 ALL Zip Codes

Female Rates

Rates Effective 3/1/2022

Attained	Preferred					
Age	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	5,103	5,993	7,247	6,084	2,106	4,601
65	1,132	1,331	1,608	1,350	467	963
66	1,132	1,331	1,608	1,350	467	963
67	1,132	1,331	1,608	1,350	467	963
68	1,144	1,344	1,625	1,364	472	998
69	1,171	1,375	1,662	1,395	483	1,038
70	1,202	1,410	1,707	1,432	496	1,078
71	1,238	1,454	1,758	1,475	511	1,116
72	1,277	1,499	1,812	1,521	527	1,154
73	1,318	1,548	1,872	1,570	544	1,193
74	1,364	1,603	1,937	1,626	563	1,234
75	1,412	1,658	2,006	1,683	582	1,273
76	1,461	1,716	2,075	1,742	603	1,314
77	1,513	1,777	2,148	1,803	624	1,358
78	1,564	1,837	2,220	1,864	645	1,403
79	1,614	1,894	2,290	1,922	665	1,448
80	1,663	1,954	2,362	1,984	686	1,496
81	1,716	2,015	2,436	2,046	708	1,544
82	1,767	2,076	2,509	2,106	729	1,590
83	1,822	2,139	2,587	2,171	751	1,638
84	1,875	2,202	2,662	2,236	773	1,686
85	1,943	2,282	2,759	2,316	801	1,747
86	1,999	2,348	2,837	2,382	824	1,798
87	2,055	2,413	2,919	2,449	848	1,848
88	2,112	2,481	3,000	2,519	872	1,901
89	2,172	2,550	3,084	2,589	896	1,953
90	2,231	2,621	3,168	2,660	920	2,007
91	2,292	2,691	3,254	2,731	945	2,061
92	2,354	2,764	3,342	2,806	971	2,117
93	2,417	2,837	3,431	2,881	997	2,174
94	2,480	2,912	3,522	2,956	1,023	2,231
95	2,544	2,988	3,613	3,034	1,050	2,289
96	2,610	3,065	3,707	3,113	1,077	2,348
97	2,677	3,145	3,802	3,192	1,104	2,409
98	2,745	3,224	3,898	3,272	1,132	2,470
99+	2,813	3,305	3,996	3,353	1,161	2,531

Attained	Standard					
Age	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	5,670	6,659	8,053	6,760	2,340	5,112
65	1,257	1,477	1,787	1,500	519	1,070
66	1,257	1,477	1,787	1,500	519	1,070
67	1,257	1,477	1,787	1,500	519	1,070
68	1,271	1,494	1,806	1,515	524	1,109
69	1,300	1,527	1,846	1,550	537	1,154
70	1,336	1,567	1,897	1,592	551	1,198
71	1,375	1,615	1,953	1,638	568	1,240
72	1,419	1,665	2,013	1,689	586	1,282
73	1,464	1,720	2,080	1,744	604	1,325
74	1,516	1,781	2,152	1,807	626	1,371
75	1,568	1,841	2,228	1,869	647	1,414
76	1,624	1,906	2,305	1,935	670	1,460
77	1,680	1,974	2,387	2,002	693	1,509
78	1,738	2,041	2,468	2,071	717	1,558
79	1,793	2,105	2,544	2,136	739	1,609
80	1,849	2,171	2,625	2,203	762	1,662
81	1,906	2,239	2,708	2,272	787	1,715
82	1,963	2,306	2,788	2,339	810	1,766
83	2,025	2,378	2,874	2,413	834	1,820
84	2,083	2,447	2,957	2,483	859	1,873
85	2,158	2,536	3,065	2,574	890	1,941
86	2,222	2,608	3,152	2,647	916	1,997
87	2,283	2,681	3,243	2,722	942	2,054
88	2,348	2,757	3,333	2,798	969	2,112
89	2,413	2,834	3,426	2,876	996	2,170
90	2,480	2,912	3,521	2,955	1,022	2,229
91	2,547	2,991	3,616	3,035	1,050	2,290
92	2,616	3,070	3,713	3,118	1,079	2,352
93	2,685	3,153	3,813	3,201	1,108	2,415
94	2,756	3,236	3,913	3,284	1,137	2,479
95	2,827	3,320	4,014	3,371	1,167	2,543
96	2,901	3,405	4,119	3,458	1,197	2,608
97	2,974	3,494	4,225	3,547	1,227	2,676
98	3,051	3,582	4,331	3,635	1,258	2,744
99+	3,127	3,672	4,440	3,727	1,290	2,812

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

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

To calculate a Household discount:

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

Modal premium x .93 = discounted premium

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

Continental Life Insurance Company of Brentwood, Tennessee

Annual Premiums
For Use in ALL Zip Codes
Male Rates

Rates Effective 3/1/2022

Attained	Preferred					
Age	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	5,869	6,893	8,334	6,995	2,422	5,291
65	1,301	1,529	1,850	1,552	537	1,108
66	1,301	1,529	1,850	1,552	537	1,108
67	1,301	1,529	1,850	1,552	537	1,108
68	1,315	1,545	1,869	1,568	543	1,148
69	1,346	1,581	1,912	1,604	555	1,194
70	1,382	1,623	1,963	1,647	570	1,240
71	1,423	1,672	2,021	1,696	588	1,283
72	1,469	1,724	2,083	1,749	606	1,327
73	1,515	1,781	2,152	1,806	626	1,371
74	1,568	1,842	2,227	1,871	647	1,419
75	1,624	1,906	2,306	1,935	669	1,464
76	1,680	1,973	2,386	2,003	693	1,511
77	1,740	2,043	2,471	2,074	718	1,561
78	1,798	2,112	2,554	2,144	742	1,613
79	1,855	2,178	2,633	2,212	765	1,665
80	1,913	2,246	2,717	2,281	789	1,721
81	1,973	2,318	2,801	2,352	814	1,776
82	2,033	2,387	2,885	2,421	838	1,828
83	2,095	2,461	2,975	2,497	864	1,884
84	2,156	2,533	3,062	2,571	889	1,939
85	2,235	2,624	3,173	2,663	921	2,010
86	2,298	2,700	3,263	2,740	948	2,067
87	2,363	2,775	3,357	2,817	975	2,125
88	2,429	2,853	3,450	2,895	1,003	2,186
89	2,497	2,932	3,546	2,978	1,030	2,246
90	2,566	3,014	3,643	3,059	1,058	2,308
91	2,635	3,094	3,741	3,142	1,087	2,370
92	2,706	3,178	3,843	3,227	1,117	2,434
93	2,780	3,263	3,946	3,313	1,147	2,500
94	2,852	3,349	4,050	3,400	1,176	2,566
95	2,927	3,437	4,156	3,488	1,208	2,632
96	3,001	3,524	4,263	3,579	1,239	2,700
97	3,079	3,616	4,372	3,671	1,270	2,770
98	3,157	3,707	4,483	3,763	1,302	2,840
99+	3,236	3,801	4,595	3,857	1,335	2,911

Attained	Standard					
Age	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	6,521	7,658	9,261	7,774	2,691	5,879
65	1,446	1,699	2,055	1,725	597	1,231
66	1,446	1,699	2,055	1,725	597	1,231
67	1,446	1,699	2,055	1,725	597	1,231
68	1,461	1,718	2,078	1,742	603	1,275
69	1,496	1,756	2,123	1,782	618	1,327
70	1,537	1,801	2,181	1,831	634	1,378
71	1,581	1,858	2,246	1,885	653	1,426
72	1,632	1,915	2,315	1,943	674	1,474
73	1,684	1,979	2,393	2,006	695	1,524
74	1,744	2,048	2,474	2,078	720	1,577
75	1,804	2,118	2,563	2,150	744	1,626
76	1,867	2,192	2,651	2,225	771	1,679
77	1,932	2,270	2,746	2,303	797	1,736
78	1,998	2,348	2,837	2,382	825	1,792
79	2,062	2,420	2,926	2,456	850	1,850
80	2,127	2,496	3,018	2,534	876	1,911
81	2,192	2,575	3,114	2,613	905	1,972
82	2,258	2,651	3,206	2,690	932	2,031
83	2,330	2,736	3,305	2,775	959	2,093
84	2,397	2,814	3,402	2,857	988	2,155
85	2,481	2,916	3,525	2,959	1,024	2,232
86	2,555	2,999	3,624	3,045	1,053	2,296
87	2,625	3,083	3,729	3,129	1,083	2,361
88	2,700	3,171	3,832	3,218	1,114	2,429
89	2,775	3,259	3,939	3,308	1,145	2,496
90	2,852	3,349	4,048	3,399	1,175	2,563
91	2,929	3,440	4,158	3,489	1,208	2,633
92	3,009	3,532	4,271	3,586	1,241	2,705
93	3,088	3,626	4,385	3,682	1,274	2,777
94	3,170	3,721	4,501	3,778	1,308	2,851
95	3,251	3,818	4,617	3,876	1,342	2,924
96	3,336	3,916	4,737	3,978	1,377	3,000
97	3,420	4,018	4,858	4,079	1,411	3,078
98	3,509	4,120	4,981	4,182	1,447	3,155
99+	3,596	4,223	5,106	4,287	1,484	3,234

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

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

To calculate a Household discount:

Annual premium x modal factor = modal premium (round to nearest whole cent)
Modal premium x .93 = discounted premium

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

Standard/Preferred rating classes are used, but all applicants in their open enrollment period or a specified guarantee issue period will receive Preferred rates.

PREMIUM INFORMATION

Continental Life Insurance Company of Brentwood, Tennessee will increase premiums due to the increase in your age on each annual anniversary of your Effective Date. The renewal premium for this policy will be the renewal premium then in effect for your attained age. The premium may also change for other reasons. Any change in premium will applyto all covered persons in your same class based on the issue state of your policy. For any premium change under this paragraph, we will give you at least 30 days advance notice in writing of such premium change.

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 issuedand 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 $1,556	$0	$1,556 (Part A Deductible)
61st thru 90th day	All but $389 a day	$389 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $778 a day	$778 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	All approved amounts All but $194.50 a day		$0 Up to $194.50 a day All cost
First 20 days		$0	
21st thru 100th day		$0	
101st day and after		$0	
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 $233 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 $233 of Medicare-Approved amounts*	$0	$0	$233 (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 $233 of Medicare-Approved amounts*	$0	$0	$233 (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 $233 of Medicare Approved amounts*	$0	$0	$233 (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 $1,556	$1,556 (Part A Deductible)	$0
61st thru 90th day	All but $389 a day	$389 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $778 a day	$778 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 All but $194.50 a day $0	$0	$0
21st thru 100th day		$0	Up to $194.50 a day All costs
101st day and after		$0	
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 $233 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 $233 of Medicare-Approved amounts*	$0	$0	$233 (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 $233 of Medicare-Approved amounts*	$0	$0	$233 (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 $233 of Medicare Approved amounts*	$0	$0	$233 (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 $1,556	$1,556 (Part A Deductible)	$0
61st thru 90th day	All but $389 a day	$389 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $778 a day	$778 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 All but $194.50 a day $0	$0	$0
21st thru 100th day		Up to $194.50 a day $0	$0
101st day and after			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 $233 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic test, durable medical equipment			
First $233 of Medicare-Approved amounts*	$0	$233 (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 $233 of Medicare-Approved amounts*	$0	$233 (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 $233 of Medicare Approved amounts*	$0	$233 (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 $1,556	$1,556 (Part A Deductible)	$0
61st thru 90th day	All but $389 a day	$389 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $778 a day	$778 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 All but $194.50 a day $0	$0	$0
21st thru 100th day		Up to $194.50 a day $0	$0
101st day and after			All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness services	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to 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 $233 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 $233 of Medicare-Approved amounts*	$0	$0	$233 (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 $233 of Medicare-Approved amounts*	$0	$0	$233 (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 $233 of Medicare Approved amounts*	$0	$0	$233 (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 Remainder of charges	 $0 $0	 $0 80% to a lifetime maximum benefit of $50,000	 $250 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 $2,490 deductible. Benefits from high deductible plan G will not begin until out-of-pocket expenses are $2,490. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid bythe policy. This does not include the plan's separate foreign travel emergency deductible.**

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,490 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2,490 DEDUCTIBLE*** YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,556	$1,556 (Part A Deductible)	$0
61st thru 90th day	All but $389 a day	$389 a day	$0
91st day and after			
*While using 60 lifetime reserve days	All but $778 a day	$778 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	$0	$0
21st thru 100th day	amounts All but	Up to $194.50 a	$0
101st day and after	$194.50 a day $0	day $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 $233 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 $2,490 deductible. Benefits from high deductible plan G will not begin until out-of-pocket expenses are $2,490. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid bythe policy. This does not include the plan's separate foreign travel emergency deductible.**

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,490 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2,490 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 $233 of Medicare-Approved amounts*	$0	$0	$233 (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 $233 of Medicare-Approved amounts*	$0	$0	$233 (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 $2,490 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2,490 DEDUCTIBLE*** YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
*Medically necessary skilled care services and medical supplies	100%	$0	$0
*Durable medical equipment			
First $233 of Medicare Approved amounts	$0	$0	$233 (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 $2,490 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2,490 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 $1,556	$1,556 (Part A Deductible)	$0
61st thru 90th day	All but $389 a day	$389 a day	$0
91st day and after			
*While using 60 lifetime reserve days	All but $778 a day	$778 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 All but $194.50 a day $0	$0	$0
21st thru 100th day		Up to $194.50 a day $0	$0
101st day and after			All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness services	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare co-payment/ coinsurance	$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to 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 $233 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 $233 of Medicare-Approved amounts*	$0	$0	$233 (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 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.
Part B Excess Charges (Above Medicare-Approved amounts)	$0	0%	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $233 of Medicare-Approved amounts*	$0	$0	$233 (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 $233 of Medicare Approved amounts*	$0	$0	$233 (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