Continental Life Insurance Company of Brentwood, Tennessee
An Aetna Company

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Outline of Coverage

Medicare Supplement Insurance

BENEFIT PLANS A, B, F, HIGH DEDUCTIBLE F, G, N

Underwritten by

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

CALIFORNIA

CONTINENTAL LIFE INSURANCE COMPANY OF BRENTWOOD, TENNESSEE
OUTLINE OF MEDICARE SUPPLEMENT COVERAGE COVER PAGE: Page 1 of 2
BENEFIT PLANS AVAILABLE: A, B, F, HIGH DEDUCTIBLE F, G, N

These charts show the benefits included in each of the standard Medicare supplement plans. Every company must make available Plan "A" Some plans may not be available in your state.

See Outlines of Coverage Sections for details about ALL Plans

Basic Benefits:

Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
Medical Expenses: Part B coinsurance (generally 20% of Medicare-Approved expenses) or, co-payments for hospital outpatient services. Plans K, L, and N require insureds to pay a portion of coinsurance or copayments
Blood: First three pints of blood each year.
Hospice: Part A coinsurance

A	B	C	D	F/F*	G	K	L	M	N
Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance, except up to $20 copayment for office visit, and up to $50 copayment for ER
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Part B Deductible		Part B Deductible					
				Part B Excess (100%)	Part B Excess (100%)				
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency			Foreign Travel Emergency	Foreign Travel Emergency
						Out-of-pocket limit $4960; paid at 100% after limit reached	Out-of-pocket limit $2480; paid at 100% after limit reached		

*Plan F also has an option called a high deductible plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2180 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed $2180. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

Continental Life Insurance Company of Brentwood, Tennessee

Annual Attained Age Premiums

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

Rates Effective 9/1/2016

Attained	Preferred					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	2,388	3,021	3,545	n/a	n/a	2,487
65	1,255	1,587	1,864	586	1,631	1,241
66	1,304	1,649	1,936	609	1,694	1,291
67	1,355	1,713	2,012	633	1,760	1,345
68	1,408	1,780	2,090	657	1,829	1,400
69	1,463	1,850	2,172	683	1,899	1,456
70	1,519	1,922	2,256	710	1,973	1,516
71	1,579	1,998	2,345	736	2,051	1,580
72	1,642	2,077	2,436	767	2,131	1,649
73	1,706	2,158	2,534	795	2,216	1,721
74	1,774	2,244	2,634	828	2,303	1,795
75	1,846	2,334	2,738	861	2,395	1,870
76	1,897	2,399	2,816	885	2,463	1,930
77	1,951	2,467	2,895	911	2,533	1,994
78	2,006	2,538	2,978	937	2,605	2,059
79	2,063	2,609	3,062	963	2,677	2,123
80	2,121	2,681	3,147	990	2,752	2,190
81	2,146	2,714	3,186	1,003	2,786	2,219
82	2,172	2,747	3,224	1,016	2,819	2,248
83	2,198	2,779	3,262	1,024	2,853	2,277
84	2,225	2,813	3,302	1,037	2,888	2,307
85	2,250	2,846	3,340	1,052	2,922	2,336
86	2,278	2,882	3,380	1,063	2,957	2,366
87	2,305	2,915	3,421	1,076	2,993	2,396
88	2,333	2,950	3,462	1,089	3,029	2,427
89	2,360	2,985	3,504	1,102	3,064	2,458
90	2,388	3,021	3,545	1,114	3,102	2,487
91	2,416	3,057	3,588	1,128	3,139	2,520
92	2,447	3,094	3,631	1,142	3,176	2,552
93	2,475	3,131	3,675	1,156	3,214	2,583
94	2,505	3,168	3,720	1,170	3,254	2,618
95	2,536	3,207	3,764	1,183	3,292	2,651
96	2,566	3,245	3,809	1,200	3,332	2,687
97	2,597	3,284	3,856	1,213	3,373	2,720
98	2,629	3,324	3,902	1,227	3,413	2,754
99	2,660	3,364	3,948	1,241	3,453	2,789

Attained	Standard					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	2,651	3,352	3,934	n/a	n/a	2,761
65	1,394	1,762	2,068	650	1,808	1,377
66	1,449	1,831	2,149	675	1,879	1,434
67	1,504	1,902	2,232	702	1,953	1,493
68	1,563	1,976	2,320	730	2,029	1,554
69	1,624	2,053	2,409	758	2,108	1,617
70	1,687	2,134	2,503	788	2,190	1,683
71	1,754	2,218	2,603	818	2,277	1,755
72	1,823	2,306	2,705	851	2,366	1,831
73	1,895	2,397	2,812	883	2,460	1,909
74	1,969	2,491	2,922	920	2,556	1,993
75	2,047	2,588	3,038	956	2,658	2,076
76	2,106	2,663	3,126	982	2,734	2,142
77	2,165	2,737	3,213	1,011	2,811	2,214
78	2,227	2,816	3,305	1,039	2,890	2,284
79	2,290	2,895	3,399	1,070	2,971	2,356
80	2,354	2,977	3,493	1,099	3,056	2,432
81	2,383	3,012	3,536	1,113	3,093	2,463
82	2,411	3,050	3,579	1,127	3,131	2,496
83	2,439	3,086	3,621	1,137	3,167	2,526
84	2,468	3,121	3,664	1,152	3,206	2,561
85	2,498	3,160	3,708	1,167	3,243	2,594
86	2,528	3,199	3,753	1,180	3,284	2,627
87	2,558	3,235	3,797	1,195	3,322	2,659
88	2,588	3,274	3,843	1,208	3,362	2,693
89	2,619	3,314	3,889	1,223	3,402	2,727
90	2,651	3,352	3,934	1,237	3,442	2,761
91	2,682	3,393	3,982	1,253	3,484	2,798
92	2,715	3,434	4,029	1,266	3,526	2,833
93	2,748	3,475	4,078	1,283	3,566	2,869
94	2,781	3,516	4,128	1,300	3,610	2,906
95	2,815	3,559	4,179	1,314	3,655	2,943
96	2,847	3,602	4,228	1,331	3,699	2,983
97	2,884	3,647	4,280	1,346	3,744	3,018
98	2,917	3,690	4,331	1,363	3,788	3,058
99	2,952	3,733	4,382	1,377	3,832	3,098

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

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

To calculate a Household discount:

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

Modal premium x .95 = discounted premium

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

Continental Life Insurance Company of Brentwood, Tennessee

Annual Attained Age Premiums

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

Rates Effective 9/1/2016

Attained	Preferred					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	2,627	3,323	3,900	n/a	n/a	2,736
65	1,381	1,746	2,050	645	1,794	1,365
66	1,434	1,814	2,130	670	1,863	1,420
67	1,491	1,884	2,213	696	1,936	1,480
68	1,549	1,958	2,299	723	2,012	1,540
69	1,609	2,035	2,389	751	2,089	1,602
70	1,671	2,114	2,482	781	2,170	1,668
71	1,737	2,198	2,580	810	2,256	1,738
72	1,806	2,285	2,680	844	2,344	1,814
73	1,877	2,374	2,787	875	2,438	1,893
74	1,951	2,468	2,897	911	2,533	1,975
75	2,031	2,567	3,012	947	2,635	2,057
76	2,087	2,639	3,098	974	2,709	2,123
77	2,146	2,714	3,185	1,002	2,786	2,193
78	2,207	2,792	3,276	1,031	2,866	2,265
79	2,269	2,870	3,368	1,059	2,945	2,335
80	2,333	2,949	3,462	1,089	3,027	2,409
81	2,361	2,985	3,505	1,103	3,065	2,441
82	2,389	3,022	3,546	1,118	3,101	2,473
83	2,418	3,057	3,588	1,126	3,138	2,505
84	2,448	3,094	3,632	1,141	3,177	2,538
85	2,475	3,131	3,674	1,157	3,214	2,570
86	2,506	3,170	3,718	1,169	3,253	2,603
87	2,536	3,207	3,763	1,184	3,292	2,636
88	2,566	3,245	3,808	1,198	3,332	2,670
89	2,596	3,284	3,854	1,212	3,370	2,704
90	2,627	3,323	3,900	1,225	3,412	2,736
91	2,658	3,363	3,947	1,241	3,453	2,772
92	2,692	3,403	3,994	1,256	3,494	2,807
93	2,723	3,444	4,043	1,272	3,535	2,841
94	2,756	3,485	4,092	1,287	3,579	2,880
95	2,790	3,528	4,140	1,301	3,621	2,916
96	2,823	3,570	4,190	1,320	3,665	2,956
97	2,857	3,612	4,242	1,334	3,710	2,992
98	2,892	3,656	4,292	1,350	3,754	3,029
99	2,926	3,700	4,343	1,365	3,798	3,068

Attained	Standard					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	2,916	3,687	4,327	n/a	n/a	3,037
65	1,533	1,938	2,275	715	1,989	1,515
66	1,594	2,014	2,364	743	2,067	1,577
67	1,654	2,092	2,455	772	2,148	1,642
68	1,719	2,174	2,552	803	2,232	1,709
69	1,786	2,258	2,650	834	2,319	1,779
70	1,856	2,347	2,753	867	2,409	1,851
71	1,929	2,440	2,863	900	2,505	1,931
72	2,005	2,537	2,976	936	2,603	2,014
73	2,085	2,637	3,093	971	2,706	2,100
74	2,166	2,740	3,214	1,012	2,812	2,192
75	2,252	2,847	3,342	1,052	2,924	2,284
76	2,317	2,929	3,439	1,080	3,007	2,356
77	2,382	3,011	3,534	1,112	3,092	2,435
78	2,450	3,098	3,636	1,143	3,179	2,512
79	2,519	3,185	3,739	1,177	3,268	2,592
80	2,589	3,275	3,842	1,209	3,362	2,675
81	2,621	3,313	3,890	1,224	3,402	2,709
82	2,652	3,355	3,937	1,240	3,444	2,746
83	2,683	3,395	3,983	1,251	3,484	2,779
84	2,715	3,433	4,030	1,267	3,527	2,817
85	2,748	3,476	4,079	1,284	3,567	2,853
86	2,781	3,519	4,128	1,298	3,612	2,890
87	2,814	3,559	4,177	1,315	3,654	2,925
88	2,847	3,601	4,227	1,329	3,698	2,962
89	2,881	3,645	4,278	1,345	3,742	3,000
90	2,916	3,687	4,327	1,361	3,786	3,037
91	2,950	3,732	4,380	1,378	3,832	3,078
92	2,987	3,777	4,432	1,393	3,879	3,116
93	3,023	3,823	4,486	1,411	3,923	3,156
94	3,059	3,868	4,541	1,430	3,971	3,197
95	3,097	3,915	4,597	1,445	4,021	3,237
96	3,132	3,962	4,651	1,464	4,069	3,281
97	3,172	4,012	4,708	1,481	4,118	3,320
98	3,209	4,059	4,764	1,499	4,167	3,364
99	3,247	4,106	4,820	1,515	4,215	3,408

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

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

To calculate a Household discount:

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

Modal premium x .95 = discounted premium

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

Continental Life Insurance Company of Brentwood, Tennessee

Annual Attained Age Premiums

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

Rates Effective 9/1/2016

Attained	Preferred					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	2,794	3,535	4,148	n/a	n/a	2,910
65	1,468	1,857	2,181	686	1,908	1,452
66	1,526	1,929	2,265	713	1,982	1,510
67	1,585	2,004	2,354	741	2,059	1,574
68	1,647	2,083	2,445	769	2,140	1,638
69	1,712	2,165	2,541	799	2,222	1,704
70	1,777	2,249	2,640	831	2,308	1,774
71	1,847	2,338	2,744	861	2,400	1,849
72	1,921	2,430	2,850	897	2,493	1,929
73	1,996	2,525	2,965	930	2,593	2,014
74	2,076	2,625	3,082	969	2,695	2,100
75	2,160	2,731	3,203	1,007	2,802	2,188
76	2,219	2,807	3,295	1,035	2,882	2,258
77	2,283	2,886	3,387	1,066	2,964	2,333
78	2,347	2,969	3,484	1,096	3,048	2,409
79	2,414	3,053	3,583	1,127	3,132	2,484
80	2,482	3,137	3,682	1,158	3,220	2,562
81	2,511	3,175	3,728	1,174	3,260	2,596
82	2,541	3,214	3,772	1,189	3,298	2,630
83	2,572	3,251	3,817	1,198	3,338	2,664
84	2,603	3,291	3,863	1,213	3,379	2,699
85	2,633	3,330	3,908	1,231	3,419	2,733
86	2,665	3,372	3,955	1,244	3,460	2,768
87	2,697	3,411	4,003	1,259	3,502	2,803
88	2,730	3,452	4,051	1,274	3,544	2,840
89	2,761	3,492	4,100	1,289	3,585	2,876
90	2,794	3,535	4,148	1,303	3,629	2,910
91	2,827	3,577	4,198	1,320	3,673	2,948
92	2,863	3,620	4,248	1,336	3,716	2,986
93	2,896	3,663	4,300	1,353	3,760	3,022
94	2,931	3,707	4,352	1,369	3,807	3,063
95	2,967	3,752	4,404	1,384	3,852	3,102
96	3,002	3,797	4,457	1,404	3,898	3,144
97	3,038	3,842	4,512	1,419	3,946	3,182
98	3,076	3,889	4,565	1,436	3,993	3,222
99	3,112	3,936	4,619	1,452	4,040	3,263

Attained	Standard					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	3,102	3,922	4,603	n/a	n/a	3,230
65	1,631	2,062	2,420	761	2,115	1,611
66	1,695	2,142	2,514	790	2,198	1,678
67	1,760	2,225	2,611	821	2,285	1,747
68	1,829	2,312	2,714	854	2,374	1,818
69	1,900	2,402	2,819	887	2,466	1,892
70	1,974	2,497	2,929	922	2,562	1,969
71	2,052	2,595	3,046	957	2,664	2,053
72	2,133	2,698	3,165	996	2,768	2,142
73	2,217	2,804	3,290	1,033	2,878	2,234
74	2,304	2,914	3,419	1,076	2,991	2,332
75	2,395	3,028	3,554	1,119	3,110	2,429
76	2,464	3,116	3,657	1,149	3,199	2,506
77	2,533	3,202	3,759	1,183	3,289	2,590
78	2,606	3,295	3,867	1,216	3,381	2,672
79	2,679	3,387	3,977	1,252	3,476	2,757
80	2,754	3,483	4,087	1,286	3,576	2,845
81	2,788	3,524	4,137	1,302	3,619	2,882
82	2,821	3,569	4,187	1,319	3,663	2,920
83	2,854	3,611	4,237	1,330	3,705	2,955
84	2,888	3,652	4,287	1,348	3,751	2,996
85	2,923	3,697	4,338	1,365	3,794	3,035
86	2,958	3,743	4,391	1,381	3,842	3,074
87	2,993	3,785	4,442	1,398	3,887	3,111
88	3,028	3,831	4,496	1,413	3,934	3,151
89	3,064	3,877	4,550	1,431	3,980	3,191
90	3,102	3,922	4,603	1,447	4,027	3,230
91	3,138	3,970	4,659	1,466	4,076	3,274
92	3,177	4,018	4,714	1,481	4,125	3,315
93	3,215	4,066	4,771	1,501	4,172	3,357
94	3,254	4,114	4,830	1,521	4,224	3,400
95	3,294	4,164	4,889	1,537	4,276	3,443
96	3,331	4,214	4,947	1,557	4,328	3,490
97	3,374	4,267	5,008	1,575	4,380	3,531
98	3,413	4,317	5,067	1,595	4,432	3,578
99	3,454	4,368	5,127	1,611	4,483	3,625

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

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

To calculate a Household discount:

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

Modal premium x .95 = discounted premium

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

Continental Life Insurance Company of Brentwood, Tennessee

Annual Attained Age Premiums

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

Rates Effective 9/1/2016

Attained	Preferred					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	2,913	3,686	4,325	n/a	n/a	3,034
65	1,531	1,936	2,274	715	1,990	1,514
66	1,591	2,012	2,362	743	2,067	1,575
67	1,653	2,090	2,455	772	2,147	1,641
68	1,718	2,172	2,550	802	2,231	1,708
69	1,785	2,257	2,650	833	2,317	1,776
70	1,853	2,345	2,752	866	2,407	1,850
71	1,926	2,438	2,861	898	2,502	1,928
72	2,003	2,534	2,972	936	2,600	2,012
73	2,081	2,633	3,091	970	2,704	2,100
74	2,164	2,738	3,213	1,010	2,810	2,190
75	2,252	2,847	3,340	1,050	2,922	2,281
76	2,314	2,927	3,436	1,080	3,005	2,355
77	2,380	3,010	3,532	1,111	3,090	2,433
78	2,447	3,096	3,633	1,143	3,178	2,512
79	2,517	3,183	3,736	1,175	3,266	2,590
80	2,588	3,271	3,839	1,208	3,357	2,672
81	2,618	3,311	3,887	1,224	3,399	2,707
82	2,650	3,351	3,933	1,240	3,439	2,743
83	2,682	3,390	3,980	1,249	3,481	2,778
84	2,715	3,432	4,028	1,265	3,523	2,815
85	2,745	3,472	4,075	1,283	3,565	2,850
86	2,779	3,516	4,124	1,297	3,608	2,887
87	2,812	3,556	4,174	1,313	3,651	2,923
88	2,846	3,599	4,224	1,329	3,695	2,961
89	2,879	3,642	4,275	1,344	3,738	2,999
90	2,913	3,686	4,325	1,359	3,784	3,034
91	2,948	3,730	4,377	1,376	3,830	3,074
92	2,985	3,775	4,430	1,393	3,875	3,113
93	3,020	3,820	4,484	1,410	3,921	3,151
94	3,056	3,865	4,538	1,427	3,970	3,194
95	3,094	3,913	4,592	1,443	4,016	3,234
96	3,131	3,959	4,647	1,464	4,065	3,278
97	3,168	4,006	4,704	1,480	4,115	3,318
98	3,207	4,055	4,760	1,497	4,164	3,360
99	3,245	4,104	4,817	1,514	4,213	3,403

Attained	Standard					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	3,234	4,089	4,799	n/a	n/a	3,368
65	1,701	2,150	2,523	793	2,206	1,680
66	1,768	2,234	2,622	824	2,292	1,749
67	1,835	2,320	2,723	856	2,383	1,821
68	1,907	2,411	2,830	891	2,475	1,896
69	1,981	2,505	2,939	925	2,572	1,973
70	2,058	2,603	3,054	961	2,672	2,053
71	2,140	2,706	3,176	998	2,778	2,141
72	2,224	2,813	3,300	1,038	2,887	2,234
73	2,312	2,924	3,431	1,077	3,001	2,329
74	2,402	3,039	3,565	1,122	3,118	2,431
75	2,497	3,157	3,706	1,166	3,243	2,533
76	2,569	3,249	3,814	1,198	3,335	2,613
77	2,641	3,339	3,920	1,233	3,429	2,701
78	2,717	3,436	4,032	1,268	3,526	2,786
79	2,794	3,532	4,147	1,305	3,625	2,874
80	2,872	3,632	4,261	1,341	3,728	2,967
81	2,907	3,675	4,314	1,358	3,773	3,005
82	2,941	3,721	4,366	1,375	3,820	3,045
83	2,976	3,765	4,418	1,387	3,864	3,082
84	3,011	3,808	4,470	1,405	3,911	3,124
85	3,048	3,855	4,524	1,424	3,956	3,165
86	3,084	3,903	4,579	1,440	4,006	3,205
87	3,121	3,947	4,632	1,458	4,053	3,244
88	3,157	3,994	4,688	1,474	4,102	3,285
89	3,195	4,043	4,745	1,492	4,150	3,327
90	3,234	4,089	4,799	1,509	4,199	3,368
91	3,272	4,139	4,858	1,529	4,250	3,414
92	3,312	4,189	4,915	1,545	4,302	3,456
93	3,353	4,240	4,975	1,565	4,351	3,500
94	3,393	4,290	5,036	1,586	4,404	3,545
95	3,434	4,342	5,098	1,603	4,459	3,590
96	3,473	4,394	5,158	1,624	4,513	3,639
97	3,518	4,449	5,222	1,642	4,568	3,682
98	3,559	4,502	5,284	1,663	4,621	3,731
99	3,601	4,554	5,346	1,680	4,675	3,780

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

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

To calculate a Household discount:

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

Modal premium x .95 = discounted premium

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

Continental Life Insurance Company of Brentwood, Tennessee

Annual Attained Age Premiums

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

Rates Effective 9/1/2016

Attained	Preferred					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	3,272	4,139	4,857	n/a	n/a	3,407
65	1,719	2,174	2,554	803	2,234	1,700
66	1,786	2,259	2,652	834	2,321	1,769
67	1,856	2,347	2,756	867	2,411	1,843
68	1,929	2,439	2,863	900	2,506	1,918
69	2,004	2,535	2,976	936	2,602	1,995
70	2,081	2,633	3,091	973	2,703	2,077
71	2,163	2,737	3,213	1,008	2,810	2,165
72	2,250	2,845	3,337	1,051	2,919	2,259
73	2,337	2,956	3,472	1,089	3,036	2,358
74	2,430	3,074	3,609	1,134	3,155	2,459
75	2,529	3,198	3,751	1,180	3,281	2,562
76	2,599	3,287	3,858	1,212	3,374	2,644
77	2,673	3,380	3,966	1,248	3,470	2,732
78	2,748	3,477	4,080	1,284	3,569	2,821
79	2,826	3,574	4,195	1,319	3,667	2,909
80	2,906	3,673	4,311	1,356	3,770	3,000
81	2,940	3,718	4,365	1,374	3,817	3,040
82	2,976	3,763	4,417	1,392	3,862	3,080
83	3,011	3,807	4,469	1,403	3,909	3,119
84	3,048	3,854	4,524	1,421	3,957	3,161
85	3,083	3,899	4,576	1,441	4,003	3,200
86	3,121	3,948	4,631	1,456	4,051	3,241
87	3,158	3,994	4,687	1,474	4,100	3,283
88	3,196	4,042	4,743	1,492	4,150	3,325
89	3,233	4,089	4,800	1,510	4,198	3,367
90	3,272	4,139	4,857	1,526	4,250	3,407
91	3,310	4,188	4,916	1,545	4,300	3,452
92	3,352	4,239	4,974	1,565	4,351	3,496
93	3,391	4,289	5,035	1,584	4,403	3,539
94	3,432	4,340	5,096	1,603	4,458	3,587
95	3,474	4,394	5,157	1,621	4,510	3,632
96	3,515	4,446	5,218	1,644	4,565	3,681
97	3,558	4,499	5,283	1,662	4,621	3,726
98	3,602	4,554	5,346	1,681	4,676	3,773
99	3,644	4,609	5,409	1,700	4,731	3,821

Attained	Standard					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	3,632	4,592	5,390	n/a	n/a	3,783
65	1,910	2,414	2,833	891	2,477	1,886
66	1,985	2,508	2,944	925	2,574	1,965
67	2,060	2,606	3,058	962	2,676	2,045
68	2,141	2,707	3,178	1,000	2,780	2,129
69	2,225	2,813	3,300	1,038	2,888	2,215
70	2,311	2,924	3,429	1,080	3,000	2,306
71	2,403	3,039	3,566	1,121	3,119	2,404
72	2,498	3,159	3,706	1,166	3,241	2,508
73	2,596	3,284	3,852	1,210	3,370	2,615
74	2,698	3,413	4,003	1,260	3,502	2,730
75	2,804	3,546	4,162	1,310	3,641	2,844
76	2,885	3,648	4,283	1,345	3,746	2,935
77	2,966	3,750	4,402	1,385	3,851	3,033
78	3,051	3,858	4,528	1,423	3,959	3,129
79	3,137	3,966	4,657	1,466	4,070	3,228
80	3,225	4,078	4,785	1,506	4,187	3,332
81	3,265	4,126	4,844	1,525	4,237	3,374
82	3,303	4,179	4,903	1,544	4,289	3,420
83	3,341	4,228	4,961	1,558	4,339	3,461
84	3,381	4,276	5,020	1,578	4,392	3,509
85	3,422	4,329	5,080	1,599	4,443	3,554
86	3,463	4,383	5,142	1,617	4,499	3,599
87	3,504	4,432	5,202	1,637	4,551	3,643
88	3,546	4,485	5,265	1,655	4,606	3,689
89	3,588	4,540	5,328	1,676	4,661	3,736
90	3,632	4,592	5,390	1,695	4,716	3,783
91	3,674	4,648	5,455	1,717	4,773	3,833
92	3,720	4,705	5,520	1,734	4,831	3,881
93	3,765	4,761	5,587	1,758	4,885	3,931
94	3,810	4,817	5,655	1,781	4,946	3,981
95	3,857	4,876	5,725	1,800	5,007	4,032
96	3,900	4,935	5,792	1,823	5,068	4,087
97	3,951	4,996	5,864	1,844	5,129	4,135
98	3,996	5,055	5,933	1,867	5,190	4,189
99	4,044	5,114	6,003	1,886	5,250	4,244

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

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

To calculate a Household discount:

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

Modal premium x .95 = discounted premium

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

Continental Life Insurance Company of Brentwood, Tennessee

Annual Attained Age Premiums

For Use in ZIP Codes: Rest of State

Rates Effective 9/1/2016

Attained	Preferred					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	2,269	2,870	3,368	n/a	n/a	2,363
65	1,192	1,508	1,771	557	1,549	1,179
66	1,239	1,567	1,839	579	1,609	1,226
67	1,287	1,627	1,911	601	1,672	1,278
68	1,338	1,691	1,986	624	1,738	1,330
69	1,390	1,758	2,063	649	1,804	1,383
70	1,443	1,826	2,143	675	1,874	1,440
71	1,500	1,898	2,228	699	1,948	1,501
72	1,560	1,973	2,314	729	2,024	1,567
73	1,621	2,050	2,407	755	2,105	1,635
74	1,685	2,132	2,502	787	2,188	1,705
75	1,754	2,217	2,601	818	2,275	1,777
76	1,802	2,279	2,675	841	2,340	1,834
77	1,853	2,344	2,750	865	2,406	1,894
78	1,906	2,411	2,829	890	2,475	1,956
79	1,960	2,479	2,909	915	2,543	2,017
80	2,015	2,547	2,990	941	2,614	2,081
81	2,039	2,578	3,027	953	2,647	2,108
82	2,063	2,610	3,063	965	2,678	2,136
83	2,088	2,640	3,099	973	2,710	2,163
84	2,114	2,672	3,137	985	2,744	2,192
85	2,138	2,704	3,173	999	2,776	2,219
86	2,164	2,738	3,211	1,010	2,809	2,248
87	2,190	2,769	3,250	1,022	2,843	2,276
88	2,216	2,803	3,289	1,035	2,878	2,306
89	2,242	2,836	3,329	1,047	2,911	2,335
90	2,269	2,870	3,368	1,058	2,947	2,363
91	2,295	2,904	3,409	1,072	2,982	2,394
92	2,325	2,939	3,449	1,085	3,017	2,424
93	2,351	2,974	3,491	1,098	3,053	2,454
94	2,380	3,010	3,534	1,112	3,091	2,487
95	2,409	3,047	3,576	1,124	3,127	2,518
96	2,438	3,083	3,619	1,140	3,165	2,553
97	2,467	3,120	3,663	1,152	3,204	2,584
98	2,498	3,158	3,707	1,166	3,242	2,616
99	2,527	3,196	3,751	1,179	3,280	2,650

Attained	Standard					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	2,518	3,184	3,737	n/a	n/a	2,623
65	1,324	1,674	1,965	618	1,718	1,308
66	1,377	1,739	2,042	641	1,785	1,362
67	1,429	1,807	2,120	667	1,855	1,418
68	1,485	1,877	2,204	694	1,928	1,476
69	1,543	1,950	2,289	720	2,003	1,536
70	1,603	2,027	2,378	749	2,081	1,599
71	1,666	2,107	2,473	777	2,163	1,667
72	1,732	2,191	2,570	808	2,248	1,739
73	1,800	2,277	2,671	839	2,337	1,814
74	1,871	2,366	2,776	874	2,428	1,893
75	1,945	2,459	2,886	908	2,525	1,972
76	2,001	2,530	2,970	933	2,597	2,035
77	2,057	2,600	3,052	960	2,670	2,103
78	2,116	2,675	3,140	987	2,746	2,170
79	2,176	2,750	3,229	1,017	2,822	2,238
80	2,236	2,828	3,318	1,044	2,903	2,310
81	2,264	2,861	3,359	1,057	2,938	2,340
82	2,290	2,898	3,400	1,071	2,974	2,371
83	2,317	2,932	3,440	1,080	3,009	2,400
84	2,345	2,965	3,481	1,094	3,046	2,433
85	2,373	3,002	3,523	1,109	3,081	2,464
86	2,402	3,039	3,565	1,121	3,120	2,496
87	2,430	3,073	3,607	1,135	3,156	2,526
88	2,459	3,110	3,651	1,148	3,194	2,558
89	2,488	3,148	3,695	1,162	3,232	2,591
90	2,518	3,184	3,737	1,175	3,270	2,623
91	2,548	3,223	3,783	1,190	3,310	2,658
92	2,579	3,262	3,828	1,203	3,350	2,691
93	2,611	3,301	3,874	1,219	3,388	2,726
94	2,642	3,340	3,922	1,235	3,430	2,761
95	2,674	3,381	3,970	1,248	3,472	2,796
96	2,705	3,422	4,017	1,264	3,514	2,834
97	2,740	3,465	4,066	1,279	3,557	2,867
98	2,771	3,506	4,114	1,295	3,599	2,905
99	2,804	3,546	4,163	1,308	3,640	2,943

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

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

To calculate a Household discount:

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

Modal premium x .95 = discounted premium

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

PREMIUM INFORMATION

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

HOUSEHOLD DISCOUNT

In order to be eligible for the Household discount under a Continental Life Insurance Company of Brentwood, Tennessee Medicare supplement plan, you must apply for a Medicare supplement plan at the same time as another Medicare eligible adult or the other Medicare eligible adult must currently be covered by a Continental Life Insurance Company of Brentwood, Tennessee Medicare supplement policy. The Medicare eligible adult must be either (a) your spouse; (b) be someone with whom you are in a civil union partnership; or (c) be a permanent resident in your home. The household discount will only be applicable if a policy for each applicant is issued. The discounted rate will be 5 percent lower than the individual rates and will apply as long as both policies remain in force.

DISCLOSURES

Use this outline to compare benefits and premium among policies.

READ YOUR POLICY VERY CAREFULLY

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to Continental Life Insurance Company of Brentwood, Tennessee, P.O. Box 14770, Lexington, KY 40512-4770. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all your payments.

POLICY REPLACEMENT

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

NOTICE

The policy may not cover all of your medical costs.

Neither Continental Life Insurance Company of Brentwood, Tennessee nor its agents are connected with Medicare.

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult *Medicare & You* for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT

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

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

THE FOLLOWING CHARTS DESCRIBE PLANS A, B, F, HIGH DEDUCTIBLE F, G and N OFFERED BY CONTINENTAL LIFE INSURANCE COMPANY OF BRENTWOOD, TENNESSEE.

PLAN A

MEDICARE (PART A) – HOSPITAL SERVICES – PER CALENDAR YEAR

*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 $1288	$0	$1288 (Part A Deductible)
61st thru 90th day	All but $322 a day	$322 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $644 a day	$644 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 $161 a day	$0	Up to $161 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 $166 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 $166 of Medicare-Approved amounts*	$0	$0	$166 (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 $166 of Medicare-Approved amounts*	$0	$0	$166 (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 $166 of Medicare Approved amounts*	$0	$0	$166 (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 $1288	$1288 (Part A Deductible)	$0
61st thru 90th day	All but $322 a day	$322 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $644 a day	$644 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 $161 a day	$0	Up to $161 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 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 $166 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 $166 of Medicare-Approved amounts*	$0	$0	$166 (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 $166 of Medicare-Approved amounts*	$0	$0	$166 (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 $166 of Medicare Approved amounts*	$0	$0	$166 (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 $1288	$1288 (Part A Deductible)	$0
61st thru 90th day	All but $322 a day	$322 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $644 a day	$644 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 $161 a day	Up to $161 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 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 $166 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 $166 of Medicare-Approved amounts*	$0	$166 (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 $166 of Medicare-Approved amounts*	$0	$166 (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 $166 of Medicare Approved amounts*	$0	$166 (Part B Deductible)	$0
•Remainder of Medicare Approved amounts	80%	20%	$0

PLAN F

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

HIGH DEDUCTIBLE PLAN F

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

*****This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2180 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses are $2180. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.**

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2180 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2180 DEDUCTIBLE*** YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1288	$1288 (Part A Deductible)	$0
61st thru 90th day	All but $322 a day	$322 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $644 a day	$644 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 $161 a day	Up to $161 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 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

HIGH DEDUCTIBLE PLAN F

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

*Once you have been billed $166 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

*****This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2180 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses are $2180. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.**

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2180 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2180 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 test, durable medical equipment			
First $166 of Medicare-Approved amounts*	$0	$166 (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 $166 of Medicare-Approved amounts*	$0	$166 (Part B Deductible)	$0
Remainder of Medicare-Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

HIGH DEDUCTIBLE PLAN F

PARTS A & B

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2180 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2180 DEDUCTIBLE*** YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
•Medically necessary skilled care services and medical supplies	100%	$0	$0
•Durable medical equipment			
•First $166 of Medicare Approved amounts*	$0	$166 (Part B Deductible)	$0
•Remainder of Medicare Approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2180 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2180 DEDUCTIBLE** YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN G

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1288	$1288 (Part A Deductible)	$0
61st thru 90th day	All but $322 a day	$322 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $644 a day	$644 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 $161 a day	Up to $161 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness services	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN G

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

*Once you have been billed $166 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 $166 of Medicare-Approved amounts*	$0	$0	$166 (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 $166 of Medicare-Approved amounts*	$0	$0	$166 (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 $166 of Medicare Approved amounts*	$0	$0	$166 (Part B Deductible)
•Remainder of Medicare Approved amounts	80%	20%	$0

PLAN G

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN N

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1288	$1288 (Part A Deductible)	$0
61st thru 90th day	All but $322 a day	$322 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $644 a day	$644 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 $161 a day	Up to $161 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness services	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare co-payment/ coinsurance	$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN N

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

*Once you have been billed $166 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 $166 of Medicare-Approved amounts*	$0	$0	$166 (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 $166 of Medicare-Approved amounts*	$0	$0	$166 (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 $166 of Medicare Approved amounts*	$0	$0	$166 (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