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**

Texas

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.

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		

*Plans 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: 733, 750-753, 760, 761, 774, 776, 777, 782, 784, 793, 794

Female Rates

Attained	Preferred					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	7,828	n/a	n/a	n/a	n/a	n/a
65	1,498	1,542	1,829	669	1,275	1,142
66	1,498	1,542	1,829	669	1,275	1,142
67	1,498	1,542	1,829	669	1,275	1,142
68	1,569	1,618	1,921	703	1,337	1,199
69	1,641	1,688	1,994	729	1,398	1,254
70	1,708	1,758	2,067	758	1,454	1,303
71	1,771	1,824	2,140	783	1,509	1,352
72	1,832	1,885	2,206	806	1,561	1,401
73	1,891	1,947	2,268	830	1,609	1,443
74	1,945	2,002	2,322	851	1,657	1,486
75	1,994	2,054	2,377	869	1,699	1,524
76	2,039	2,100	2,423	888	1,737	1,558
77	2,082	2,145	2,463	902	1,774	1,593
78	2,125	2,187	2,502	917	1,809	1,623
79	2,160	2,225	2,538	929	1,840	1,650
80	2,194	2,259	2,568	942	1,870	1,677
81	2,225	2,292	2,602	953	1,896	1,702
82	2,256	2,324	2,637	965	1,923	1,725
83	2,284	2,354	2,667	978	1,946	1,747
84	2,314	2,382	2,698	988	1,971	1,771
85	2,343	2,410	2,729	999	1,995	1,789
86	2,369	2,438	2,758	1,009	2,017	1,809
87	2,392	2,463	2,785	1,020	2,038	1,827
88	2,415	2,487	2,812	1,029	2,060	1,847
89	2,439	2,512	2,832	1,037	2,079	1,865
90	2,460	2,533	2,858	1,047	2,096	1,881
91	2,481	2,555	2,881	1,055	2,115	1,896
92	2,501	2,576	2,898	1,061	2,130	1,910
93	2,519	2,593	2,918	1,067	2,144	1,923
94	2,535	2,609	2,933	1,074	2,159	1,935
95	2,547	2,623	2,946	1,080	2,172	1,946
96	2,565	2,639	2,964	1,086	2,184	1,958
97	2,579	2,654	2,977	1,093	2,198	1,970
98	2,594	2,671	2,993	1,096	2,209	1,980
99	2,609	2,685	3,006	1,099	2,223	1,994

Attained	Standard					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	8,697	n/a	n/a	n/a	n/a	n/a
65	1,663	1,711	2,032	743	1,417	1,270
66	1,663	1,711	2,032	743	1,417	1,270
67	1,663	1,711	2,032	743	1,417	1,270
68	1,745	1,796	2,132	782	1,487	1,334
69	1,823	1,876	2,218	813	1,555	1,394
70	1,895	1,953	2,298	840	1,612	1,449
71	1,969	2,026	2,377	869	1,676	1,503
72	2,037	2,096	2,451	898	1,734	1,556
73	2,100	2,162	2,519	922	1,791	1,604
74	2,160	2,225	2,582	946	1,840	1,651
75	2,215	2,282	2,642	966	1,888	1,691
76	2,268	2,333	2,691	986	1,930	1,731
77	2,314	2,382	2,738	1,003	1,972	1,771
78	2,359	2,429	2,782	1,019	2,010	1,802
79	2,400	2,473	2,820	1,032	2,045	1,832
80	2,439	2,512	2,855	1,045	2,079	1,865
81	2,475	2,547	2,892	1,059	2,108	1,891
82	2,507	2,583	2,929	1,074	2,137	1,917
83	2,540	2,617	2,965	1,086	2,164	1,940
84	2,569	2,647	2,998	1,096	2,192	1,964
85	2,601	2,678	3,034	1,110	2,216	1,987
86	2,632	2,709	3,065	1,121	2,243	2,010
87	2,658	2,737	3,095	1,133	2,264	2,031
88	2,684	2,765	3,121	1,143	2,289	2,050
89	2,709	2,790	3,149	1,153	2,308	2,070
90	2,736	2,815	3,174	1,162	2,330	2,088
91	2,757	2,837	3,197	1,171	2,349	2,106
92	2,778	2,861	3,223	1,180	2,367	2,123
93	2,798	2,881	3,242	1,187	2,384	2,138
94	2,816	2,900	3,258	1,194	2,399	2,153
95	2,832	2,915	3,274	1,198	2,413	2,167
96	2,849	2,933	3,291	1,205	2,427	2,176
97	2,866	2,952	3,307	1,212	2,440	2,187
98	2,882	2,968	3,326	1,219	2,455	2,201
99	2,899	2,987	3,343	1,224	2,470	2,215

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: 733, 750-753, 760, 761, 774, 776, 777, 782, 784, 793, 794

Male Rates

Attained Age	Preferred					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	9,003	n/a	n/a	n/a	n/a	n/a
65	1,720	1,772	2,105	771	1,466	1,313
66	1,720	1,772	2,105	771	1,466	1,313
67	1,720	1,772	2,105	771	1,466	1,313
68	1,807	1,860	2,206	806	1,536	1,380
69	1,888	1,944	2,294	841	1,608	1,441
70	1,962	2,021	2,378	871	1,671	1,500
71	2,037	2,096	2,460	900	1,734	1,556
72	2,106	2,170	2,538	929	1,795	1,610
73	2,172	2,236	2,605	953	1,853	1,661
74	2,236	2,302	2,676	980	1,906	1,708
75	2,292	2,360	2,735	1,001	1,954	1,753
76	2,345	2,414	2,785	1,020	1,999	1,792
77	2,395	2,468	2,832	1,037	2,040	1,830
78	2,441	2,514	2,878	1,055	2,080	1,868
79	2,484	2,558	2,920	1,067	2,116	1,900
80	2,523	2,600	2,958	1,082	2,149	1,929
81	2,560	2,636	2,993	1,096	2,182	1,956
82	2,596	2,673	3,034	1,110	2,210	1,981
83	2,630	2,708	3,068	1,122	2,240	2,009
84	2,660	2,739	3,103	1,136	2,268	2,032
85	2,691	2,772	3,137	1,150	2,294	2,057
86	2,721	2,803	3,171	1,162	2,320	2,080
87	2,752	2,834	3,204	1,172	2,344	2,101
88	2,780	2,862	3,232	1,185	2,368	2,124
89	2,807	2,891	3,258	1,194	2,390	2,144
90	2,831	2,913	3,284	1,203	2,412	2,162
91	2,852	2,937	3,310	1,212	2,432	2,179
92	2,876	2,960	3,333	1,221	2,450	2,195
93	2,898	2,984	3,353	1,227	2,468	2,211
94	2,914	3,002	3,373	1,234	2,483	2,226
95	2,929	3,019	3,389	1,242	2,498	2,239
96	2,946	3,035	3,405	1,248	2,512	2,252
97	2,965	3,053	3,425	1,254	2,527	2,267
98	2,983	3,071	3,441	1,262	2,542	2,279
99	3,002	3,090	3,459	1,266	2,556	2,294

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

Attained Age	Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	10,007	n/a	n/a	n/a	n/a	n/a
65	1,910	1,967	2,338	856	1,628	1,461
66	1,910	1,967	2,338	856	1,628	1,461
67	1,910	1,967	2,338	856	1,628	1,461
68	2,007	2,067	2,454	898	1,709	1,533
69	2,095	2,157	2,548	933	1,786	1,602
70	2,179	2,245	2,642	966	1,857	1,666
71	2,260	2,329	2,735	1,001	1,927	1,728
72	2,343	2,410	2,820	1,032	1,994	1,789
73	2,414	2,486	2,896	1,060	2,057	1,845
74	2,484	2,558	2,969	1,088	2,116	1,900
75	2,547	2,623	3,038	1,112	2,169	1,945
76	2,605	2,682	3,096	1,133	2,220	1,992
77	2,662	2,743	3,149	1,153	2,268	2,032
78	2,713	2,793	3,197	1,170	2,310	2,072
79	2,761	2,844	3,243	1,187	2,352	2,108
80	2,805	2,889	3,283	1,203	2,389	2,144
81	2,846	2,930	3,327	1,219	2,423	2,172
82	2,883	2,969	3,368	1,233	2,456	2,203
83	2,920	3,007	3,410	1,249	2,489	2,232
84	2,958	3,044	3,449	1,263	2,519	2,261
85	2,991	3,081	3,487	1,278	2,550	2,285
86	3,026	3,115	3,522	1,289	2,578	2,310
87	3,054	3,148	3,556	1,302	2,605	2,336
88	3,088	3,179	3,590	1,314	2,630	2,360
89	3,117	3,209	3,623	1,326	2,655	2,382
90	3,145	3,237	3,652	1,337	2,681	2,404
91	3,171	3,265	3,679	1,347	2,703	2,423
92	3,195	3,290	3,702	1,355	2,721	2,443
93	3,215	3,311	3,725	1,364	2,740	2,459
94	3,236	3,333	3,746	1,371	2,759	2,474
95	3,257	3,355	3,764	1,379	2,775	2,487
96	3,275	3,374	3,786	1,385	2,791	2,502
97	3,295	3,395	3,803	1,392	2,807	2,517
98	3,317	3,414	3,823	1,400	2,823	2,533
99	3,335	3,435	3,842	1,409	2,842	2,547

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: 770-773, 775

Female Rates

Attained Age	Preferred					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	8,236	n/a	n/a	n/a	n/a	n/a
65	1,577	1,623	1,924	704	1,342	1,202
66	1,577	1,623	1,924	704	1,342	1,202
67	1,577	1,623	1,924	704	1,342	1,202
68	1,650	1,702	2,021	739	1,407	1,262
69	1,727	1,776	2,098	767	1,471	1,319
70	1,797	1,850	2,174	797	1,529	1,371
71	1,863	1,919	2,252	824	1,588	1,423
72	1,928	1,983	2,321	848	1,642	1,474
73	1,989	2,049	2,386	874	1,693	1,519
74	2,046	2,107	2,443	895	1,744	1,563
75	2,098	2,161	2,501	915	1,787	1,603
76	2,145	2,209	2,549	934	1,827	1,640
77	2,190	2,257	2,592	949	1,867	1,676
78	2,236	2,301	2,633	964	1,903	1,707
79	2,272	2,341	2,670	978	1,936	1,736
80	2,309	2,376	2,702	991	1,967	1,764
81	2,341	2,412	2,738	1,003	1,995	1,791
82	2,374	2,445	2,775	1,015	2,023	1,815
83	2,403	2,477	2,806	1,029	2,047	1,838
84	2,435	2,506	2,839	1,039	2,074	1,863
85	2,465	2,536	2,871	1,051	2,099	1,883
86	2,493	2,565	2,902	1,061	2,122	1,903
87	2,517	2,592	2,931	1,073	2,144	1,923
88	2,541	2,617	2,958	1,083	2,167	1,943
89	2,566	2,643	2,980	1,091	2,188	1,963
90	2,588	2,666	3,007	1,101	2,206	1,980
91	2,610	2,689	3,031	1,110	2,225	1,995
92	2,632	2,710	3,049	1,117	2,241	2,010
93	2,650	2,729	3,070	1,123	2,255	2,023
94	2,667	2,745	3,086	1,130	2,271	2,036
95	2,680	2,760	3,100	1,136	2,286	2,047
96	2,698	2,777	3,118	1,142	2,298	2,061
97	2,714	2,793	3,133	1,150	2,312	2,073
98	2,730	2,811	3,150	1,153	2,324	2,084
99	2,745	2,825	3,163	1,157	2,339	2,098

Attained Age	Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	9,151	n/a	n/a	n/a	n/a	n/a
65	1,750	1,800	2,138	782	1,491	1,336
66	1,750	1,800	2,138	782	1,491	1,336
67	1,750	1,800	2,138	782	1,491	1,336
68	1,836	1,890	2,243	823	1,565	1,404
69	1,918	1,974	2,334	855	1,636	1,467
70	1,994	2,055	2,418	883	1,696	1,525
71	2,072	2,132	2,501	915	1,763	1,581
72	2,143	2,206	2,579	945	1,825	1,637
73	2,209	2,275	2,650	970	1,884	1,688
74	2,272	2,341	2,716	996	1,936	1,738
75	2,330	2,401	2,779	1,016	1,987	1,779
76	2,386	2,455	2,831	1,037	2,030	1,821
77	2,435	2,506	2,881	1,055	2,075	1,863
78	2,482	2,556	2,927	1,072	2,115	1,896
79	2,525	2,602	2,967	1,085	2,151	1,928
80	2,566	2,643	3,004	1,100	2,188	1,963
81	2,604	2,680	3,043	1,114	2,218	1,989
82	2,638	2,718	3,082	1,130	2,248	2,017
83	2,673	2,754	3,119	1,142	2,277	2,041
84	2,703	2,785	3,154	1,153	2,306	2,067
85	2,737	2,818	3,192	1,168	2,332	2,091
86	2,770	2,851	3,225	1,180	2,360	2,115
87	2,796	2,880	3,256	1,192	2,382	2,137
88	2,824	2,909	3,284	1,203	2,408	2,157
89	2,851	2,935	3,313	1,214	2,428	2,178
90	2,879	2,962	3,340	1,222	2,451	2,197
91	2,900	2,985	3,364	1,232	2,472	2,216
92	2,923	3,010	3,392	1,241	2,490	2,234
93	2,944	3,031	3,411	1,249	2,508	2,249
94	2,963	3,052	3,428	1,256	2,524	2,265
95	2,980	3,067	3,445	1,261	2,539	2,280
96	2,997	3,086	3,463	1,268	2,553	2,289
97	3,015	3,106	3,480	1,275	2,568	2,301
98	3,032	3,123	3,499	1,283	2,583	2,316
99	3,050	3,142	3,517	1,287	2,599	2,330

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: 770-773, 775

Male Rates

Attained Age	Preferred					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	9,473	n/a	n/a	n/a	n/a	n/a
65	1,810	1,865	2,214	811	1,543	1,382
66	1,810	1,865	2,214	811	1,543	1,382
67	1,810	1,865	2,214	811	1,543	1,382
68	1,901	1,957	2,321	848	1,617	1,452
69	1,987	2,045	2,414	885	1,692	1,516
70	2,064	2,126	2,502	916	1,758	1,578
71	2,143	2,206	2,588	947	1,825	1,637
72	2,216	2,283	2,670	978	1,889	1,694
73	2,286	2,352	2,741	1,003	1,949	1,747
74	2,352	2,422	2,816	1,031	2,005	1,797
75	2,412	2,483	2,877	1,053	2,056	1,844
76	2,467	2,540	2,931	1,073	2,103	1,885
77	2,520	2,597	2,980	1,091	2,147	1,925
78	2,569	2,645	3,029	1,110	2,189	1,965
79	2,614	2,691	3,072	1,123	2,226	1,999
80	2,655	2,736	3,112	1,139	2,261	2,029
81	2,693	2,773	3,150	1,153	2,295	2,058
82	2,731	2,812	3,192	1,168	2,326	2,085
83	2,767	2,850	3,228	1,181	2,357	2,114
84	2,799	2,882	3,265	1,195	2,386	2,138
85	2,831	2,916	3,301	1,210	2,414	2,165
86	2,863	2,949	3,336	1,222	2,441	2,189
87	2,896	2,981	3,371	1,233	2,466	2,211
88	2,925	3,012	3,400	1,246	2,491	2,235
89	2,954	3,042	3,428	1,256	2,514	2,255
90	2,979	3,065	3,456	1,266	2,537	2,275
91	3,001	3,090	3,482	1,275	2,559	2,293
92	3,026	3,115	3,507	1,285	2,577	2,310
93	3,049	3,140	3,528	1,291	2,597	2,327
94	3,066	3,158	3,549	1,298	2,612	2,343
95	3,082	3,176	3,566	1,307	2,628	2,356
96	3,100	3,193	3,583	1,313	2,643	2,369
97	3,119	3,213	3,603	1,319	2,658	2,385
98	3,139	3,231	3,620	1,327	2,674	2,398
99	3,158	3,251	3,640	1,332	2,690	2,414

Attained Age	Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	10,529	n/a	n/a	n/a	n/a	n/a
65	2,010	2,069	2,460	900	1,713	1,537
66	2,010	2,069	2,460	900	1,713	1,537
67	2,010	2,069	2,460	900	1,713	1,537
68	2,111	2,174	2,582	945	1,798	1,613
69	2,205	2,270	2,681	981	1,879	1,686
70	2,293	2,362	2,779	1,016	1,954	1,753
71	2,378	2,450	2,877	1,053	2,028	1,819
72	2,465	2,536	2,967	1,085	2,098	1,883
73	2,540	2,616	3,047	1,116	2,165	1,941
74	2,614	2,691	3,124	1,145	2,226	1,999
75	2,680	2,760	3,197	1,170	2,282	2,046
76	2,741	2,822	3,257	1,192	2,335	2,096
77	2,801	2,886	3,313	1,214	2,386	2,138
78	2,854	2,939	3,364	1,231	2,431	2,180
79	2,905	2,992	3,412	1,249	2,474	2,218
80	2,951	3,040	3,455	1,266	2,513	2,255
81	2,995	3,083	3,501	1,283	2,549	2,286
82	3,033	3,124	3,544	1,297	2,585	2,318
83	3,072	3,164	3,588	1,314	2,618	2,349
84	3,112	3,203	3,629	1,329	2,650	2,379
85	3,147	3,242	3,669	1,344	2,683	2,404
86	3,184	3,278	3,706	1,356	2,713	2,431
87	3,214	3,312	3,741	1,370	2,741	2,458
88	3,249	3,344	3,778	1,383	2,767	2,483
89	3,279	3,376	3,812	1,395	2,794	2,506
90	3,309	3,406	3,843	1,407	2,821	2,529
91	3,336	3,435	3,871	1,417	2,844	2,549
92	3,361	3,462	3,895	1,425	2,863	2,570
93	3,383	3,484	3,919	1,435	2,883	2,587
94	3,405	3,507	3,941	1,442	2,903	2,603
95	3,427	3,530	3,960	1,451	2,920	2,617
96	3,446	3,550	3,983	1,457	2,937	2,633
97	3,467	3,572	4,001	1,464	2,954	2,649
98	3,490	3,592	4,022	1,473	2,971	2,666
99	3,509	3,614	4,043	1,482	2,990	2,680

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

Female Rates

Attained Age	Preferred					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	6,807	n/a	n/a	n/a	n/a	n/a
65	1,303	1,341	1,590	582	1,109	993
66	1,303	1,341	1,590	582	1,109	993
67	1,303	1,341	1,590	582	1,109	993
68	1,364	1,407	1,670	611	1,163	1,043
69	1,427	1,468	1,734	634	1,216	1,090
70	1,485	1,529	1,797	659	1,264	1,133
71	1,540	1,586	1,861	681	1,312	1,176
72	1,593	1,639	1,918	701	1,357	1,218
73	1,644	1,693	1,972	722	1,399	1,255
74	1,691	1,741	2,019	740	1,441	1,292
75	1,734	1,786	2,067	756	1,477	1,325
76	1,773	1,826	2,107	772	1,510	1,355
77	1,810	1,865	2,142	784	1,543	1,385
78	1,848	1,902	2,176	797	1,573	1,411
79	1,878	1,935	2,207	808	1,600	1,435
80	1,908	1,964	2,233	819	1,626	1,458
81	1,935	1,993	2,263	829	1,649	1,480
82	1,962	2,021	2,293	839	1,672	1,500
83	1,986	2,047	2,319	850	1,692	1,519
84	2,012	2,071	2,346	859	1,714	1,540
85	2,037	2,096	2,373	869	1,735	1,556
86	2,060	2,120	2,398	877	1,754	1,573
87	2,080	2,142	2,422	887	1,772	1,589
88	2,100	2,163	2,445	895	1,791	1,606
89	2,121	2,184	2,463	902	1,808	1,622
90	2,139	2,203	2,485	910	1,823	1,636
91	2,157	2,222	2,505	917	1,839	1,649
92	2,175	2,240	2,520	923	1,852	1,661
93	2,190	2,255	2,537	928	1,864	1,672
94	2,204	2,269	2,550	934	1,877	1,683
95	2,215	2,281	2,562	939	1,889	1,692
96	2,230	2,295	2,577	944	1,899	1,703
97	2,243	2,308	2,589	950	1,911	1,713
98	2,256	2,323	2,603	953	1,921	1,722
99	2,269	2,335	2,614	956	1,933	1,734

Attained Age	Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	7,563	n/a	n/a	n/a	n/a	n/a
65	1,446	1,488	1,767	646	1,232	1,104
66	1,446	1,488	1,767	646	1,232	1,104
67	1,446	1,488	1,767	646	1,232	1,104
68	1,517	1,562	1,854	680	1,293	1,160
69	1,585	1,631	1,929	707	1,352	1,212
70	1,648	1,698	1,998	730	1,402	1,260
71	1,712	1,762	2,067	756	1,457	1,307
72	1,771	1,823	2,131	781	1,508	1,353
73	1,826	1,880	2,190	802	1,557	1,395
74	1,878	1,935	2,245	823	1,600	1,436
75	1,926	1,984	2,297	840	1,642	1,470
76	1,972	2,029	2,340	857	1,678	1,505
77	2,012	2,071	2,381	872	1,715	1,540
78	2,051	2,112	2,419	886	1,748	1,567
79	2,087	2,150	2,452	897	1,778	1,593
80	2,121	2,184	2,483	909	1,808	1,622
81	2,152	2,215	2,515	921	1,833	1,644
82	2,180	2,246	2,547	934	1,858	1,667
83	2,209	2,276	2,578	944	1,882	1,687
84	2,234	2,302	2,607	953	1,906	1,708
85	2,262	2,329	2,638	965	1,927	1,728
86	2,289	2,356	2,665	975	1,950	1,748
87	2,311	2,380	2,691	985	1,969	1,766
88	2,334	2,404	2,714	994	1,990	1,783
89	2,356	2,426	2,738	1,003	2,007	1,800
90	2,379	2,448	2,760	1,010	2,026	1,816
91	2,397	2,467	2,780	1,018	2,043	1,831
92	2,416	2,488	2,803	1,026	2,058	1,846
93	2,433	2,505	2,819	1,032	2,073	1,859
94	2,449	2,522	2,833	1,038	2,086	1,872
95	2,463	2,535	2,847	1,042	2,098	1,884
96	2,477	2,550	2,862	1,048	2,110	1,892
97	2,492	2,567	2,876	1,054	2,122	1,902
98	2,506	2,581	2,892	1,060	2,135	1,914
99	2,521	2,597	2,907	1,064	2,148	1,926

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

Male Rates

Attained Age	Preferred					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	7,829	n/a	n/a	n/a	n/a	n/a
65	1,496	1,541	1,830	670	1,275	1,142
66	1,496	1,541	1,830	670	1,275	1,142
67	1,496	1,541	1,830	670	1,275	1,142
68	1,571	1,617	1,918	701	1,336	1,200
69	1,642	1,690	1,995	731	1,398	1,253
70	1,706	1,757	2,068	757	1,453	1,304
71	1,771	1,823	2,139	783	1,508	1,353
72	1,831	1,887	2,207	808	1,561	1,400
73	1,889	1,944	2,265	829	1,611	1,444
74	1,944	2,002	2,327	852	1,657	1,485
75	1,993	2,052	2,378	870	1,699	1,524
76	2,039	2,099	2,422	887	1,738	1,558
77	2,083	2,146	2,463	902	1,774	1,591
78	2,123	2,186	2,503	917	1,809	1,624
79	2,160	2,224	2,539	928	1,840	1,652
80	2,194	2,261	2,572	941	1,869	1,677
81	2,226	2,292	2,603	953	1,897	1,701
82	2,257	2,324	2,638	965	1,922	1,723
83	2,287	2,355	2,668	976	1,948	1,747
84	2,313	2,382	2,698	988	1,972	1,767
85	2,340	2,410	2,728	1,000	1,995	1,789
86	2,366	2,437	2,757	1,010	2,017	1,809
87	2,393	2,464	2,786	1,019	2,038	1,827
88	2,417	2,489	2,810	1,030	2,059	1,847
89	2,441	2,514	2,833	1,038	2,078	1,864
90	2,462	2,533	2,856	1,046	2,097	1,880
91	2,480	2,554	2,878	1,054	2,115	1,895
92	2,501	2,574	2,898	1,062	2,130	1,909
93	2,520	2,595	2,916	1,067	2,146	1,923
94	2,534	2,610	2,933	1,073	2,159	1,936
95	2,547	2,625	2,947	1,080	2,172	1,947
96	2,562	2,639	2,961	1,085	2,184	1,958
97	2,578	2,655	2,978	1,090	2,197	1,971
98	2,594	2,670	2,992	1,097	2,210	1,982
99	2,610	2,687	3,008	1,101	2,223	1,995

Attained Age	Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	8,702	n/a	n/a	n/a	n/a	n/a
65	1,661	1,710	2,033	744	1,416	1,270
66	1,661	1,710	2,033	744	1,416	1,270
67	1,661	1,710	2,033	744	1,416	1,270
68	1,745	1,797	2,134	781	1,486	1,333
69	1,822	1,876	2,216	811	1,553	1,393
70	1,895	1,952	2,297	840	1,615	1,449
71	1,965	2,025	2,378	870	1,676	1,503
72	2,037	2,096	2,452	897	1,734	1,556
73	2,099	2,162	2,518	922	1,789	1,604
74	2,160	2,224	2,582	946	1,840	1,652
75	2,215	2,281	2,642	967	1,886	1,691
76	2,265	2,332	2,692	985	1,930	1,732
77	2,315	2,385	2,738	1,003	1,972	1,767
78	2,359	2,429	2,780	1,017	2,009	1,802
79	2,401	2,473	2,820	1,032	2,045	1,833
80	2,439	2,512	2,855	1,046	2,077	1,864
81	2,475	2,548	2,893	1,060	2,107	1,889
82	2,507	2,582	2,929	1,072	2,136	1,916
83	2,539	2,615	2,965	1,086	2,164	1,941
84	2,572	2,647	2,999	1,098	2,190	1,966
85	2,601	2,679	3,032	1,111	2,217	1,987
86	2,631	2,709	3,063	1,121	2,242	2,009
87	2,656	2,737	3,092	1,132	2,265	2,031
88	2,685	2,764	3,122	1,143	2,287	2,052
89	2,710	2,790	3,150	1,153	2,309	2,071
90	2,735	2,815	3,176	1,163	2,331	2,090
91	2,757	2,839	3,199	1,171	2,350	2,107
92	2,778	2,861	3,219	1,178	2,366	2,124
93	2,796	2,879	3,239	1,186	2,383	2,138
94	2,814	2,898	3,257	1,192	2,399	2,151
95	2,832	2,917	3,273	1,199	2,413	2,163
96	2,848	2,934	3,292	1,204	2,427	2,176
97	2,865	2,952	3,307	1,210	2,441	2,189
98	2,884	2,969	3,324	1,217	2,455	2,203
99	2,900	2,987	3,341	1,225	2,471	2,215

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.

Premiums payable other than annually will be determined according to the following factors:

Semi-annual: 0.5200 Quarterly: 0.2650 Monthly EFT: 0.0833.

HOUSEHOLD DISCOUNT

In order to be eligible for the Household discount under a Continental Life Insurance Company of Brentwood, Tennessee Medicare supplement plan, you must apply for a Medicare supplement plan at the same time as another Medicare eligible adult or the other Medicare eligible adult must currently be covered by a Continental Life Insurance Company of Brentwood, Tennessee Medicare supplement policy. The Medicare eligible adult must be either (a) your spouse; or (b) 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 1188, Brentwood, Tennessee 37024. 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.

LIMITATIONS AND EXCLUSIONS

This policy does not cover any expenses of the type excluded by Medicare or not covered under the terms of this policy.

Benefits covered by this policy will not duplicate Medicare benefits.

We will not be liable for any loss which was caused by your committing or attempting to commit any felony or from engaging in an illegal occupation.

REFUND OF PREMIUM

The company shall refund any premium paid for the period beyond the end of the policy month in which the death or cancellation occurred. Unearned premium shall be paid in a lump sum to your estate no later than thirty (30) days after receipt of proof of death or cancellation is received by the company.

COMPLETE ANSWERS ARE VERY IMPORTANT

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

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

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

PLAN A

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

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

**$0 Indicates your liability for covered charges. You are responsible for all other non-covered charges.

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 $161.00 a day	$0	Up to $161.00 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.

**$0 Indicates your liability for covered charges. You are responsible for all other non-covered charges.

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.

**$0 Indicates your liability for covered charges. You are responsible for all other non-covered charges.

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 $161.00 a day	$0	Up to $161.00 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 $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.

**$0 Indicates your liability for covered charges. You are responsible for all other non-covered charges.

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.

**$0 Indicates your liability for covered charges. You are responsible for all other non-covered charges.

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 $161.00 a day	Up to $161.00 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 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 $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.

**$0 Indicates your liability for covered charges. You are responsible for all other non-covered charges.

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 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.

**$0 Indicates your liability for covered charges. You are responsible for all other non-covered charges.

*****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. This includes the Medicare deductibles for Part A and Part B, but does 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 $161.00 a day	Up to $161.00 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 Available as long as your doctor certifies you are terminally ill and you elect to receive these 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.

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.

**$0 Indicates your liability for covered charges. You are responsible for all other non-covered charges.

****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. This includes the Medicare deductibles for Part A and Part B, but does 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.

**$0 Indicates your liability for covered charges. You are responsible for all other non-covered charges.

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 $161.00 a day	Up to $161.00 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 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 $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.

**$0 Indicates your liability for covered charges. You are responsible for all other non-covered charges.

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.

**$0 Indicates your liability for covered charges. You are responsible for all other non-covered charges.

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 $161.00 a day	Up to $161.00 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 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 $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.

**$0 Indicates your liability for covered charges. You are responsible for all other non-covered charges.

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