Outline of coverage

Medicare Supplement Insurance

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

California

Underwritten by

Continental Life Insurance Company of Brentwood, Tennessee

An Aetna Company

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CLIMS05024CA

Rates effective: 09/2022 A

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

This chart shows the benefits included in each of the standard Medicare supplement plans.Every company must make Plan "A" available. Some plans may not be available. Only applicants **first** eligible for Medicare before 2020 may purchase Plans C, F, and high deductible F.
Note: A means 100% of the benefit is paid.

Benefits	Plans Available to All Applicants								Medicare first eligible before 2020 only	
	A	B	D	G[1]	K	L	M	N	C	F[1]
Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Medicare Part B coinsurance or copayment	✓	✓	✓	✓	50%	75%	✓	✓ copays apply[3]	✓	✓
Blood (first three pints)	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Part A hospice care coinsurance or copayment	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Skilled nursing facility coinsurance			✓	✓	50%	75%	✓	✓	✓	✓
Medicare Part A deductible		✓	✓	✓	50%	75%	50%	✓	✓	✓
Medicare Part B deductible									✓	✓
Medicare Part B excess charges				✓						✓
Foreign travel emergency (up to plan limits)			✓	✓			✓	✓	✓	✓
Out-of-pocket limit in 2022[2]					$6,620[2]	$3,310[2]				

Plans F and G also have a high deductible option, which require first paying a plan deductible of $2,490 before the plan begins to pay. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High deductible plan G does not cover the Medicare Part B deductible. However, high deductible plans F and G count your payment of the Medicare Part B deductible toward meeting the plan deductible.

2 Plans K and L pay 100% of covered services for the rest of the calendar year once you meet the out-of-pocket yearly limit.

3 Plan N pays 100% of the Part B coinsurance, except for a copayment of up to $20 for some office visits and up to a $50 copayment for emergency room visits that do not result in an inpatient admission.

Continental Life Insurance Company of Brentwood, Tennessee

Annual Attained Age Premiums

For Use in ZIP Codes: Rest of State

Rates Effective 9/1/2022

Attained Age	Preferred					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	2,947	3,726	5,219	n/a	3,827	2,892
65	1,548	1,958	2,745	513	2,011	1,443
66	1,608	2,034	2,849	534	2,090	1,502
67	1,671	2,114	2,961	554	2,171	1,564
68	1,738	2,195	3,077	575	2,255	1,628
69	1,805	2,282	3,199	599	2,344	1,693
70	1,874	2,370	3,320	622	2,434	1,762
71	1,947	2,465	3,453	644	2,530	1,837
72	2,025	2,562	3,586	672	2,629	1,917
73	2,103	2,663	3,730	695	2,734	2,001
74	2,188	2,769	3,878	725	2,841	2,087
75	2,278	2,879	4,031	753	2,955	2,175
76	2,340	2,958	4,145	775	3,038	2,245
77	2,405	3,042	4,263	797	3,126	2,319
78	2,474	3,131	4,384	820	3,213	2,395
79	2,545	3,219	4,508	844	3,302	2,468
80	2,616	3,307	4,633	867	3,394	2,548
81	2,648	3,347	4,690	878	3,437	2,580
82	2,680	3,390	4,747	889	3,477	2,613
83	2,711	3,428	4,802	897	3,520	2,648
84	2,745	3,470	4,862	907	3,562	2,682
85	2,775	3,510	4,917	921	3,605	2,716
86	2,809	3,556	4,975	931	3,648	2,751
87	2,842	3,595	5,036	941	3,691	2,787
88	2,878	3,639	5,097	954	3,736	2,821
89	2,911	3,682	5,159	965	3,779	2,859
90	2,947	3,726	5,219	975	3,827	2,892
91	2,981	3,772	5,282	988	3,872	2,930
92	3,019	3,817	5,347	999	3,917	2,968
93	3,053	3,862	5,409	1,012	3,964	3,004
94	3,089	3,907	5,477	1,025	4,014	3,045
95	3,128	3,956	5,542	1,036	4,060	3,084
96	3,165	4,003	5,607	1,051	4,111	3,125
97	3,203	4,051	5,676	1,061	4,161	3,163
98	3,242	4,099	5,744	1,074	4,210	3,203
99	3,280	4,149	5,812	1,087	4,259	3,242

Attained Age	Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	3,270	4,133	5,791	n/a	4,246	3,211
65	1,720	2,173	3,044	569	2,231	1,601
66	1,789	2,258	3,162	591	2,317	1,668
67	1,855	2,347	3,287	615	2,409	1,737
68	1,928	2,437	3,416	639	2,502	1,808
69	2,004	2,532	3,545	663	2,600	1,881
70	2,081	2,632	3,683	691	2,702	1,956
71	2,164	2,736	3,831	716	2,808	2,041
72	2,249	2,843	3,982	745	2,918	2,130
73	2,337	2,956	4,140	773	3,035	2,219
74	2,430	3,072	4,301	806	3,152	2,318
75	2,525	3,192	4,474	837	3,278	2,415
76	2,597	3,285	4,603	860	3,373	2,490
77	2,670	3,376	4,731	884	3,468	2,575
78	2,746	3,473	4,866	909	3,563	2,656
79	2,824	3,572	5,004	937	3,665	2,739
80	2,903	3,672	5,142	962	3,770	2,829
81	2,939	3,715	5,205	974	3,814	2,863
82	2,974	3,763	5,269	987	3,862	2,903
83	3,008	3,807	5,331	996	3,906	2,937
84	3,044	3,849	5,393	1,008	3,954	2,977
85	3,082	3,898	5,459	1,022	4,000	3,016
86	3,118	3,946	5,524	1,033	4,051	3,054
87	3,155	3,991	5,590	1,046	4,097	3,091
88	3,192	4,039	5,658	1,058	4,147	3,132
89	3,232	4,089	5,725	1,071	4,196	3,171
90	3,270	4,133	5,791	1,083	4,246	3,211
91	3,309	4,184	5,862	1,096	4,298	3,255
92	3,349	4,236	5,931	1,109	4,350	3,295
93	3,391	4,286	6,004	1,123	4,399	3,335
94	3,430	4,337	6,077	1,138	4,453	3,379
95	3,472	4,391	6,154	1,150	4,508	3,423
96	3,511	4,443	6,224	1,165	4,564	3,469
97	3,558	4,499	6,300	1,179	4,619	3,509
98	3,598	4,551	6,376	1,193	4,672	3,556
99	3,641	4,605	6,451	1,206	4,728	3,602

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: 920, 922, 930-931, 937-938, 944, 958

Rates Effective 9/1/2022

Attained	Preferred					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	3,102	3,922	5,494	n/a	4,028	3,044
65	1,629	2,061	2,889	540	2,117	1,519
66	1,693	2,141	2,999	562	2,200	1,581
67	1,759	2,225	3,117	583	2,285	1,646
68	1,829	2,311	3,239	605	2,374	1,714
69	1,900	2,402	3,367	630	2,467	1,782
70	1,973	2,495	3,495	655	2,562	1,855
71	2,049	2,595	3,635	678	2,663	1,934
72	2,132	2,697	3,775	707	2,767	2,018
73	2,214	2,803	3,926	732	2,878	2,106
74	2,303	2,915	4,082	763	2,990	2,197
75	2,398	3,031	4,243	793	3,110	2,289
76	2,463	3,114	4,363	816	3,198	2,363
77	2,532	3,202	4,487	839	3,290	2,441
78	2,604	3,296	4,615	863	3,382	2,521
79	2,679	3,388	4,745	888	3,476	2,598
80	2,754	3,481	4,877	913	3,573	2,682
81	2,787	3,523	4,937	924	3,618	2,716
82	2,821	3,568	4,997	936	3,660	2,751
83	2,854	3,608	5,055	944	3,705	2,787
84	2,889	3,653	5,118	955	3,749	2,823
85	2,921	3,695	5,176	969	3,795	2,859
86	2,957	3,743	5,237	980	3,840	2,896
87	2,992	3,784	5,301	991	3,885	2,934
88	3,029	3,831	5,365	1,004	3,933	2,969
89	3,064	3,876	5,430	1,016	3,978	3,009
90	3,102	3,922	5,494	1,026	4,028	3,044
91	3,138	3,970	5,560	1,040	4,076	3,084
92	3,178	4,018	5,628	1,052	4,123	3,124
93	3,214	4,065	5,694	1,065	4,173	3,162
94	3,252	4,113	5,765	1,079	4,225	3,205
95	3,293	4,164	5,834	1,090	4,274	3,246
96	3,332	4,214	5,902	1,106	4,327	3,289
97	3,372	4,264	5,975	1,117	4,380	3,329
98	3,413	4,315	6,046	1,131	4,432	3,372
99	3,453	4,367	6,118	1,144	4,483	3,413

Modal Factors: Semi-Annual: 0.5200

Attained	Standard					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	3,442	4,351	6,096	n/a	4,469	3,380
65	1,810	2,287	3,204	599	2,348	1,685
66	1,883	2,377	3,328	622	2,439	1,756
67	1,953	2,470	3,460	647	2,536	1,828
68	2,029	2,565	3,596	673	2,634	1,903
69	2,109	2,665	3,732	698	2,737	1,980
70	2,191	2,771	3,877	727	2,844	2,059
71	2,278	2,880	4,033	754	2,956	2,148
72	2,367	2,993	4,192	784	3,072	2,242
73	2,460	3,112	4,358	814	3,195	2,336
74	2,558	3,234	4,527	848	3,318	2,440
75	2,658	3,360	4,709	881	3,451	2,542
76	2,734	3,458	4,845	905	3,551	2,621
77	2,811	3,554	4,980	931	3,651	2,710
78	2,891	3,656	5,122	957	3,751	2,796
79	2,973	3,760	5,267	986	3,858	2,883
80	3,056	3,865	5,413	1,013	3,968	2,978
81	3,094	3,911	5,479	1,025	4,015	3,014
82	3,130	3,961	5,546	1,039	4,065	3,056
83	3,166	4,007	5,612	1,048	4,112	3,092
84	3,204	4,052	5,677	1,061	4,162	3,134
85	3,244	4,103	5,746	1,076	4,210	3,175
86	3,282	4,154	5,815	1,087	4,264	3,215
87	3,321	4,201	5,884	1,101	4,313	3,254
88	3,360	4,252	5,956	1,114	4,365	3,297
89	3,402	4,304	6,026	1,127	4,417	3,338
90	3,442	4,351	6,096	1,140	4,469	3,380
91	3,483	4,404	6,170	1,154	4,524	3,426
92	3,525	4,459	6,243	1,167	4,579	3,468
93	3,569	4,512	6,320	1,182	4,630	3,511
94	3,610	4,565	6,397	1,198	4,687	3,557
95	3,655	4,622	6,478	1,211	4,745	3,603
96	3,696	4,677	6,552	1,226	4,804	3,652
97	3,745	4,736	6,632	1,241	4,862	3,694
98	3,787	4,791	6,712	1,256	4,918	3,743
99	3,833	4,847	6,790	1,269	4,977	3,792

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 9/1/2022

Attained	Preferred					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	3,412	4,314	6,043	n/a	4,431	3,348
65	1,792	2,267	3,178	594	2,329	1,671
66	1,862	2,355	3,299	618	2,420	1,739
67	1,935	2,448	3,429	641	2,514	1,811
68	2,012	2,542	3,563	666	2,611	1,885
69	2,090	2,642	3,704	693	2,714	1,960
70	2,170	2,745	3,845	721	2,818	2,041
71	2,254	2,855	3,999	746	2,929	2,127
72	2,345	2,967	4,153	778	3,044	2,220
73	2,435	3,083	4,319	805	3,166	2,317
74	2,533	3,207	4,490	839	3,289	2,417
75	2,638	3,334	4,667	872	3,421	2,518
76	2,709	3,425	4,799	898	3,518	2,599
77	2,785	3,522	4,936	923	3,619	2,685
78	2,864	3,626	5,077	949	3,720	2,773
79	2,947	3,727	5,220	977	3,824	2,858
80	3,029	3,829	5,365	1,004	3,930	2,950
81	3,066	3,875	5,431	1,016	3,980	2,988
82	3,103	3,925	5,497	1,030	4,026	3,026
83	3,139	3,969	5,561	1,038	4,076	3,066
84	3,178	4,018	5,630	1,051	4,124	3,105
85	3,213	4,065	5,694	1,066	4,175	3,145
86	3,253	4,117	5,761	1,078	4,224	3,186
87	3,291	4,162	5,831	1,090	4,274	3,227
88	3,332	4,214	5,902	1,104	4,326	3,266
89	3,370	4,264	5,973	1,118	4,376	3,310
90	3,412	4,314	6,043	1,129	4,431	3,348
91	3,452	4,367	6,116	1,144	4,484	3,392
92	3,496	4,420	6,191	1,157	4,535	3,436
93	3,535	4,472	6,263	1,172	4,590	3,478
94	3,577	4,524	6,342	1,187	4,648	3,526
95	3,622	4,580	6,417	1,199	4,701	3,571
96	3,665	4,635	6,492	1,217	4,760	3,618
97	3,709	4,690	6,573	1,229	4,818	3,662
98	3,754	4,747	6,651	1,244	4,875	3,709
99	3,798	4,804	6,730	1,258	4,931	3,754

Modal Factors: Semi-Annual: 0.5200

Attained	Standard					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	3,786	4,786	6,706	n/a	4,916	3,718
65	1,991	2,516	3,524	659	2,583	1,854
66	2,071	2,615	3,661	684	2,683	1,932
67	2,148	2,717	3,806	712	2,790	2,011
68	2,232	2,822	3,956	740	2,897	2,093
69	2,320	2,932	4,105	768	3,011	2,178
70	2,410	3,048	4,265	800	3,128	2,265
71	2,506	3,168	4,436	829	3,252	2,363
72	2,604	3,292	4,611	862	3,379	2,466
73	2,706	3,423	4,794	895	3,515	2,570
74	2,814	3,557	4,980	933	3,650	2,684
75	2,924	3,696	5,180	969	3,796	2,796
76	3,007	3,804	5,330	996	3,906	2,883
77	3,092	3,909	5,478	1,024	4,016	2,981
78	3,180	4,022	5,634	1,053	4,126	3,076
79	3,270	4,136	5,794	1,085	4,244	3,171
80	3,362	4,252	5,954	1,114	4,365	3,276
81	3,403	4,302	6,027	1,128	4,417	3,315
82	3,443	4,357	6,101	1,143	4,472	3,362
83	3,483	4,408	6,173	1,153	4,523	3,401
84	3,524	4,457	6,245	1,167	4,578	3,447
85	3,568	4,513	6,321	1,184	4,631	3,493
86	3,610	4,569	6,397	1,196	4,690	3,537
87	3,653	4,621	6,472	1,211	4,744	3,579
88	3,696	4,677	6,552	1,225	4,802	3,627
89	3,742	4,734	6,629	1,240	4,859	3,672
90	3,786	4,786	6,706	1,254	4,916	3,718
91	3,831	4,844	6,787	1,269	4,976	3,769
92	3,878	4,905	6,867	1,284	5,037	3,815
93	3,926	4,963	6,952	1,300	5,093	3,862
94	3,971	5,022	7,037	1,318	5,156	3,913
95	4,021	5,084	7,126	1,332	5,220	3,963
96	4,066	5,145	7,207	1,349	5,284	4,017
97	4,120	5,210	7,295	1,365	5,348	4,063
98	4,166	5,270	7,383	1,382	5,410	4,117
99	4,216	5,332	7,469	1,396	5,475	4,171

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 9/1/2022

Attained	Preferred					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	3,629	4,589	6,428	n/a	4,713	3,561
65	1,906	2,411	3,380	632	2,477	1,777
66	1,981	2,505	3,509	658	2,574	1,850
67	2,058	2,603	3,647	682	2,673	1,926
68	2,140	2,704	3,790	708	2,778	2,005
69	2,223	2,810	3,939	737	2,886	2,085
70	2,308	2,919	4,089	766	2,998	2,170
71	2,397	3,036	4,253	793	3,116	2,263
72	2,494	3,155	4,417	827	3,237	2,361
73	2,590	3,280	4,593	856	3,367	2,464
74	2,695	3,411	4,776	893	3,498	2,570
75	2,806	3,546	4,964	928	3,639	2,678
76	2,882	3,643	5,105	955	3,742	2,765
77	2,962	3,746	5,250	982	3,849	2,856
78	3,047	3,856	5,400	1,010	3,957	2,950
79	3,134	3,964	5,552	1,039	4,067	3,040
80	3,222	4,073	5,706	1,068	4,180	3,138
81	3,261	4,122	5,776	1,081	4,233	3,178
82	3,301	4,175	5,846	1,095	4,282	3,219
83	3,339	4,221	5,914	1,104	4,335	3,261
84	3,380	4,274	5,988	1,117	4,386	3,303
85	3,418	4,323	6,056	1,134	4,440	3,345
86	3,460	4,379	6,127	1,147	4,493	3,388
87	3,501	4,427	6,202	1,159	4,545	3,433
88	3,544	4,482	6,277	1,175	4,602	3,474
89	3,585	4,535	6,353	1,189	4,654	3,521
90	3,629	4,589	6,428	1,200	4,713	3,561
91	3,671	4,645	6,505	1,217	4,769	3,608
92	3,718	4,701	6,585	1,231	4,824	3,655
93	3,760	4,756	6,662	1,246	4,882	3,700
94	3,805	4,812	6,745	1,262	4,943	3,750
95	3,853	4,872	6,826	1,275	5,001	3,798
96	3,898	4,930	6,905	1,294	5,063	3,848
97	3,945	4,989	6,991	1,307	5,125	3,895
98	3,993	5,049	7,074	1,323	5,185	3,945
99	4,040	5,109	7,158	1,338	5,245	3,993

Modal Factors: Semi-Annual: 0.5200

Attained	Standard					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	4,027	5,091	7,132	n/a	5,229	3,955
65	2,118	2,676	3,749	701	2,747	1,971
66	2,203	2,781	3,894	728	2,854	2,055
67	2,285	2,890	4,048	757	2,967	2,139
68	2,374	3,001	4,207	787	3,082	2,227
69	2,468	3,118	4,366	817	3,202	2,317
70	2,563	3,242	4,536	851	3,327	2,409
71	2,665	3,370	4,719	882	3,459	2,513
72	2,769	3,502	4,905	917	3,594	2,623
73	2,878	3,641	5,099	952	3,738	2,733
74	2,993	3,784	5,297	992	3,882	2,855
75	3,110	3,931	5,510	1,031	4,038	2,974
76	3,199	4,046	5,669	1,059	4,155	3,067
77	3,289	4,158	5,827	1,089	4,272	3,171
78	3,382	4,278	5,993	1,120	4,389	3,271
79	3,478	4,399	6,162	1,154	4,514	3,373
80	3,576	4,522	6,333	1,185	4,643	3,484
81	3,620	4,576	6,410	1,199	4,698	3,526
82	3,662	4,634	6,489	1,216	4,756	3,576
83	3,704	4,688	6,566	1,226	4,811	3,618
84	3,749	4,741	6,642	1,241	4,870	3,667
85	3,795	4,801	6,723	1,259	4,926	3,715
86	3,840	4,860	6,804	1,272	4,989	3,762
87	3,886	4,915	6,884	1,288	5,046	3,807
88	3,931	4,975	6,969	1,303	5,107	3,857
89	3,980	5,036	7,050	1,319	5,168	3,905
90	4,027	5,091	7,132	1,334	5,229	3,955
91	4,075	5,153	7,219	1,350	5,293	4,008
92	4,124	5,217	7,304	1,365	5,357	4,058
93	4,176	5,279	7,394	1,383	5,417	4,108
94	4,224	5,341	7,484	1,402	5,484	4,162
95	4,276	5,408	7,579	1,417	5,552	4,216
96	4,324	5,472	7,666	1,434	5,621	4,273
97	4,382	5,541	7,759	1,452	5,689	4,322
98	4,431	5,605	7,853	1,470	5,754	4,379
99	4,485	5,671	7,944	1,485	5,823	4,437

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 9/1/2022

Attained Age	Preferred					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	3,784	4,785	6,703	n/a	4,914	3,714
65	1,987	2,514	3,525	659	2,583	1,853
66	2,065	2,612	3,659	686	2,684	1,929
67	2,146	2,715	3,803	711	2,788	2,008
68	2,231	2,819	3,952	738	2,896	2,091
69	2,318	2,930	4,108	769	3,010	2,174
70	2,407	3,044	4,264	799	3,126	2,263
71	2,500	3,166	4,435	827	3,249	2,359
72	2,601	3,290	4,606	863	3,376	2,462
73	2,701	3,420	4,790	893	3,511	2,569
74	2,810	3,556	4,980	931	3,648	2,680
75	2,926	3,698	5,176	967	3,794	2,793
76	3,005	3,799	5,323	996	3,902	2,883
77	3,089	3,906	5,474	1,024	4,014	2,978
78	3,177	4,021	5,630	1,053	4,126	3,076
79	3,268	4,133	5,789	1,083	4,241	3,170
80	3,360	4,247	5,950	1,114	4,359	3,272
81	3,400	4,298	6,023	1,127	4,414	3,314
82	3,442	4,353	6,096	1,142	4,465	3,356
83	3,482	4,402	6,167	1,152	4,520	3,400
84	3,525	4,457	6,244	1,165	4,574	3,444
85	3,564	4,508	6,315	1,182	4,630	3,488
86	3,608	4,566	6,389	1,196	4,685	3,533
87	3,650	4,616	6,467	1,209	4,740	3,579
88	3,695	4,674	6,545	1,225	4,798	3,622
89	3,738	4,729	6,625	1,240	4,853	3,671
90	3,784	4,785	6,703	1,252	4,914	3,714
91	3,828	4,843	6,783	1,269	4,973	3,762
92	3,877	4,902	6,866	1,283	5,030	3,811
93	3,921	4,959	6,947	1,299	5,091	3,858
94	3,967	5,018	7,033	1,316	5,155	3,910
95	4,017	5,080	7,117	1,330	5,214	3,960
96	4,065	5,141	7,200	1,349	5,279	4,013
97	4,114	5,202	7,290	1,363	5,344	4,061
98	4,164	5,264	7,376	1,380	5,407	4,114
99	4,213	5,328	7,464	1,396	5,469	4,164

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	4,199	5,308	7,437	n/a	5,452	4,124
65	2,208	2,790	3,909	731	2,865	2,056
66	2,297	2,900	4,060	759	2,976	2,142
67	2,383	3,013	4,221	789	3,094	2,230
68	2,475	3,129	4,387	821	3,213	2,322
69	2,573	3,251	4,553	852	3,339	2,416
70	2,673	3,381	4,730	887	3,470	2,512
71	2,779	3,514	4,920	920	3,606	2,621
72	2,888	3,651	5,114	956	3,748	2,735
73	3,001	3,797	5,317	993	3,898	2,850
74	3,121	3,945	5,523	1,035	4,048	2,977
75	3,243	4,099	5,745	1,075	4,210	3,101
76	3,335	4,219	5,911	1,104	4,332	3,198
77	3,429	4,336	6,076	1,136	4,454	3,306
78	3,527	4,460	6,249	1,168	4,576	3,411
79	3,627	4,587	6,426	1,203	4,707	3,517
80	3,728	4,715	6,604	1,236	4,841	3,633
81	3,775	4,771	6,684	1,251	4,898	3,677
82	3,819	4,832	6,766	1,268	4,959	3,728
83	3,863	4,889	6,847	1,279	5,017	3,772
84	3,909	4,943	6,926	1,294	5,078	3,823
85	3,958	5,006	7,010	1,313	5,136	3,874
86	4,004	5,068	7,094	1,326	5,202	3,922
87	4,052	5,125	7,178	1,343	5,262	3,970
88	4,099	5,187	7,266	1,359	5,325	4,022
89	4,150	5,251	7,352	1,375	5,389	4,072
90	4,199	5,308	7,437	1,391	5,452	4,124
91	4,249	5,373	7,527	1,408	5,519	4,180
92	4,301	5,440	7,616	1,424	5,586	4,231
93	4,354	5,505	7,710	1,442	5,649	4,283
94	4,404	5,569	7,804	1,462	5,718	4,340
95	4,459	5,639	7,903	1,477	5,789	4,396
96	4,509	5,706	7,993	1,496	5,861	4,455
97	4,569	5,778	8,091	1,514	5,932	4,507
98	4,620	5,845	8,189	1,532	6,000	4,566
99	4,676	5,913	8,284	1,548	6,072	4,626

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 9/1/2022

Attained	Preferred					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	4,250	5,373	7,527	n/a	5,518	4,170
65	2,232	2,824	3,958	740	2,900	2,081
66	2,319	2,933	4,109	770	3,014	2,166
67	2,410	3,048	4,270	799	3,130	2,255
68	2,506	3,166	4,437	829	3,252	2,348
69	2,603	3,291	4,613	863	3,380	2,441
70	2,703	3,418	4,788	897	3,510	2,541
71	2,807	3,555	4,980	929	3,648	2,650
72	2,921	3,695	5,172	969	3,791	2,765
73	3,033	3,840	5,379	1,003	3,943	2,885
74	3,155	3,994	5,592	1,045	4,096	3,010
75	3,285	4,152	5,813	1,086	4,261	3,136
76	3,374	4,266	5,977	1,118	4,381	3,237
77	3,469	4,387	6,147	1,149	4,507	3,344
78	3,567	4,516	6,323	1,182	4,633	3,454
79	3,670	4,642	6,501	1,217	4,762	3,559
80	3,773	4,769	6,681	1,251	4,895	3,674
81	3,818	4,827	6,764	1,266	4,957	3,721
82	3,865	4,888	6,846	1,282	5,014	3,769
83	3,910	4,943	6,925	1,293	5,076	3,818
84	3,958	5,005	7,012	1,308	5,136	3,868
85	4,002	5,062	7,091	1,328	5,199	3,917
86	4,051	5,128	7,175	1,343	5,261	3,968
87	4,099	5,184	7,262	1,358	5,322	4,020
88	4,150	5,248	7,350	1,375	5,388	4,068
89	4,198	5,310	7,439	1,392	5,450	4,122
90	4,250	5,373	7,527	1,406	5,518	4,170
91	4,299	5,439	7,617	1,425	5,584	4,225
92	4,354	5,505	7,710	1,441	5,649	4,280
93	4,403	5,569	7,801	1,459	5,717	4,332
94	4,455	5,635	7,898	1,478	5,788	4,391
95	4,511	5,705	7,993	1,493	5,855	4,447
96	4,565	5,773	8,086	1,515	5,928	4,506
97	4,620	5,842	8,186	1,530	6,001	4,561
98	4,676	5,912	8,283	1,549	6,072	4,620
99	4,731	5,983	8,382	1,567	6,142	4,676

Modal Factors: Semi-Annual: 0.5200

Attained	Standard					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	4,716	5,961	8,352	n/a	6,123	4,631
65	2,480	3,133	4,389	821	3,217	2,308
66	2,580	3,256	4,559	852	3,341	2,406
67	2,676	3,384	4,740	886	3,474	2,504
68	2,780	3,514	4,927	922	3,609	2,607
69	2,889	3,651	5,113	956	3,750	2,713
70	3,002	3,796	5,311	996	3,896	2,821
71	3,121	3,946	5,525	1,033	4,050	2,943
72	3,243	4,100	5,743	1,074	4,209	3,072
73	3,370	4,263	5,970	1,115	4,377	3,200
74	3,504	4,431	6,202	1,162	4,546	3,343
75	3,641	4,603	6,451	1,207	4,728	3,483
76	3,746	4,737	6,638	1,240	4,865	3,591
77	3,851	4,869	6,823	1,275	5,002	3,713
78	3,961	5,009	7,017	1,311	5,139	3,831
79	4,073	5,151	7,216	1,351	5,285	3,950
80	4,187	5,295	7,416	1,388	5,436	4,080
81	4,239	5,358	7,506	1,404	5,501	4,129
82	4,288	5,427	7,598	1,423	5,569	4,187
83	4,337	5,490	7,688	1,436	5,633	4,236
84	4,389	5,551	7,777	1,454	5,702	4,294
85	4,444	5,621	7,872	1,474	5,768	4,350
86	4,496	5,691	7,967	1,489	5,842	4,405
87	4,550	5,755	8,061	1,508	5,909	4,458
88	4,603	5,825	8,160	1,526	5,980	4,517
89	4,661	5,896	8,256	1,544	6,051	4,573
90	4,716	5,961	8,352	1,562	6,123	4,631
91	4,772	6,033	8,453	1,581	6,198	4,694
92	4,829	6,109	8,553	1,599	6,273	4,751
93	4,890	6,181	8,658	1,619	6,343	4,810
94	4,946	6,254	8,764	1,641	6,421	4,873
95	5,007	6,332	8,875	1,659	6,501	4,936
96	5,064	6,407	8,976	1,680	6,581	5,003
97	5,131	6,488	9,086	1,700	6,661	5,061
98	5,188	6,564	9,195	1,721	6,738	5,128
99	5,251	6,640	9,302	1,739	6,818	5,195

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; (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 BENEFIT PERIOD

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,556	$0	$1,556 (Part A Deductible)
61st thru 90th day	All but $389 a day	$389 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $778 a day	$778 a day	$0
•Once lifetime reserve days are used:			
•Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
•Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $194.50 a day	$0	Up to $194.50 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 $233 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $233 of Medicare-Approved amounts*	$0	$0	$233 (Part B Deductible)
Remainder of Medicare-Approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-Approved amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $233 of Medicare-Approved amounts*	$0	$0	$233 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
•Medically necessary skilled care services and medical supplies	100%	$0	$0
•Durable medical equipment			
•First $233 of Medicare Approved amounts*	$0	$0	$233 (Part B Deductible)
•Remainder of Medicare Approved amounts	80%	20%	$0

PLAN B

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,556	$1,556 (Part A Deductible)	$0
61st thru 90th day	All but $389 a day	$389 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $778 a day	$778 a day	$0
•Once lifetime reserve days are used:			
•Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
•Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $194.50 a day	$0	Up to $194.50 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 $233 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $233 of Medicare-Approved amounts*	$0	$0	$233 (Part B Deductible)
Remainder of Medicare-Approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-Approved amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $233 of Medicare-Approved amounts*	$0	$0	$233 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
•Medically necessary skilled care services and medical supplies	100%	$0	$0
•Durable medical equipment			
•First $233 of Medicare Approved amounts*	$0	$0	$233 (Part B Deductible)
•Remainder of Medicare Approved amounts	80%	20%	$0

PLAN F

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,556	$1,556 (Part A Deductible)	$0
61st thru 90th day	All but $389 a day	$389 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $778 a day	$778 a day	$0
•Once lifetime reserve days are used:			
•Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
•Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $194.50 a day	Up to $194.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

PLAN F

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

*Once you have been billed $233 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic test, durable medical equipment			
First $233 of Medicare-Approved amounts*	$0	$233 (Part B Deductible)	$0
Remainder of Medicare-Approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-Approved amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $233 of Medicare-Approved amounts*	$0	$233 (Part B Deductible)	$0
Remainder of Medicare-Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
•Medically necessary skilled care services and medical supplies	100%	$0	$0
•Durable medical equipment			
•First $233 of Medicare Approved amounts*	$0	$233 (Part B Deductible)	$0
•Remainder of Medicare Approved amounts	80%	20%	$0

PLAN F

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

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 $2,490 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses are $2,490. 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 $2,490 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2,490 DEDUCTIBLE*** YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,556	$1,556 (Part A Deductible)	$0
61st thru 90th day	All but $389 a day	$389 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $778 a day	$778 a day	$0
•Once lifetime reserve days are used:			
•Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
•Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $194.50 a day	Up to $194.50 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 $233 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

*****This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2,490 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses are $2,490. 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 $2,490 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2,490 DEDUCTIBLE*** YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic test, durable medical equipment			
First $233 of Medicare-Approved amounts*	$0	$233 (Part B Deductible)	$0
Remainder of Medicare-Approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-Approved amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $233 of Medicare-Approved amounts*	$0	$233 (Part B Deductible)	$0
Remainder of Medicare-Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

HIGH DEDUCTIBLE PLAN F

PARTS A & B

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,490 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2,490 DEDUCTIBLE*** YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
•Medically necessary skilled care services and medical supplies	100%	$0	$0
•Durable medical equipment •First $233 of Medicare Approved amounts*	$0	$233 (Part B Deductible)	$0
•Remainder of Medicare Approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,490 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2,490 DEDUCTIBLE** YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN G

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,556	$1,556 (Part A Deductible)	$0
61st thru 90th day	All but $389 a day	$389 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $778 a day	$778 a day	$0
•Once lifetime reserve days are used:			
•Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
•Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $194.50 a day	Up to $194.50 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 $233 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $233 of Medicare-Approved amounts*	$0	$0	$233 (Part B Deductible)
Remainder of Medicare-Approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-Approved amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $233 of Medicare-Approved amounts*	$0	$0	$233 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
•Medically necessary skilled care services and medical supplies	100%	$0	$0
•Durable medical equipment			
•First $233 of Medicare Approved amounts*	$0	$0	$233 (Part B Deductible)
•Remainder of Medicare Approved amounts	80%	20%	$0
•			

PLAN G

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

PLAN N

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,556	$1,556 (Part A Deductible)	$0
61st thru 90th day	All but $389 a day	$389 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $778 a day	$778 a day	$0
•Once lifetime reserve days are used:			
•Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
•Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $194.50 a day	Up to $194.50 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 N

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

*Once you have been billed $233 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic test, durable medical equipment			
First $233 of Medicare-Approved amounts*	$0	$0	$233 (Part B Deductible)
Remainder of Medicare-Approved amounts	Generally 80%	Balance, other than up to $20 per office visit and up to $50 per emergency room visit. The co-payment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Up to $20 per office visit and up to $50 per emergency room visit. The 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 $233 of Medicare-Approved amounts*	$0	$0	$233 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN N

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
•Medically necessary skilled care services and medical supplies	100%	$0	$0
*Durable medical equipment			
•First $233 of Medicare Approved amounts*	$0	$0	$233 (Part B Deductible)
*Remainder of Medicare Approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

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