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

AetnaSeniorProducts.com

CLIMS05024CA

Rates effective: 09/2024 A

CONTINENTAL LIFE INSURANCE COMPANY OF BRENTWOOD, TENNESSEE
OUTLINE OF MEDICARE SUPPLEMENT COVERAGE COVER PAGE
BENEFIT PLANS AVAILABLE: A, B, F, HIGH DEDUCTIBLE F, 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 2024[2]					**$7,060[2]**	**$3,530[2]**				

[1] Plans F and G also have a high deductible option, which require first paying a plan deductible of **$2,800** before the plan begins to pay. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High deductible plan G does not cover the Medicare Part B deductible. However, high deductible plans F and G count your payment of the Medicare Part B deductible toward meeting the plan deductible.

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

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

Continental Life Insurance Company of Brentwood, Tennessee

Annual premiums

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

Rates effective 9/1/2024

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	4,729	5,980	8,378	n/a	6,377	4,953
65	2,484	3,143	4,405	838	3,351	2,471
66	2,582	3,265	4,573	873	3,483	2,573
67	2,682	3,392	4,753	906	3,618	2,678
68	2,788	3,525	4,939	940	3,758	2,789
69	2,898	3,662	5,133	980	3,906	2,900
70	3,009	3,804	5,329	1,018	4,055	3,018
71	3,124	3,958	5,543	1,054	4,215	3,147
72	3,251	4,113	5,757	1,097	4,381	3,283
73	3,377	4,274	5,986	1,138	4,555	3,426
74	3,511	4,446	6,224	1,185	4,733	3,576
75	3,657	4,622	6,469	1,233	4,924	3,724
76	3,755	4,748	6,653	1,269	5,064	3,844
77	3,862	4,883	6,842	1,303	5,209	3,972
78	3,970	5,027	7,038	1,340	5,355	4,102
79	4,085	5,165	7,235	1,380	5,503	4,228
80	4,200	5,307	7,436	1,419	5,657	4,365
81	4,250	5,372	7,528	1,436	5,728	4,420
82	4,302	5,440	7,620	1,455	5,794	4,477
83	4,352	5,501	7,708	1,466	5,865	4,535
84	4,405	5,570	7,804	1,484	5,935	4,594
85	4,454	5,635	7,893	1,504	6,009	4,651
86	4,509	5,707	7,986	1,522	6,080	4,713
87	4,563	5,769	8,083	1,540	6,151	4,773
88	4,618	5,842	8,180	1,559	6,227	4,831
89	4,672	5,910	8,280	1,578	6,297	4,896
90	4,729	5,980	8,378	1,593	6,377	4,953
91	4,785	6,054	8,478	1,615	6,453	5,018
92	4,846	6,127	8,582	1,634	6,528	5,084
93	4,902	6,198	8,683	1,654	6,606	5,144
94	4,959	6,272	8,790	1,677	6,690	5,214
95	5,021	6,349	8,897	1,695	6,766	5,281
96	5,081	6,427	9,000	1,718	6,850	5,351
97	5,142	6,502	9,111	1,736	6,935	5,417
98	5,205	6,580	9,219	1,758	7,016	5,487
99	5,266	6,658	9,328	1,777	7,098	5,554

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	5,248	6,635	9,295	n/a	7,076	5,501
65	2,761	3,487	4,885	930	3,717	2,741
66	2,872	3,625	5,074	966	3,862	2,858
67	2,978	3,768	5,276	1,004	4,015	2,974
68	3,093	3,911	5,484	1,047	4,169	3,096
69	3,215	4,063	5,691	1,085	4,333	3,222
70	3,341	4,226	5,912	1,129	4,502	3,350
71	3,474	4,391	6,150	1,171	4,680	3,495
72	3,609	4,565	6,392	1,218	4,864	3,648
73	3,751	4,746	6,646	1,265	5,059	3,802
74	3,900	4,932	6,902	1,317	5,253	3,970
75	4,052	5,124	7,180	1,369	5,464	4,136
76	4,169	5,273	7,387	1,406	5,622	4,263
77	4,287	5,420	7,594	1,447	5,781	4,410
78	4,409	5,575	7,810	1,486	5,939	4,550
79	4,533	5,733	8,031	1,532	6,107	4,691
80	4,661	5,892	8,254	1,574	6,283	4,844
81	4,718	5,964	8,354	1,592	6,357	4,905
82	4,773	6,040	8,456	1,614	6,436	4,973
83	4,827	6,109	8,558	1,628	6,510	5,031
84	4,885	6,179	8,657	1,648	6,588	5,099
85	4,946	6,255	8,761	1,671	6,665	5,166
86	5,005	6,335	8,867	1,688	6,750	5,231
87	5,064	6,406	8,972	1,710	6,828	5,295
88	5,124	6,484	9,082	1,732	6,912	5,365
89	5,187	6,562	9,189	1,751	6,992	5,432
90	5,248	6,635	9,295	1,771	7,076	5,501
91	5,310	6,714	9,409	1,793	7,162	5,575
92	5,375	6,799	9,519	1,813	7,250	5,643
93	5,442	6,880	9,637	1,836	7,330	5,713
94	5,505	6,961	9,754	1,862	7,420	5,788
95	5,573	7,047	9,878	1,882	7,512	5,862
96	5,636	7,132	9,991	1,904	7,605	5,943
97	5,710	7,221	10,113	1,928	7,697	6,012
98	5,775	7,306	10,235	1,952	7,786	6,091
99	5,846	7,390	10,354	1,971	7,879	6,169

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 periods, use preferred rates.

Modal factors

Semi-annual 0.5200

Quarterly 0.2650

Monthly 0.0833

Continental Life Insurance Company of Brentwood, Tennessee

Annual premiums

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

Rates effective 9/1/2024

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	4,211	5,325	7,460	n/a	5,679	4,410
65	2,212	2,799	3,922	747	2,984	2,201
66	2,300	2,907	4,072	777	3,101	2,291
67	2,389	3,021	4,232	806	3,222	2,385
68	2,483	3,139	4,398	837	3,346	2,484
69	2,580	3,261	4,571	872	3,478	2,583
70	2,679	3,388	4,746	906	3,611	2,688
71	2,782	3,525	4,936	938	3,754	2,802
72	2,895	3,662	5,126	977	3,902	2,923
73	3,007	3,806	5,330	1,014	4,057	3,051
74	3,127	3,959	5,542	1,055	4,215	3,184
75	3,256	4,116	5,761	1,098	4,385	3,316
76	3,344	4,229	5,924	1,130	4,509	3,423
77	3,439	4,348	6,093	1,160	4,638	3,537
78	3,536	4,476	6,267	1,193	4,769	3,653
79	3,638	4,599	6,443	1,229	4,901	3,765
80	3,741	4,726	6,622	1,264	5,037	3,887
81	3,784	4,784	6,704	1,279	5,101	3,936
82	3,831	4,845	6,786	1,296	5,159	3,987
83	3,876	4,898	6,864	1,305	5,223	4,038
84	3,922	4,961	6,949	1,321	5,285	4,091
85	3,966	5,018	7,028	1,340	5,351	4,142
86	4,015	5,083	7,111	1,355	5,414	4,197
87	4,064	5,137	7,198	1,371	5,478	4,250
88	4,113	5,202	7,285	1,388	5,545	4,302
89	4,160	5,263	7,374	1,405	5,607	4,360
90	4,211	5,325	7,460	1,419	5,679	4,410
91	4,261	5,391	7,549	1,438	5,746	4,469
92	4,315	5,456	7,642	1,455	5,813	4,527
93	4,365	5,519	7,732	1,473	5,883	4,581
94	4,416	5,585	7,828	1,493	5,957	4,643
95	4,471	5,653	7,923	1,509	6,026	4,703
96	4,525	5,723	8,014	1,530	6,100	4,765
97	4,579	5,790	8,113	1,546	6,176	4,824
98	4,635	5,860	8,209	1,565	6,248	4,886
99	4,690	5,929	8,307	1,582	6,321	4,946

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	4,674	5,908	8,278	n/a	6,301	4,898
65	2,458	3,105	4,351	828	3,310	2,441
66	2,557	3,228	4,519	860	3,439	2,545
67	2,652	3,355	4,698	894	3,576	2,649
68	2,755	3,483	4,884	932	3,712	2,757
69	2,863	3,619	5,068	966	3,859	2,869
70	2,976	3,764	5,264	1,005	4,009	2,983
71	3,094	3,910	5,477	1,043	4,168	3,112
72	3,213	4,065	5,693	1,085	4,331	3,249
73	3,340	4,226	5,918	1,126	4,505	3,386
74	3,473	4,392	6,146	1,172	4,677	3,536
75	3,609	4,563	6,394	1,219	4,865	3,683
76	3,712	4,696	6,578	1,252	5,007	3,797
77	3,817	4,826	6,762	1,288	5,148	3,927
78	3,926	4,964	6,955	1,324	5,289	4,052
79	4,037	5,106	7,152	1,364	5,439	4,177
80	4,150	5,247	7,351	1,402	5,595	4,314
81	4,202	5,311	7,440	1,418	5,661	4,368
82	4,250	5,379	7,530	1,437	5,732	4,429
83	4,298	5,440	7,621	1,449	5,797	4,480
84	4,351	5,502	7,709	1,468	5,867	4,541
85	4,404	5,571	7,802	1,488	5,935	4,601
86	4,457	5,641	7,896	1,503	6,011	4,658
87	4,509	5,705	7,990	1,523	6,080	4,715
88	4,563	5,774	8,087	1,542	6,155	4,778
89	4,619	5,844	8,183	1,559	6,227	4,837
90	4,674	5,908	8,278	1,577	6,301	4,898
91	4,729	5,979	8,379	1,597	6,378	4,964
92	4,786	6,055	8,477	1,614	6,456	5,025
93	4,846	6,127	8,581	1,635	6,527	5,087
94	4,902	6,199	8,686	1,658	6,608	5,155
95	4,963	6,276	8,796	1,676	6,689	5,220
96	5,019	6,351	8,897	1,696	6,772	5,292
97	5,085	6,431	9,006	1,717	6,854	5,353
98	5,142	6,506	9,115	1,739	6,933	5,424
99	5,206	6,581	9,221	1,756	7,016	5,494

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 periods, use preferred rates.

Modal factors

Semi-annual 0.5200

Quarterly 0.2650

Monthly 0.0833

Continental Life Insurance Company of Brentwood, Tennessee

Annual premiums

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

Rates effective 9/1/2024

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	4,039	5,107	7,155	n/a	5,446	4,230
65	2,121	2,684	3,762	716	2,862	2,111
66	2,205	2,788	3,905	745	2,974	2,197
67	2,291	2,897	4,059	773	3,090	2,287
68	2,381	3,010	4,218	803	3,209	2,382
69	2,475	3,127	4,384	837	3,336	2,477
70	2,569	3,249	4,551	869	3,463	2,578
71	2,668	3,380	4,734	900	3,600	2,687
72	2,776	3,512	4,916	937	3,742	2,803
73	2,884	3,650	5,112	972	3,890	2,926
74	2,999	3,797	5,315	1,012	4,042	3,054
75	3,123	3,948	5,525	1,053	4,205	3,180
76	3,207	4,055	5,682	1,083	4,324	3,283
77	3,298	4,170	5,843	1,113	4,448	3,392
78	3,391	4,293	6,010	1,144	4,574	3,503
79	3,489	4,411	6,179	1,178	4,700	3,611
80	3,587	4,533	6,351	1,212	4,831	3,728
81	3,629	4,588	6,429	1,226	4,892	3,774
82	3,674	4,646	6,508	1,243	4,948	3,824
83	3,717	4,698	6,582	1,252	5,009	3,873
84	3,762	4,757	6,664	1,267	5,068	3,923
85	3,804	4,812	6,740	1,285	5,132	3,972
86	3,850	4,874	6,820	1,300	5,192	4,025
87	3,897	4,927	6,903	1,315	5,253	4,076
88	3,944	4,989	6,986	1,331	5,318	4,125
89	3,990	5,047	7,071	1,348	5,377	4,182
90	4,039	5,107	7,155	1,361	5,446	4,230
91	4,087	5,170	7,240	1,379	5,511	4,286
92	4,138	5,232	7,329	1,396	5,575	4,342
93	4,186	5,293	7,415	1,412	5,642	4,393
94	4,235	5,356	7,507	1,432	5,713	4,453
95	4,288	5,422	7,598	1,447	5,779	4,510
96	4,340	5,488	7,686	1,467	5,850	4,570
97	4,391	5,553	7,781	1,482	5,923	4,626
98	4,445	5,620	7,873	1,501	5,992	4,686
99	4,497	5,686	7,967	1,517	6,062	4,743

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	4,482	5,666	7,938	n/a	6,043	4,698
65	2,358	2,978	4,172	794	3,174	2,341
66	2,452	3,096	4,334	825	3,298	2,441
67	2,544	3,218	4,506	858	3,429	2,540
68	2,642	3,340	4,684	894	3,560	2,644
69	2,746	3,470	4,860	927	3,701	2,752
70	2,854	3,609	5,049	964	3,845	2,861
71	2,967	3,750	5,252	1,000	3,997	2,985
72	3,082	3,898	5,459	1,040	4,154	3,116
73	3,203	4,053	5,676	1,080	4,321	3,247
74	3,331	4,212	5,894	1,124	4,486	3,391
75	3,461	4,376	6,132	1,169	4,666	3,532
76	3,560	4,503	6,309	1,200	4,802	3,641
77	3,661	4,629	6,485	1,236	4,937	3,766
78	3,765	4,761	6,670	1,269	5,072	3,886
79	3,872	4,896	6,859	1,308	5,216	4,006
80	3,980	5,032	7,049	1,344	5,366	4,137
81	4,029	5,093	7,135	1,360	5,429	4,189
82	4,076	5,159	7,221	1,378	5,497	4,247
83	4,122	5,217	7,309	1,390	5,560	4,296
84	4,172	5,277	7,393	1,408	5,627	4,355
85	4,224	5,342	7,482	1,427	5,692	4,412
86	4,274	5,410	7,572	1,441	5,765	4,467
87	4,324	5,471	7,662	1,460	5,831	4,522
88	4,376	5,538	7,756	1,479	5,903	4,582
89	4,430	5,604	7,847	1,495	5,972	4,639
90	4,482	5,666	7,938	1,513	6,043	4,698
91	4,535	5,734	8,036	1,532	6,117	4,761
92	4,590	5,807	8,129	1,548	6,192	4,819
93	4,647	5,876	8,230	1,568	6,260	4,879
94	4,701	5,945	8,330	1,590	6,337	4,943
95	4,760	6,018	8,436	1,608	6,415	5,006
96	4,813	6,091	8,533	1,626	6,495	5,075
97	4,877	6,167	8,637	1,646	6,573	5,134
98	4,932	6,240	8,741	1,667	6,649	5,202
99	4,992	6,311	8,843	1,684	6,729	5,269

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 periods, use preferred rates.

Modal factors

Semi-annual 0.5200

Quarterly 0.2650

Monthly.....0.0833

Continental Life Insurance Company of Brentwood, Tennessee

Annual premiums

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

Rates effective 9/1/2024

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	3,797	4,802	6,727	n/a	5,121	3,977
65	1,994	2,523	3,537	673	2,691	1,984
66	2,074	2,621	3,672	701	2,796	2,066
67	2,154	2,724	3,816	727	2,905	2,151
68	2,239	2,830	3,966	755	3,017	2,240
69	2,327	2,940	4,122	787	3,136	2,329
70	2,416	3,055	4,279	817	3,256	2,423
71	2,508	3,178	4,451	846	3,385	2,527
72	2,610	3,302	4,622	881	3,518	2,636
73	2,712	3,432	4,806	914	3,658	2,751
74	2,819	3,570	4,997	952	3,801	2,871
75	2,936	3,711	5,194	990	3,953	2,990
76	3,015	3,813	5,342	1,019	4,066	3,087
77	3,101	3,920	5,493	1,046	4,182	3,189
78	3,188	4,036	5,651	1,076	4,300	3,293
79	3,280	4,147	5,809	1,108	4,419	3,395
80	3,373	4,261	5,971	1,140	4,542	3,505
81	3,412	4,313	6,045	1,153	4,599	3,549
82	3,454	4,368	6,118	1,168	4,652	3,595
83	3,495	4,417	6,189	1,177	4,709	3,641
84	3,537	4,473	6,266	1,191	4,765	3,688
85	3,576	4,524	6,337	1,208	4,825	3,735
86	3,620	4,583	6,412	1,222	4,882	3,784
87	3,664	4,632	6,490	1,236	4,939	3,832
88	3,708	4,690	6,568	1,252	5,000	3,879
89	3,751	4,745	6,648	1,267	5,056	3,931
90	3,797	4,802	6,727	1,279	5,121	3,977
91	3,842	4,861	6,807	1,297	5,181	4,029
92	3,891	4,919	6,890	1,312	5,242	4,082
93	3,936	4,976	6,972	1,328	5,304	4,131
94	3,982	5,036	7,058	1,346	5,371	4,187
95	4,032	5,097	7,143	1,361	5,433	4,241
96	4,080	5,160	7,226	1,379	5,500	4,297
97	4,128	5,221	7,315	1,394	5,568	4,349
98	4,179	5,283	7,402	1,411	5,633	4,406
99	4,228	5,346	7,490	1,427	5,699	4,459

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	4,214	5,327	7,464	n/a	5,682	4,417
65	2,217	2,800	3,923	747	2,984	2,201
66	2,306	2,911	4,074	776	3,101	2,295
67	2,391	3,025	4,236	806	3,224	2,388
68	2,484	3,141	4,403	840	3,347	2,486
69	2,582	3,263	4,569	871	3,479	2,587
70	2,683	3,394	4,747	906	3,615	2,690
71	2,790	3,526	4,938	941	3,758	2,806
72	2,897	3,665	5,133	978	3,905	2,929
73	3,012	3,810	5,336	1,015	4,062	3,053
74	3,132	3,960	5,542	1,057	4,217	3,188
75	3,254	4,114	5,765	1,099	4,387	3,321
76	3,347	4,234	5,931	1,129	4,514	3,423
77	3,442	4,352	6,097	1,162	4,642	3,541
78	3,540	4,476	6,271	1,194	4,769	3,653
79	3,640	4,604	6,448	1,230	4,904	3,766
80	3,742	4,731	6,628	1,264	5,045	3,890
81	3,788	4,788	6,708	1,278	5,104	3,938
82	3,832	4,850	6,789	1,296	5,168	3,993
83	3,875	4,905	6,872	1,307	5,227	4,039
84	3,923	4,961	6,951	1,323	5,290	4,094
85	3,971	5,023	7,035	1,342	5,352	4,148
86	4,018	5,086	7,119	1,355	5,420	4,200
87	4,066	5,144	7,204	1,373	5,482	4,252
88	4,114	5,206	7,292	1,390	5,550	4,308
89	4,165	5,269	7,378	1,406	5,614	4,362
90	4,214	5,327	7,464	1,422	5,682	4,417
91	4,264	5,391	7,555	1,440	5,751	4,476
92	4,315	5,459	7,643	1,455	5,821	4,531
93	4,369	5,524	7,737	1,474	5,885	4,587
94	4,420	5,589	7,832	1,495	5,958	4,648
95	4,475	5,658	7,931	1,511	6,031	4,707
96	4,525	5,727	8,022	1,529	6,106	4,772
97	4,585	5,798	8,120	1,548	6,180	4,827
98	4,637	5,866	8,218	1,568	6,251	4,891
99	4,694	5,933	8,314	1,583	6,326	4,953

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 periods, use preferred rates.

Modal factors

Semi-annual	0.5200
Quarterly	0.2650
Monthly	0.0833

Continental Life Insurance Company of Brentwood, Tennessee

Annual premiums

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

Rates effective 9/1/2024

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	3,452	4,365	6,115	n/a	4,655	3,615
65	1,813	2,294	3,215	612	2,446	1,804
66	1,885	2,383	3,338	637	2,542	1,878
67	1,958	2,476	3,469	661	2,641	1,955
68	2,035	2,573	3,605	686	2,743	2,036
69	2,115	2,673	3,747	715	2,851	2,117
70	2,196	2,777	3,890	743	2,960	2,203
71	2,280	2,889	4,046	769	3,077	2,297
72	2,373	3,002	4,202	801	3,198	2,396
73	2,465	3,120	4,369	831	3,325	2,501
74	2,563	3,245	4,543	865	3,455	2,610
75	2,669	3,374	4,722	900	3,594	2,718
76	2,741	3,466	4,856	926	3,696	2,806
77	2,819	3,564	4,994	951	3,802	2,899
78	2,898	3,669	5,137	978	3,909	2,994
79	2,982	3,770	5,281	1,007	4,017	3,086
80	3,066	3,874	5,428	1,036	4,129	3,186
81	3,102	3,921	5,495	1,048	4,181	3,226
82	3,140	3,971	5,562	1,062	4,229	3,268
83	3,177	4,015	5,626	1,070	4,281	3,310
84	3,215	4,066	5,696	1,083	4,332	3,353
85	3,251	4,113	5,761	1,098	4,386	3,395
86	3,291	4,166	5,829	1,111	4,438	3,440
87	3,331	4,211	5,900	1,124	4,490	3,484
88	3,371	4,264	5,971	1,138	4,545	3,526
89	3,410	4,314	6,044	1,152	4,596	3,574
90	3,452	4,365	6,115	1,163	4,655	3,615
91	3,493	4,419	6,188	1,179	4,710	3,663
92	3,537	4,472	6,264	1,193	4,765	3,711
93	3,578	4,524	6,338	1,207	4,822	3,755
94	3,620	4,578	6,416	1,224	4,883	3,806
95	3,665	4,634	6,494	1,237	4,939	3,855
96	3,709	4,691	6,569	1,254	5,000	3,906
97	3,753	4,746	6,650	1,267	5,062	3,954
98	3,799	4,803	6,729	1,283	5,121	4,005
99	3,844	4,860	6,809	1,297	5,181	4,054

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	3,831	4,843	6,785	n/a	5,165	4,015
65	2,015	2,545	3,566	679	2,713	2,001
66	2,096	2,646	3,704	705	2,819	2,086
67	2,174	2,750	3,851	733	2,931	2,171
68	2,258	2,855	4,003	764	3,043	2,260
69	2,347	2,966	4,154	792	3,163	2,352
70	2,439	3,085	4,315	824	3,286	2,445
71	2,536	3,205	4,489	855	3,416	2,551
72	2,634	3,332	4,666	889	3,550	2,663
73	2,738	3,464	4,851	923	3,693	2,775
74	2,847	3,600	5,038	961	3,834	2,898
75	2,958	3,740	5,241	999	3,988	3,019
76	3,043	3,849	5,392	1,026	4,104	3,112
77	3,129	3,956	5,543	1,056	4,220	3,219
78	3,218	4,069	5,701	1,085	4,335	3,321
79	3,309	4,185	5,862	1,118	4,458	3,424
80	3,402	4,301	6,025	1,149	4,586	3,536
81	3,444	4,353	6,098	1,162	4,640	3,580
82	3,484	4,409	6,172	1,178	4,698	3,630
83	3,523	4,459	6,247	1,188	4,752	3,672
84	3,566	4,510	6,319	1,203	4,809	3,722
85	3,610	4,566	6,395	1,220	4,865	3,771
86	3,653	4,624	6,472	1,232	4,927	3,818
87	3,696	4,676	6,549	1,248	4,984	3,865
88	3,740	4,733	6,629	1,264	5,045	3,916
89	3,786	4,790	6,707	1,278	5,104	3,965
90	3,831	4,843	6,785	1,293	5,165	4,015
91	3,876	4,901	6,868	1,309	5,228	4,069
92	3,923	4,963	6,948	1,323	5,292	4,119
93	3,972	5,022	7,034	1,340	5,350	4,170
94	4,018	5,081	7,120	1,359	5,416	4,225
95	4,068	5,144	7,210	1,374	5,483	4,279
96	4,114	5,206	7,293	1,390	5,551	4,338
97	4,168	5,271	7,382	1,407	5,618	4,388
98	4,215	5,333	7,471	1,425	5,683	4,446
99	4,267	5,394	7,558	1,439	5,751	4,503

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 periods, use preferred rates.

Modal factors

Semi-annual 0.5200

Quarterly 0.2650

Monthly 0.0833

Continental Life Insurance Company of Brentwood, Tennessee

Annual premiums

For Use in ZIP Codes: Rest of State

Rates effective 9/1/2024

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	3,279	4,147	5,809	n/a	4,422	3,434
65	1,722	2,179	3,054	581	2,324	1,714
66	1,791	2,264	3,171	605	2,415	1,784
67	1,860	2,352	3,296	628	2,509	1,857
68	1,933	2,444	3,425	652	2,606	1,934
69	2,009	2,539	3,560	679	2,708	2,011
70	2,086	2,638	3,696	706	2,812	2,093
71	2,166	2,745	3,844	731	2,923	2,182
72	2,254	2,852	3,992	761	3,038	2,276
73	2,342	2,964	4,151	789	3,159	2,376
74	2,435	3,083	4,316	822	3,282	2,480
75	2,536	3,205	4,486	855	3,414	2,582
76	2,604	3,293	4,613	880	3,511	2,666
77	2,678	3,386	4,744	903	3,612	2,754
78	2,753	3,486	4,880	929	3,714	2,844
79	2,833	3,582	5,017	957	3,816	2,932
80	2,913	3,680	5,157	984	3,923	3,027
81	2,947	3,725	5,220	996	3,972	3,065
82	2,983	3,772	5,284	1,009	4,018	3,105
83	3,018	3,814	5,345	1,017	4,067	3,145
84	3,054	3,863	5,411	1,029	4,115	3,185
85	3,088	3,907	5,473	1,043	4,167	3,225
86	3,126	3,958	5,538	1,055	4,216	3,268
87	3,164	4,000	5,605	1,068	4,266	3,310
88	3,202	4,051	5,672	1,081	4,318	3,350
89	3,240	4,098	5,742	1,094	4,366	3,395
90	3,279	4,147	5,809	1,105	4,422	3,434
91	3,318	4,198	5,879	1,120	4,475	3,480
92	3,360	4,248	5,951	1,133	4,527	3,525
93	3,399	4,298	6,021	1,147	4,581	3,567
94	3,439	4,349	6,095	1,163	4,639	3,616
95	3,482	4,402	6,169	1,175	4,692	3,662
96	3,524	4,456	6,241	1,191	4,750	3,711
97	3,565	4,509	6,318	1,204	4,809	3,756
98	3,609	4,563	6,393	1,219	4,865	3,805
99	3,652	4,617	6,469	1,232	4,922	3,851

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	3,639	4,601	6,446	n/a	4,907	3,814
65	1,914	2,418	3,388	645	2,577	1,901
66	1,991	2,514	3,519	670	2,678	1,982
67	2,065	2,613	3,658	696	2,784	2,062
68	2,145	2,712	3,803	726	2,891	2,147
69	2,230	2,818	3,946	752	3,005	2,234
70	2,317	2,931	4,099	783	3,122	2,323
71	2,409	3,045	4,265	812	3,245	2,423
72	2,502	3,165	4,433	845	3,373	2,530
73	2,601	3,291	4,608	877	3,508	2,636
74	2,705	3,420	4,786	913	3,642	2,753
75	2,810	3,553	4,979	949	3,789	2,868
76	2,891	3,657	5,122	975	3,899	2,956
77	2,973	3,758	5,266	1,003	4,009	3,058
78	3,057	3,866	5,416	1,031	4,118	3,155
79	3,144	3,976	5,569	1,062	4,235	3,253
80	3,232	4,086	5,724	1,092	4,357	3,359
81	3,272	4,135	5,793	1,104	4,408	3,401
82	3,310	4,189	5,863	1,119	4,463	3,449
83	3,347	4,236	5,935	1,129	4,514	3,488
84	3,388	4,285	6,003	1,143	4,569	3,536
85	3,430	4,338	6,075	1,159	4,622	3,582
86	3,470	4,393	6,148	1,170	4,681	3,627
87	3,511	4,442	6,222	1,186	4,735	3,672
88	3,553	4,496	6,298	1,201	4,793	3,720
89	3,597	4,551	6,372	1,214	4,849	3,767
90	3,639	4,601	6,446	1,228	4,907	3,814
91	3,682	4,656	6,525	1,244	4,967	3,866
92	3,727	4,715	6,601	1,257	5,027	3,913
93	3,773	4,771	6,682	1,273	5,083	3,962
94	3,817	4,827	6,764	1,291	5,145	4,014
95	3,865	4,887	6,850	1,305	5,209	4,065
96	3,908	4,946	6,928	1,321	5,273	4,121
97	3,960	5,007	7,013	1,337	5,337	4,169
98	4,004	5,066	7,097	1,354	5,399	4,224
99	4,054	5,124	7,180	1,367	5,463	4,278

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 periods, use preferred rates.

Modal factors

Semi-annual	0.5200
Quarterly	0.2650
Monthly	0.0833

PREMIUM INFORMATION

Continental Life Insurance Company of Brentwood, Tennessee can only raise your premium if we raise the premium for all policies like yours in this state. Premiums for this policy will increase due to the increase in your age. Upon attainment of an age requiring a rate increase, the renewal premium for the policy will be the renewal premium then in effect for your attained age. Other policies may be provided with Issue Age rating and do not increase with age. You should compare Issue Age with Attained Age policies.

Premiums payable other than annually will be determined according to the following factors: Semi-annual: 0.5200 Quarterly: 0.2650 Monthly EFT: 0.0833.

HOUSEHOLD DISCOUNT

In order to be eligible for the Household discount under a Continental Life Insurance Company of Brentwood, Tennessee Medicare supplement plan, you must apply for a Medicare supplement plan at the same time as another Medicare eligible adult or the other Medicare eligible adult must currently 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 $1,632	$0	$1,632 (Part A Deductible)
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after While using 60 lifetime reserve days	All but $816 a day	$816 a day	$0
Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $204 a day	$0	Up to $204 a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

PLAN A

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

*Once you have been billed $240 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $240 of Medicare-Approved amounts*	$0	$0	$240 (Part B Deductible)
Remainder of Medicare-Approved amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare-Approved amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $240 of Medicare-Approved amounts*	$0	$0	$240 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
First $240 of Medicare-Approved amounts*	$0	$0	$240 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	$0

PLAN B

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,632	$1,632 (Part A Deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after While using 60 lifetime reserve days	All but $816 a day	$816 a day	$0
Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $204 a day	$0	Up to $204 a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

PLAN B

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

*Once you have been billed $240 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $240 of Medicare-Approved amounts*	$0	$0	$240 (Part B Deductible)
Remainder of Medicare-Approved amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare-Approved amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $240 of Medicare-Approved amounts*	$0	$0	$240 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
First $240 of Medicare-Approved amounts*	$0	$0	$240 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	$0

PLAN F

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,632	$1,632 (Part A Deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after While using 60 lifetime reserve days	All but $816 a day	$816 a day	$0
Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $204 a day	Up to $204 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

PLAN F

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

*Once you have been billed $240 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $240 of Medicare-Approved amounts*	$0	$240 (Part B Deductible)	$0
Remainder of Medicare-Approved amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare-Approved amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $240 of Medicare-Approved amounts*	$0	$240 (Part B Deductible)	$0
Remainder of Medicare-Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
First $240 of Medicare-Approved amounts*	$0	$240 (Part B Deductible)	$0
Remainder of Medicare-Approved amounts	80%	20%	$0

PLAN F

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

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 $2,800 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses are $2,800. 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 $2,800 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2,800 DEDUCTIBLE*** YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,632	$1,632 (Part A Deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after While using 60 lifetime reserve days	All but $816 a day	$816 a day	$0
Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $204 a day	Up to $204 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

HIGH DEDUCTIBLE PLAN F

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

*Once you have been billed $240 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

*****This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2,800 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses are $2,800. 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 $2,800 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2,800 DEDUCTIBLE*** YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $240 of Medicare-Approved amounts*	$0	$240 (Part B Deductible)	$0
Remainder of Medicare-Approved amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare-Approved amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $240 of Medicare-Approved amounts*	$0	$240 (Part B Deductible)	$0
Remainder of Medicare-Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

HIGH DEDUCTIBLE PLAN F

PARTS A & B

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,800 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2,800 DEDUCTIBLE** YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
First $240 of Medicare-Approved amounts*	$0	$240 (Part B Deductible)	$0
Remainder of Medicare-Approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,800 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2,800 DEDUCTIBLE** YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN G

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,632	$1,632 (Part A Deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after While using 60 lifetime reserve days	All but $816 a day	$816 a day	$0
Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $204 a day	Up to $204 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

PLAN G

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

*Once you have been billed $240 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $240 of Medicare-Approved amounts*	$0	$0	$240 (Part B Deductible)
Remainder of Medicare-Approved amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare-Approved amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $240 of Medicare-Approved amounts*	$0	$0	$240 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
First $240 of Medicare-Approved amounts*	$0	$0	$240 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	$0

PLAN G

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

PLAN N

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,632	$1,632 (Part A Deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after While using 60 lifetime reserve days	All but $816 a day	$816 a day	$0
Once lifetime reserve days are used:			
Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $204 a day	Up to $204 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

PLAN N

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

*Once you have been billed $240 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $240 of Medicare-Approved amounts*	$0	$0	$240 (Part B Deductible)
Remainder of Medicare-Approved amounts	Generally 80%	Balance, other than up to $20 per office visit and up to $50 per emergency room visit. The co-payment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
PART B EXCESS CHARGES (Above Medicare-Approved amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $240 of Medicare-Approved amounts*	$0	$0	$240 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN N

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
First $240 of Medicare-Approved amounts*	$0	$0	$240 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

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