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: 09/2025 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 2025[2]					**$7,220[2]**	**$3,610[2]**				

[1] Plans F and G also have a high deductible option, which require first paying a plan deductible of **$2,870** 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 9/1/2025

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	5,055	5,980	8,378	n/a	7,016	5,547
65	2,655	3,143	4,405	922	3,687	2,767
66	2,761	3,265	4,573	960	3,831	2,881
67	2,867	3,392	4,753	996	3,980	3,000
68	2,980	3,525	4,939	1,034	4,133	3,124
69	3,098	3,662	5,133	1,078	4,296	3,248
70	3,217	3,804	5,329	1,119	4,461	3,380
71	3,339	3,958	5,543	1,159	4,637	3,525
72	3,476	4,113	5,757	1,207	4,820	3,677
73	3,610	4,274	5,986	1,252	5,011	3,837
74	3,754	4,446	6,224	1,304	5,207	4,005
75	3,909	4,622	6,469	1,356	5,416	4,170
76	4,014	4,748	6,653	1,396	5,570	4,306
77	4,129	4,883	6,842	1,433	5,729	4,448
78	4,244	5,027	7,038	1,474	5,891	4,594
79	4,368	5,165	7,235	1,518	6,054	4,735
80	4,491	5,307	7,436	1,562	6,223	4,888
81	4,543	5,372	7,528	1,580	6,301	4,950
82	4,599	5,440	7,620	1,600	6,373	5,014
83	4,653	5,501	7,708	1,612	6,451	5,079
84	4,709	5,570	7,804	1,632	6,528	5,144
85	4,761	5,635	7,893	1,655	6,610	5,209
86	4,820	5,707	7,986	1,674	6,688	5,279
87	4,879	5,769	8,083	1,693	6,766	5,346
88	4,937	5,842	8,180	1,715	6,850	5,410
89	4,994	5,910	8,280	1,736	6,927	5,484
90	5,055	5,980	8,378	1,752	7,016	5,547
91	5,116	6,054	8,478	1,777	7,098	5,621
92	5,180	6,127	8,582	1,797	7,182	5,694
93	5,240	6,198	8,683	1,819	7,266	5,762
94	5,302	6,272	8,790	1,844	7,358	5,840
95	5,368	6,349	8,897	1,865	7,443	5,916
96	5,432	6,427	9,000	1,889	7,535	5,994
97	5,496	6,502	9,111	1,910	7,628	6,066
98	5,564	6,580	9,219	1,933	7,717	6,146
99	5,629	6,658	9,328	1,955	7,808	6,220

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	5,610	6,635	9,295	n/a	7,784	6,161
65	2,951	3,487	4,885	1,023	4,088	3,070
66	3,070	3,625	5,074	1,063	4,248	3,200
67	3,184	3,768	5,276	1,104	4,417	3,332
68	3,307	3,911	5,484	1,151	4,585	3,467
69	3,437	4,063	5,691	1,193	4,766	3,609
70	3,572	4,226	5,912	1,241	4,953	3,751
71	3,714	4,391	6,150	1,289	5,148	3,914
72	3,858	4,565	6,392	1,340	5,350	4,087
73	4,010	4,746	6,646	1,391	5,565	4,258
74	4,169	4,932	6,902	1,448	5,777	4,447
75	4,332	5,124	7,180	1,506	6,010	4,632
76	4,457	5,273	7,387	1,547	6,184	4,774
77	4,583	5,420	7,594	1,592	6,360	4,939
78	4,713	5,575	7,810	1,636	6,534	5,096
79	4,846	5,733	8,031	1,685	6,718	5,254
80	4,983	5,892	8,254	1,732	6,912	5,425
81	5,044	5,964	8,354	1,751	6,992	5,494
82	5,102	6,040	8,456	1,776	7,080	5,570
83	5,159	6,109	8,558	1,791	7,161	5,635
84	5,222	6,179	8,657	1,813	7,247	5,712
85	5,287	6,255	8,761	1,839	7,332	5,787
86	5,350	6,335	8,867	1,856	7,425	5,858
87	5,413	6,406	8,972	1,881	7,510	5,931
88	5,477	6,484	9,082	1,904	7,604	6,009
89	5,544	6,562	9,189	1,926	7,691	6,084
90	5,610	6,635	9,295	1,948	7,784	6,161
91	5,676	6,714	9,409	1,973	7,879	6,243
92	5,746	6,799	9,519	1,993	7,975	6,320
93	5,817	6,880	9,637	2,019	8,062	6,398
94	5,884	6,961	9,754	2,048	8,162	6,483
95	5,958	7,047	9,878	2,070	8,262	6,565
96	6,025	7,132	9,991	2,095	8,365	6,657
97	6,105	7,221	10,113	2,121	8,467	6,734
98	6,173	7,306	10,235	2,148	8,564	6,823
99	6,249	7,390	10,354	2,169	8,667	6,909

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 9/1/2025

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	4,502	5,325	7,460	n/a	6,248	4,940
65	2,364	2,799	3,922	821	3,283	2,464
66	2,458	2,907	4,072	855	3,411	2,566
67	2,553	3,021	4,232	887	3,544	2,672
68	2,654	3,139	4,398	921	3,681	2,782
69	2,758	3,261	4,571	960	3,826	2,893
70	2,865	3,388	4,746	997	3,972	3,010
71	2,973	3,525	4,936	1,032	4,130	3,139
72	3,095	3,662	5,126	1,075	4,292	3,274
73	3,215	3,806	5,330	1,115	4,463	3,417
74	3,343	3,959	5,542	1,161	4,637	3,566
75	3,481	4,116	5,761	1,208	4,823	3,714
76	3,575	4,229	5,924	1,243	4,961	3,834
77	3,677	4,348	6,093	1,276	5,102	3,961
78	3,780	4,476	6,267	1,313	5,246	4,091
79	3,889	4,599	6,443	1,352	5,391	4,216
80	3,999	4,726	6,622	1,391	5,541	4,353
81	4,046	4,784	6,704	1,407	5,611	4,408
82	4,096	4,845	6,786	1,425	5,675	4,465
83	4,143	4,898	6,864	1,436	5,745	4,523
84	4,193	4,961	6,949	1,453	5,813	4,581
85	4,240	5,018	7,028	1,474	5,887	4,638
86	4,292	5,083	7,111	1,491	5,956	4,701
87	4,344	5,137	7,198	1,508	6,026	4,760
88	4,397	5,202	7,285	1,527	6,100	4,818
89	4,447	5,263	7,374	1,546	6,168	4,884
90	4,502	5,325	7,460	1,560	6,248	4,940
91	4,555	5,391	7,549	1,582	6,321	5,006
92	4,613	5,456	7,642	1,601	6,395	5,070
93	4,667	5,519	7,732	1,620	6,471	5,131
94	4,721	5,585	7,828	1,642	6,553	5,201
95	4,780	5,653	7,923	1,660	6,628	5,268
96	4,837	5,723	8,014	1,682	6,710	5,338
97	4,895	5,790	8,113	1,701	6,793	5,402
98	4,954	5,860	8,209	1,721	6,872	5,473
99	5,013	5,929	8,307	1,741	6,953	5,539

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	4,996	5,908	8,278	n/a	6,932	5,486
65	2,628	3,105	4,351	911	3,640	2,734
66	2,734	3,228	4,519	947	3,783	2,850
67	2,835	3,355	4,698	983	3,933	2,967
68	2,945	3,483	4,884	1,025	4,083	3,088
69	3,061	3,619	5,068	1,063	4,244	3,213
70	3,181	3,764	5,264	1,105	4,410	3,340
71	3,307	3,910	5,477	1,148	4,585	3,486
72	3,436	4,065	5,693	1,193	4,764	3,639
73	3,571	4,226	5,918	1,238	4,956	3,792
74	3,712	4,392	6,146	1,290	5,145	3,960
75	3,858	4,563	6,394	1,341	5,352	4,125
76	3,969	4,696	6,578	1,377	5,507	4,252
77	4,081	4,826	6,762	1,418	5,663	4,398
78	4,197	4,964	6,955	1,457	5,818	4,538
79	4,315	5,106	7,152	1,501	5,983	4,679
80	4,437	5,247	7,351	1,542	6,155	4,831
81	4,492	5,311	7,440	1,559	6,227	4,892
82	4,543	5,379	7,530	1,581	6,305	4,961
83	4,595	5,440	7,621	1,595	6,377	5,018
84	4,651	5,502	7,709	1,614	6,454	5,086
85	4,708	5,571	7,802	1,637	6,529	5,153
86	4,764	5,641	7,896	1,653	6,612	5,217
87	4,820	5,705	7,990	1,675	6,688	5,281
88	4,878	5,774	8,087	1,696	6,771	5,351
89	4,937	5,844	8,183	1,715	6,849	5,418
90	4,996	5,908	8,278	1,735	6,932	5,486
91	5,054	5,979	8,379	1,757	7,016	5,560
92	5,117	6,055	8,477	1,775	7,102	5,628
93	5,180	6,127	8,581	1,798	7,180	5,697
94	5,240	6,199	8,686	1,824	7,269	5,773
95	5,306	6,276	8,796	1,843	7,358	5,846
96	5,366	6,351	8,897	1,865	7,449	5,928
97	5,436	6,431	9,006	1,889	7,540	5,996
98	5,497	6,506	9,115	1,913	7,626	6,076
99	5,564	6,581	9,221	1,931	7,718	6,152

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 9/1/2025

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	4,317	5,107	7,155	n/a	5,992	4,737
65	2,267	2,684	3,762	787	3,148	2,363
66	2,358	2,788	3,905	820	3,271	2,461
67	2,449	2,897	4,059	851	3,399	2,562
68	2,545	3,010	4,218	883	3,530	2,668
69	2,645	3,127	4,384	921	3,669	2,774
70	2,747	3,249	4,551	956	3,810	2,886
71	2,851	3,380	4,734	990	3,960	3,010
72	2,968	3,512	4,916	1,031	4,116	3,140
73	3,083	3,650	5,112	1,069	4,280	3,277
74	3,206	3,797	5,315	1,114	4,447	3,420
75	3,338	3,948	5,525	1,158	4,625	3,561
76	3,428	4,055	5,682	1,192	4,757	3,677
77	3,526	4,170	5,843	1,224	4,893	3,799
78	3,625	4,293	6,010	1,259	5,031	3,923
79	3,730	4,411	6,179	1,296	5,170	4,044
80	3,835	4,533	6,351	1,334	5,314	4,175
81	3,880	4,588	6,429	1,349	5,381	4,227
82	3,928	4,646	6,508	1,367	5,443	4,282
83	3,973	4,698	6,582	1,377	5,510	4,337
84	4,021	4,757	6,664	1,393	5,575	4,393
85	4,066	4,812	6,740	1,413	5,645	4,448
86	4,116	4,874	6,820	1,430	5,712	4,508
87	4,166	4,927	6,903	1,446	5,779	4,565
88	4,217	4,989	6,986	1,465	5,850	4,620
89	4,265	5,047	7,071	1,482	5,916	4,684
90	4,317	5,107	7,155	1,496	5,992	4,737
91	4,369	5,170	7,240	1,517	6,062	4,801
92	4,424	5,232	7,329	1,535	6,133	4,863
93	4,475	5,293	7,415	1,554	6,206	4,921
94	4,528	5,356	7,507	1,575	6,284	4,988
95	4,584	5,422	7,598	1,592	6,357	5,052
96	4,639	5,488	7,686	1,613	6,435	5,119
97	4,694	5,553	7,781	1,631	6,515	5,181
98	4,751	5,620	7,873	1,651	6,591	5,249
99	4,808	5,686	7,967	1,670	6,668	5,312

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	4,791	5,666	7,938	n/a	6,648	5,261
65	2,520	2,978	4,172	874	3,491	2,622
66	2,622	3,096	4,334	908	3,628	2,733
67	2,719	3,218	4,506	943	3,772	2,845
68	2,824	3,340	4,684	983	3,916	2,961
69	2,936	3,470	4,860	1,019	4,070	3,082
70	3,050	3,609	5,049	1,060	4,230	3,203
71	3,172	3,750	5,252	1,101	4,397	3,343
72	3,295	3,898	5,459	1,144	4,569	3,490
73	3,425	4,053	5,676	1,188	4,753	3,636
74	3,560	4,212	5,894	1,237	4,934	3,798
75	3,700	4,376	6,132	1,286	5,133	3,956
76	3,806	4,503	6,309	1,321	5,281	4,077
77	3,914	4,629	6,485	1,360	5,431	4,218
78	4,025	4,761	6,670	1,397	5,580	4,352
79	4,138	4,896	6,859	1,439	5,738	4,487
80	4,255	5,032	7,049	1,479	5,903	4,633
81	4,308	5,093	7,135	1,495	5,972	4,692
82	4,357	5,159	7,221	1,516	6,047	4,757
83	4,406	5,217	7,309	1,529	6,116	4,812
84	4,460	5,277	7,393	1,548	6,189	4,878
85	4,515	5,342	7,482	1,570	6,262	4,942
86	4,569	5,410	7,572	1,585	6,341	5,003
87	4,623	5,471	7,662	1,606	6,414	5,065
88	4,678	5,538	7,756	1,626	6,494	5,132
89	4,735	5,604	7,847	1,645	6,568	5,196
90	4,791	5,666	7,938	1,664	6,648	5,261
91	4,847	5,734	8,036	1,685	6,729	5,332
92	4,907	5,807	8,129	1,702	6,811	5,397
93	4,968	5,876	8,230	1,725	6,885	5,464
94	5,025	5,945	8,330	1,749	6,971	5,536
95	5,088	6,018	8,436	1,768	7,056	5,607
96	5,146	6,091	8,533	1,789	7,144	5,685
97	5,214	6,167	8,637	1,811	7,231	5,751
98	5,272	6,240	8,741	1,835	7,314	5,827
99	5,336	6,311	8,843	1,852	7,401	5,900

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 9/1/2025

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	4,059	4,802	6,727	n/a	5,633	4,454
65	2,132	2,523	3,537	740	2,960	2,222
66	2,217	2,621	3,672	771	3,076	2,313
67	2,302	2,724	3,816	800	3,196	2,409
68	2,393	2,830	3,966	831	3,319	2,508
69	2,487	2,940	4,122	866	3,450	2,608
70	2,583	3,055	4,279	899	3,582	2,714
71	2,681	3,178	4,451	931	3,724	2,830
72	2,791	3,302	4,622	969	3,870	2,952
73	2,899	3,432	4,806	1,005	4,024	3,081
74	3,014	3,570	4,997	1,047	4,181	3,215
75	3,138	3,711	5,194	1,089	4,348	3,348
76	3,223	3,813	5,342	1,121	4,473	3,457
77	3,315	3,920	5,493	1,151	4,600	3,572
78	3,408	4,036	5,651	1,184	4,730	3,688
79	3,507	4,147	5,809	1,219	4,861	3,802
80	3,606	4,261	5,971	1,254	4,996	3,925
81	3,648	4,313	6,045	1,268	5,059	3,974
82	3,693	4,368	6,118	1,285	5,117	4,026
83	3,736	4,417	6,189	1,295	5,180	4,078
84	3,781	4,473	6,266	1,310	5,242	4,131
85	3,823	4,524	6,337	1,329	5,308	4,182
86	3,870	4,583	6,412	1,344	5,370	4,238
87	3,917	4,632	6,490	1,360	5,433	4,292
88	3,964	4,690	6,568	1,377	5,500	4,344
89	4,010	4,745	6,648	1,394	5,562	4,403
90	4,059	4,802	6,727	1,407	5,633	4,454
91	4,107	4,861	6,807	1,427	5,699	4,513
92	4,159	4,919	6,890	1,443	5,766	4,572
93	4,208	4,976	6,972	1,461	5,834	4,627
94	4,257	5,036	7,058	1,481	5,908	4,689
95	4,310	5,097	7,143	1,497	5,976	4,750
96	4,362	5,160	7,226	1,517	6,050	4,813
97	4,413	5,221	7,315	1,533	6,125	4,871
98	4,467	5,283	7,402	1,552	6,196	4,935
99	4,520	5,346	7,490	1,570	6,269	4,994

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	4,505	5,327	7,464	n/a	6,250	4,947
65	2,369	2,800	3,923	822	3,282	2,465
66	2,465	2,911	4,074	854	3,411	2,570
67	2,556	3,025	4,236	887	3,546	2,675
68	2,655	3,141	4,403	924	3,682	2,784
69	2,760	3,263	4,569	958	3,827	2,897
70	2,868	3,394	4,747	997	3,977	3,012
71	2,982	3,526	4,938	1,035	4,134	3,143
72	3,098	3,665	5,133	1,076	4,296	3,281
73	3,220	3,810	5,336	1,117	4,468	3,419
74	3,347	3,960	5,542	1,163	4,639	3,571
75	3,478	4,114	5,765	1,209	4,826	3,719
76	3,578	4,234	5,931	1,242	4,965	3,834
77	3,680	4,352	6,097	1,278	5,106	3,966
78	3,784	4,476	6,271	1,313	5,246	4,092
79	3,891	4,604	6,448	1,353	5,394	4,219
80	4,001	4,731	6,628	1,390	5,550	4,356
81	4,050	4,788	6,708	1,406	5,614	4,411
82	4,096	4,850	6,789	1,426	5,685	4,473
83	4,143	4,905	6,872	1,438	5,750	4,524
84	4,193	4,961	6,951	1,455	5,819	4,586
85	4,245	5,023	7,035	1,476	5,887	4,646
86	4,296	5,086	7,119	1,491	5,962	4,704
87	4,346	5,144	7,204	1,510	6,030	4,762
88	4,398	5,206	7,292	1,529	6,105	4,825
89	4,452	5,269	7,378	1,547	6,175	4,885
90	4,505	5,327	7,464	1,564	6,250	4,947
91	4,557	5,391	7,555	1,584	6,326	5,013
92	4,613	5,459	7,643	1,601	6,403	5,074
93	4,671	5,524	7,737	1,621	6,474	5,137
94	4,725	5,589	7,832	1,645	6,554	5,205
95	4,784	5,658	7,931	1,662	6,634	5,271
96	4,838	5,727	8,022	1,682	6,717	5,345
97	4,902	5,798	8,120	1,703	6,798	5,407
98	4,957	5,866	8,218	1,725	6,876	5,478
99	5,017	5,933	8,314	1,741	6,959	5,547

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

To calculate a household discount:

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

Modal premium **x** .95 **= discounted premium**

If applying during Open Enrollment or Guaranteed Issue 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 9/1/2025

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	3,690	4,365	6,115	n/a	5,121	4,049
65	1,938	2,294	3,215	673	2,691	2,020
66	2,015	2,383	3,338	701	2,796	2,103
67	2,093	2,476	3,469	727	2,905	2,190
68	2,175	2,573	3,605	755	3,017	2,280
69	2,261	2,673	3,747	787	3,136	2,371
70	2,348	2,777	3,890	817	3,256	2,467
71	2,437	2,889	4,046	846	3,385	2,573
72	2,537	3,002	4,202	881	3,518	2,684
73	2,635	3,120	4,369	914	3,658	2,801
74	2,740	3,245	4,543	952	3,801	2,923
75	2,853	3,374	4,722	990	3,953	3,044
76	2,930	3,466	4,856	1,019	4,066	3,143
77	3,014	3,564	4,994	1,046	4,182	3,247
78	3,098	3,669	5,137	1,076	4,300	3,353
79	3,188	3,770	5,281	1,108	4,419	3,456
80	3,278	3,874	5,428	1,140	4,542	3,568
81	3,316	3,921	5,495	1,153	4,599	3,613
82	3,357	3,971	5,562	1,168	4,652	3,660
83	3,396	4,015	5,626	1,177	4,709	3,707
84	3,437	4,066	5,696	1,191	4,765	3,755
85	3,475	4,113	5,761	1,208	4,825	3,802
86	3,518	4,166	5,829	1,222	4,882	3,853
87	3,561	4,211	5,900	1,236	4,939	3,902
88	3,604	4,264	5,971	1,252	5,000	3,949
89	3,645	4,314	6,044	1,267	5,056	4,003
90	3,690	4,365	6,115	1,279	5,121	4,049
91	3,734	4,419	6,188	1,297	5,181	4,103
92	3,781	4,472	6,264	1,312	5,242	4,156
93	3,825	4,524	6,338	1,328	5,304	4,206
94	3,870	4,578	6,416	1,346	5,371	4,263
95	3,918	4,634	6,494	1,361	5,433	4,318
96	3,965	4,691	6,569	1,379	5,500	4,375
97	4,012	4,746	6,650	1,394	5,568	4,428
98	4,061	4,803	6,729	1,411	5,633	4,486
99	4,109	4,860	6,809	1,427	5,699	4,540

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	4,095	4,843	6,785	n/a	5,682	4,497
65	2,154	2,545	3,566	747	2,984	2,241
66	2,241	2,646	3,704	776	3,101	2,336
67	2,324	2,750	3,851	806	3,224	2,432
68	2,414	2,855	4,003	840	3,347	2,531
69	2,509	2,966	4,154	871	3,479	2,634
70	2,607	3,085	4,315	906	3,615	2,738
71	2,711	3,205	4,489	941	3,758	2,857
72	2,816	3,332	4,666	978	3,905	2,983
73	2,927	3,464	4,851	1,015	4,062	3,108
74	3,043	3,600	5,038	1,057	4,217	3,246
75	3,162	3,740	5,241	1,099	4,387	3,381
76	3,253	3,849	5,392	1,129	4,514	3,485
77	3,345	3,956	5,543	1,162	4,642	3,605
78	3,440	4,069	5,701	1,194	4,769	3,720
79	3,537	4,185	5,862	1,230	4,904	3,835
80	3,637	4,301	6,025	1,264	5,045	3,960
81	3,682	4,353	6,098	1,278	5,104	4,010
82	3,724	4,409	6,172	1,296	5,168	4,066
83	3,766	4,459	6,247	1,307	5,227	4,113
84	3,812	4,510	6,319	1,323	5,290	4,169
85	3,859	4,566	6,395	1,342	5,352	4,224
86	3,905	4,624	6,472	1,355	5,420	4,276
87	3,951	4,676	6,549	1,373	5,482	4,329
88	3,998	4,733	6,629	1,390	5,550	4,386
89	4,047	4,790	6,707	1,406	5,614	4,441
90	4,095	4,843	6,785	1,422	5,682	4,497
91	4,143	4,901	6,868	1,440	5,751	4,557
92	4,194	4,963	6,948	1,455	5,821	4,613
93	4,246	5,022	7,034	1,474	5,885	4,670
94	4,295	5,081	7,120	1,495	5,958	4,732
95	4,349	5,144	7,210	1,511	6,031	4,792
96	4,398	5,206	7,293	1,529	6,106	4,859
97	4,456	5,271	7,382	1,548	6,180	4,915
98	4,506	5,333	7,471	1,568	6,251	4,980
99	4,561	5,394	7,558	1,583	6,326	5,043

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 9/1/2025

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	3,506	4,147	5,809	n/a	4,865	3,847
65	1,841	2,179	3,054	639	2,556	1,919
66	1,914	2,264	3,171	666	2,656	1,998
67	1,988	2,352	3,296	691	2,760	2,081
68	2,066	2,444	3,425	717	2,866	2,166
69	2,148	2,539	3,560	748	2,979	2,252
70	2,231	2,638	3,696	776	3,093	2,344
71	2,315	2,745	3,844	804	3,216	2,444
72	2,410	2,852	3,992	837	3,342	2,550
73	2,503	2,964	4,151	868	3,475	2,661
74	2,603	3,083	4,316	904	3,611	2,777
75	2,710	3,205	4,486	941	3,755	2,892
76	2,784	3,293	4,613	968	3,863	2,986
77	2,863	3,386	4,744	994	3,973	3,085
78	2,943	3,486	4,880	1,022	4,085	3,185
79	3,029	3,582	5,017	1,053	4,198	3,283
80	3,114	3,680	5,157	1,083	4,315	3,390
81	3,150	3,725	5,220	1,095	4,369	3,432
82	3,189	3,772	5,284	1,110	4,419	3,477
83	3,226	3,814	5,345	1,118	4,474	3,522
84	3,265	3,863	5,411	1,131	4,527	3,567
85	3,301	3,907	5,473	1,148	4,584	3,612
86	3,342	3,958	5,538	1,161	4,638	3,660
87	3,383	4,000	5,605	1,174	4,692	3,707
88	3,424	4,051	5,672	1,189	4,750	3,752
89	3,463	4,098	5,742	1,204	4,803	3,803
90	3,506	4,147	5,809	1,215	4,865	3,847
91	3,547	4,198	5,879	1,232	4,922	3,898
92	3,592	4,248	5,951	1,246	4,980	3,948
93	3,634	4,298	6,021	1,262	5,039	3,996
94	3,677	4,349	6,095	1,279	5,102	4,050
95	3,722	4,402	6,169	1,293	5,161	4,102
96	3,767	4,456	6,241	1,310	5,225	4,156
97	3,811	4,509	6,318	1,324	5,290	4,207
98	3,858	4,563	6,393	1,340	5,351	4,262
99	3,904	4,617	6,469	1,356	5,414	4,313

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	3,890	4,601	6,446	n/a	5,398	4,272
65	2,046	2,418	3,388	710	2,835	2,129
66	2,129	2,514	3,519	737	2,946	2,219
67	2,208	2,613	3,658	766	3,063	2,310
68	2,293	2,712	3,803	798	3,180	2,404
69	2,384	2,818	3,946	827	3,305	2,502
70	2,477	2,931	4,099	861	3,434	2,601
71	2,575	3,045	4,265	894	3,570	2,714
72	2,675	3,165	4,433	929	3,710	2,834
73	2,781	3,291	4,608	964	3,859	2,953
74	2,891	3,420	4,786	1,004	4,006	3,084
75	3,004	3,553	4,979	1,044	4,168	3,212
76	3,090	3,657	5,122	1,073	4,288	3,311
77	3,178	3,758	5,266	1,104	4,410	3,425
78	3,268	3,866	5,416	1,134	4,531	3,534
79	3,360	3,976	5,569	1,169	4,659	3,643
80	3,455	4,086	5,724	1,201	4,793	3,762
81	3,498	4,135	5,793	1,214	4,849	3,810
82	3,538	4,189	5,863	1,231	4,910	3,863
83	3,578	4,236	5,935	1,242	4,966	3,907
84	3,621	4,285	6,003	1,257	5,026	3,961
85	3,666	4,338	6,075	1,275	5,084	4,013
86	3,710	4,393	6,148	1,287	5,149	4,062
87	3,753	4,442	6,222	1,304	5,208	4,113
88	3,798	4,496	6,298	1,321	5,273	4,167
89	3,845	4,551	6,372	1,336	5,333	4,219
90	3,890	4,601	6,446	1,351	5,398	4,272
91	3,936	4,656	6,525	1,368	5,463	4,329
92	3,984	4,715	6,601	1,382	5,530	4,382
93	4,034	4,771	6,682	1,400	5,591	4,437
94	4,080	4,827	6,764	1,420	5,660	4,495
95	4,132	4,887	6,850	1,435	5,729	4,552
96	4,178	4,946	6,928	1,453	5,801	4,616
97	4,233	5,007	7,013	1,471	5,871	4,669
98	4,281	5,066	7,097	1,490	5,938	4,731
99	4,333	5,124	7,180	1,504	6,010	4,791

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 $1,676	$0	$1,676 (Part A Deductible)
61st thru 90th day	All but $419 a day	$419 a day	$0
91st day and after While using 60 lifetime reserve days	All but $838 a day	$838 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 $209.50 a day	$0	Up to $209.50 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 $257 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 $257 of Medicare-Approved amounts*	$0	$0	$257 (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 $257 of Medicare-Approved amounts*	$0	$0	$257 (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 $257 of Medicare-Approved amounts*	$0	$0	$257 (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 $1,676	$1,676 (Part A Deductible)	$0
61st thru 90th day	All but $419 a day	$419 a day	$0
91st day and after While using 60 lifetime reserve days	All but $838 a day	$838 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 $209.50 a day	$0	Up to $209.50 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 $257 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 $257 of Medicare-Approved amounts*	$0	$0	$257 (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 $257 of Medicare-Approved amounts*	$0	$0	$257 (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 $257 of Medicare-Approved amounts*	$0	$0	$257 (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 $1,676	$1,676 (Part A Deductible)	$0
61st thru 90th day	All but $419 a day	$419 a day	$0
91st day and after While using 60 lifetime reserve days	All but $838 a day	$838 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 $209.50 a day	Up to $209.50 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 $257 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 $257 of Medicare-Approved amounts*	$0	$257 (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 $257 of Medicare-Approved amounts*	$0	$257 (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 $257 of Medicare-Approved amounts*	$0	$257 (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 $2,870 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses are $2,870. 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 $2,870 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2,870 DEDUCTIBLE*** YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,676	$1,676 (Part A Deductible)	$0
61st thru 90th day	All but $419 a day	$419 a day	$0
91st day and after While using 60 lifetime reserve days	All but $838 a day	$838 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 $209.50 a day	Up to $209.50 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.

HIGH DEDUCTIBLE PLAN F

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

*Once you have been billed $257 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 $2,870 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses are $2,870. 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 $2,870 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2,870 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 $257 of Medicare-Approved amounts*	$0	$257 (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 $257 of Medicare-Approved amounts*	$0	$257 (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 $2,870 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2,870 DEDUCTIBLE** YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
First $257 of Medicare-Approved amounts*	$0	$257 (Part B Deductible)	$0
Remainder of Medicare-Approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,870 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2,870 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 $1,676	$1,676 (Part A Deductible)	$0
61st thru 90th day	All but $419 a day	$419 a day	$0
91st day and after While using 60 lifetime reserve days	All but $838 a day	$838 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 $209.50 a day	Up to $209.50 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 G

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

*Once you have been billed $257 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 $257 of Medicare-Approved amounts*	$0	$0	$257 (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 $257 of Medicare-Approved amounts*	$0	$0	$257 (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 $257 of Medicare-Approved amounts*	$0	$0	$257 (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 $1,676	$1,676 (Part A Deductible)	$0
61st thru 90th day	All but $419 a day	$419 a day	$0
91st day and after While using 60 lifetime reserve days	All but $838 a day	$838 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 $209.50 a day	Up to $209.50 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 N

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

*Once you have been billed $257 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 $257 of Medicare-Approved amounts*	$0	$0	$257 (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 $257 of Medicare-Approved amounts*	$0	$0	$257 (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 $257 of Medicare-Approved amounts*	$0	$0	$257 (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