Outline of coverage

Medicare Supplement Insurance

Benefit Plans A, B, F, G, High Deductible G, N

Michigan

Underwritten by

Continental Life Insurance Company of Brentwood, Tennessee

An Aetna Company

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CLIMS04879MI

Rates effective: 05/2024 B

CONTINENTAL LIFE INSURANCE COMPANY OF BRENTWOOD, TENNESSEE
OUTLINE OF MEDICARE SUPPLEMENT COVERAGE COVER PAGE
BENEFIT PLANS AVAILABLE: A, B, F, G, HIGH DEDUCTIBLE 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: 480-485

Female rates

Rates effective 5/1/2024

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
65	1,792	1,923	2,410	1,836	654	1,307
66	1,792	1,923	2,410	1,836	654	1,307
67	1,792	1,923	2,410	1,836	654	1,307
68	1,813	1,945	2,436	1,857	661	1,353
69	1,853	1,989	2,492	1,900	677	1,408
70	1,902	2,041	2,557	1,950	694	1,462
71	1,961	2,102	2,634	2,008	715	1,513
72	2,022	2,169	2,717	2,069	737	1,565
73	2,086	2,237	2,805	2,137	760	1,619
74	2,158	2,317	2,902	2,212	788	1,673
75	2,236	2,399	3,004	2,290	815	1,728
76	2,313	2,483	3,109	2,369	844	1,782
77	2,394	2,571	3,218	2,455	874	1,842
78	2,477	2,657	3,328	2,538	903	1,903
79	2,553	2,739	3,432	2,617	932	1,964
80	2,634	2,824	3,542	2,699	961	2,030
81	2,717	2,915	3,651	2,784	991	2,094
82	2,797	3,001	3,762	2,867	1,020	2,156
83	2,884	3,094	3,876	2,955	1,052	2,223
84	2,968	3,185	3,989	3,040	1,082	2,288
85	3,076	3,300	4,136	3,151	1,122	2,370
86	3,163	3,396	4,254	3,242	1,154	2,438
87	3,253	3,490	4,374	3,334	1,186	2,508
88	3,343	3,588	4,498	3,427	1,220	2,577
89	3,439	3,688	4,624	3,521	1,254	2,649
90	3,532	3,791	4,749	3,620	1,288	2,723
91	3,630	3,894	4,878	3,719	1,324	2,796
92	3,726	3,998	5,009	3,817	1,359	2,872
93	3,826	4,105	5,142	3,919	1,394	2,949
94	3,927	4,213	5,278	4,022	1,432	3,026
95	4,030	4,324	5,417	4,128	1,469	3,105
96	4,135	4,435	5,558	4,235	1,508	3,185
97	4,240	4,547	5,699	4,343	1,547	3,266
98	4,346	4,664	5,841	4,452	1,585	3,350
99+	4,455	4,779	5,988	4,564	1,625	3,433

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
65	1,991	2,139	2,677	2,042	727	1,452
66	1,991	2,139	2,677	2,042	727	1,452
67	1,991	2,139	2,677	2,042	727	1,452
68	2,013	2,159	2,707	2,063	734	1,504
69	2,058	2,208	2,768	2,108	753	1,565
70	2,114	2,269	2,840	2,167	771	1,624
71	2,176	2,335	2,926	2,230	795	1,681
72	2,245	2,410	3,020	2,301	819	1,740
73	2,318	2,486	3,116	2,375	845	1,798
74	2,400	2,574	3,226	2,458	876	1,859
75	2,484	2,663	3,338	2,544	905	1,919
76	2,571	2,758	3,454	2,634	939	1,980
77	2,660	2,855	3,577	2,728	971	2,047
78	2,751	2,952	3,699	2,821	1,003	2,114
79	2,837	3,044	3,816	2,908	1,036	2,183
80	2,926	3,139	3,933	2,999	1,068	2,257
81	3,020	3,239	4,058	3,093	1,102	2,325
82	3,109	3,335	4,180	3,183	1,133	2,396
83	3,206	3,440	4,309	3,283	1,169	2,469
84	3,299	3,538	4,433	3,378	1,202	2,541
85	3,416	3,666	4,595	3,501	1,247	2,634
86	3,515	3,772	4,728	3,601	1,282	2,708
87	3,615	3,880	4,859	3,704	1,318	2,788
88	3,717	3,988	4,996	3,808	1,355	2,865
89	3,821	4,097	5,136	3,914	1,393	2,943
90	3,926	4,210	5,277	4,021	1,432	3,026
91	4,032	4,326	5,420	4,132	1,471	3,107
92	4,141	4,443	5,566	4,242	1,510	3,192
93	4,250	4,560	5,714	4,357	1,551	3,276
94	4,362	4,681	5,866	4,469	1,592	3,362
95	4,476	4,804	6,018	4,588	1,634	3,451
96	4,593	4,929	6,174	4,704	1,675	3,538
97	4,710	5,053	6,331	4,826	1,718	3,630
98	4,829	5,183	6,492	4,947	1,760	3,722
99+	4,951	5,309	6,655	5,073	1,806	3,815

The above rates do not include the $20 one-time policy fee.

To calculate a household discount:

Annual premium **x** modal factor **= modal premium** (round to nearest whole cent)
Modal premium **x** .93 **= 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: 480-485

Male rates

Rates effective 5/1/2024

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
65	2,063	2,212	2,769	2,114	753	1,503
66	2,063	2,212	2,769	2,114	753	1,503
67	2,063	2,212	2,769	2,114	753	1,503
68	2,085	2,235	2,802	2,134	760	1,556
69	2,130	2,288	2,867	2,184	778	1,620
70	2,189	2,349	2,941	2,242	798	1,681
71	2,256	2,418	3,029	2,309	824	1,741
72	2,323	2,494	3,126	2,381	847	1,800
73	2,400	2,575	3,226	2,458	875	1,862
74	2,484	2,663	3,339	2,544	906	1,924
75	2,571	2,758	3,457	2,634	937	1,986
76	2,660	2,855	3,576	2,727	971	2,048
77	2,751	2,956	3,703	2,822	1,005	2,118
78	2,850	3,056	3,827	2,919	1,038	2,187
79	2,938	3,151	3,949	3,011	1,072	2,259
80	3,029	3,250	4,072	3,104	1,105	2,335
81	3,126	3,351	4,199	3,203	1,139	2,407
82	3,217	3,453	4,327	3,296	1,172	2,480
83	3,318	3,560	4,458	3,398	1,210	2,557
84	3,414	3,661	4,590	3,498	1,244	2,630
85	3,536	3,795	4,756	3,625	1,291	2,728
86	3,638	3,904	4,890	3,728	1,327	2,804
87	3,741	4,015	5,029	3,836	1,364	2,883
88	3,845	4,126	5,172	3,942	1,403	2,965
89	3,952	4,241	5,317	4,050	1,442	3,046
90	4,060	4,359	5,461	4,161	1,481	3,132
91	4,171	4,477	5,608	4,274	1,521	3,216
92	4,286	4,597	5,761	4,391	1,563	3,304
93	4,399	4,719	5,913	4,508	1,604	3,389
94	4,516	4,846	6,070	4,626	1,648	3,481
95	4,631	4,973	6,231	4,747	1,690	3,572
96	4,754	5,101	6,389	4,868	1,734	3,662
97	4,875	5,230	6,554	4,995	1,778	3,756
98	4,996	5,363	6,719	5,120	1,823	3,853
99+	5,122	5,496	6,887	5,248	1,868	3,948

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
65	2,291	2,461	3,077	2,349	837	1,670
66	2,291	2,461	3,077	2,349	837	1,670
67	2,291	2,461	3,077	2,349	837	1,670
68	2,317	2,484	3,112	2,373	844	1,730
69	2,368	2,541	3,185	2,425	866	1,800
70	2,431	2,607	3,268	2,492	887	1,867
71	2,502	2,686	3,367	2,566	915	1,934
72	2,582	2,772	3,472	2,645	942	2,001
73	2,664	2,861	3,584	2,732	972	2,068
74	2,761	2,960	3,710	2,828	1,008	2,139
75	2,855	3,063	3,839	2,924	1,041	2,206
76	2,956	3,172	3,971	3,028	1,080	2,278
77	3,059	3,284	4,114	3,137	1,118	2,353
78	3,165	3,396	4,254	3,244	1,153	2,431
79	3,264	3,500	4,388	3,344	1,192	2,510
80	3,367	3,611	4,524	3,448	1,227	2,595
81	3,472	3,723	4,667	3,558	1,266	2,675
82	3,576	3,837	4,806	3,662	1,303	2,755
83	3,684	3,956	4,953	3,776	1,344	2,840
84	3,794	4,069	5,097	3,884	1,383	2,923
85	3,930	4,215	5,285	4,027	1,435	3,030
86	4,042	4,340	5,435	4,142	1,475	3,116
87	4,158	4,462	5,586	4,259	1,516	3,205
88	4,274	4,585	5,746	4,377	1,558	3,294
89	4,393	4,714	5,908	4,502	1,602	3,384
90	4,512	4,845	6,068	4,625	1,648	3,481
91	4,635	4,974	6,233	4,752	1,691	3,575
92	4,760	5,109	6,401	4,879	1,737	3,670
93	4,887	5,245	6,572	5,008	1,784	3,767
94	5,014	5,383	6,744	5,140	1,831	3,866
95	5,148	5,524	6,924	5,275	1,878	3,969
96	5,284	5,668	7,102	5,411	1,926	4,069
97	5,417	5,811	7,281	5,551	1,976	4,172
98	5,552	5,960	7,465	5,689	2,025	4,281
99+	5,691	6,106	7,652	5,833	2,078	4,387

The above rates do not include the $20 one-time policy fee.

To calculate a household discount:

Annual premium **x** modal factor **= modal premium** (round to nearest whole cent)
Modal premium **x** .93 **= 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: 486-489 and 492

Female rates

Rates effective 5/1/2024

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
65	1,528	1,639	2,054	1,565	557	1,114
66	1,528	1,639	2,054	1,565	557	1,114
67	1,528	1,639	2,054	1,565	557	1,114
68	1,545	1,658	2,077	1,583	564	1,153
69	1,580	1,695	2,125	1,619	577	1,200
70	1,621	1,740	2,180	1,662	592	1,246
71	1,671	1,792	2,245	1,712	609	1,290
72	1,723	1,849	2,316	1,764	628	1,334
73	1,778	1,907	2,391	1,822	648	1,380
74	1,840	1,975	2,474	1,886	672	1,426
75	1,906	2,045	2,560	1,952	695	1,473
76	1,972	2,116	2,650	2,020	720	1,519
77	2,040	2,191	2,744	2,092	745	1,570
78	2,111	2,265	2,837	2,163	770	1,622
79	2,177	2,335	2,926	2,231	795	1,674
80	2,245	2,408	3,019	2,300	820	1,731
81	2,316	2,485	3,113	2,373	844	1,785
82	2,385	2,558	3,207	2,444	869	1,838
83	2,459	2,637	3,304	2,519	896	1,895
84	2,530	2,715	3,401	2,592	922	1,950
85	2,622	2,813	3,526	2,686	957	2,021
86	2,697	2,895	3,626	2,763	984	2,078
87	2,773	2,975	3,728	2,842	1,011	2,138
88	2,850	3,059	3,834	2,921	1,040	2,196
89	2,932	3,144	3,942	3,001	1,069	2,258
90	3,011	3,231	4,049	3,086	1,098	2,321
91	3,094	3,320	4,158	3,170	1,128	2,384
92	3,176	3,408	4,270	3,254	1,159	2,448
93	3,261	3,500	4,384	3,340	1,189	2,514
94	3,348	3,591	4,499	3,429	1,221	2,579
95	3,435	3,686	4,618	3,519	1,252	2,647
96	3,525	3,780	4,738	3,610	1,285	2,715
97	3,614	3,876	4,858	3,702	1,319	2,784
98	3,704	3,976	4,980	3,795	1,351	2,856
99+	3,798	4,074	5,104	3,891	1,385	2,927

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
65	1,697	1,823	2,282	1,741	620	1,238
66	1,697	1,823	2,282	1,741	620	1,238
67	1,697	1,823	2,282	1,741	620	1,238
68	1,716	1,841	2,308	1,759	626	1,282
69	1,754	1,882	2,360	1,797	642	1,334
70	1,802	1,934	2,421	1,847	657	1,384
71	1,855	1,991	2,494	1,901	678	1,433
72	1,914	2,054	2,574	1,961	698	1,483
73	1,976	2,120	2,656	2,025	721	1,533
74	2,046	2,194	2,750	2,096	747	1,585
75	2,117	2,270	2,845	2,168	772	1,636
76	2,191	2,351	2,944	2,245	801	1,688
77	2,267	2,434	3,049	2,325	828	1,745
78	2,345	2,517	3,153	2,404	855	1,802
79	2,418	2,595	3,253	2,479	883	1,861
80	2,494	2,676	3,353	2,556	910	1,924
81	2,574	2,761	3,459	2,636	939	1,982
82	2,650	2,843	3,563	2,713	966	2,043
83	2,733	2,933	3,673	2,799	996	2,105
84	2,812	3,016	3,779	2,880	1,024	2,166
85	2,912	3,125	3,917	2,985	1,063	2,245
86	2,996	3,216	4,030	3,070	1,093	2,309
87	3,082	3,307	4,142	3,157	1,123	2,376
88	3,169	3,400	4,259	3,246	1,155	2,442
89	3,257	3,492	4,378	3,336	1,188	2,508
90	3,347	3,589	4,498	3,428	1,221	2,579
91	3,437	3,688	4,621	3,522	1,254	2,649
92	3,530	3,788	4,744	3,616	1,288	2,721
93	3,623	3,888	4,871	3,714	1,322	2,792
94	3,718	3,990	5,000	3,810	1,357	2,866
95	3,816	4,096	5,130	3,911	1,393	2,942
96	3,916	4,202	5,263	4,010	1,428	3,016
97	4,015	4,308	5,397	4,114	1,464	3,094
98	4,116	4,418	5,534	4,217	1,501	3,173
99+	4,220	4,526	5,673	4,324	1,539	3,252

The above rates do not include the $20 one-time policy fee.

To calculate a household discount:

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

Modal premium **x** .93 **= 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: 486-489 and 492

Male rates

Rates effective 5/1/2024

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
65	1,759	1,886	2,361	1,802	642	1,281
66	1,759	1,886	2,361	1,802	642	1,281
67	1,759	1,886	2,361	1,802	642	1,281
68	1,777	1,905	2,389	1,819	648	1,326
69	1,816	1,950	2,444	1,862	664	1,381
70	1,866	2,002	2,507	1,912	680	1,433
71	1,923	2,061	2,582	1,969	702	1,484
72	1,980	2,126	2,664	2,030	722	1,534
73	2,046	2,195	2,750	2,096	746	1,587
74	2,117	2,270	2,846	2,168	773	1,640
75	2,191	2,351	2,947	2,245	799	1,693
76	2,267	2,434	3,048	2,324	828	1,746
77	2,345	2,520	3,156	2,406	857	1,805
78	2,429	2,605	3,262	2,489	885	1,865
79	2,504	2,686	3,366	2,567	914	1,926
80	2,582	2,771	3,472	2,646	942	1,991
81	2,664	2,857	3,580	2,730	971	2,052
82	2,742	2,943	3,689	2,810	999	2,114
83	2,829	3,035	3,800	2,896	1,032	2,180
84	2,910	3,121	3,912	2,982	1,061	2,242
85	3,014	3,235	4,054	3,090	1,100	2,325
86	3,101	3,328	4,168	3,178	1,132	2,390
87	3,189	3,423	4,287	3,270	1,163	2,458
88	3,278	3,517	4,409	3,360	1,196	2,527
89	3,369	3,615	4,532	3,453	1,229	2,597
90	3,461	3,716	4,655	3,547	1,263	2,670
91	3,556	3,817	4,781	3,643	1,297	2,741
92	3,654	3,919	4,911	3,743	1,332	2,816
93	3,750	4,023	5,041	3,843	1,368	2,889
94	3,850	4,131	5,174	3,944	1,405	2,967
95	3,948	4,239	5,311	4,047	1,440	3,045
96	4,053	4,348	5,446	4,150	1,478	3,122
97	4,156	4,458	5,587	4,258	1,515	3,202
98	4,259	4,572	5,727	4,365	1,554	3,284
99+	4,366	4,685	5,871	4,474	1,592	3,365

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
65	1,953	2,098	2,623	2,002	713	1,424
66	1,953	2,098	2,623	2,002	713	1,424
67	1,953	2,098	2,623	2,002	713	1,424
68	1,975	2,117	2,653	2,023	720	1,475
69	2,019	2,166	2,715	2,068	738	1,534
70	2,073	2,222	2,786	2,125	756	1,591
71	2,133	2,290	2,870	2,187	780	1,648
72	2,201	2,363	2,960	2,255	803	1,706
73	2,271	2,439	3,056	2,329	829	1,763
74	2,354	2,523	3,163	2,411	859	1,823
75	2,434	2,611	3,273	2,493	887	1,880
76	2,520	2,704	3,385	2,581	920	1,942
77	2,607	2,800	3,507	2,674	953	2,006
78	2,698	2,895	3,626	2,765	983	2,073
79	2,782	2,984	3,741	2,851	1,016	2,139
80	2,870	3,078	3,856	2,939	1,046	2,212
81	2,960	3,174	3,978	3,033	1,080	2,281
82	3,048	3,271	4,097	3,122	1,111	2,348
83	3,141	3,373	4,222	3,219	1,146	2,421
84	3,234	3,468	4,345	3,311	1,179	2,492
85	3,350	3,593	4,505	3,433	1,223	2,583
86	3,446	3,699	4,633	3,531	1,257	2,656
87	3,544	3,803	4,762	3,631	1,293	2,732
88	3,643	3,908	4,898	3,732	1,328	2,808
89	3,745	4,019	5,037	3,838	1,366	2,885
90	3,846	4,130	5,173	3,943	1,405	2,967
91	3,951	4,240	5,313	4,051	1,441	3,047
92	4,058	4,356	5,457	4,159	1,481	3,128
93	4,166	4,471	5,602	4,269	1,520	3,212
94	4,274	4,588	5,749	4,382	1,561	3,296
95	4,389	4,709	5,902	4,497	1,601	3,383
96	4,504	4,832	6,054	4,612	1,642	3,468
97	4,618	4,954	6,207	4,732	1,685	3,557
98	4,733	5,080	6,364	4,850	1,726	3,649
99+	4,852	5,205	6,523	4,972	1,771	3,740

The above rates do not include the $20 one-time policy fee.

To calculate a household discount:

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

Modal premium **x** .93 **= 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: Rest of State

Female rates

Rates effective 5/1/2024

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
65	1,469	1,576	1,975	1,505	536	1,071
66	1,469	1,576	1,975	1,505	536	1,071
67	1,469	1,576	1,975	1,505	536	1,071
68	1,486	1,594	1,997	1,522	542	1,109
69	1,519	1,630	2,043	1,557	555	1,154
70	1,559	1,673	2,096	1,598	569	1,198
71	1,607	1,723	2,159	1,646	586	1,240
72	1,657	1,778	2,227	1,696	604	1,283
73	1,710	1,834	2,299	1,752	623	1,327
74	1,769	1,899	2,379	1,813	646	1,371
75	1,833	1,966	2,462	1,877	668	1,416
76	1,896	2,035	2,548	1,942	692	1,461
77	1,962	2,107	2,638	2,012	716	1,510
78	2,030	2,178	2,728	2,080	740	1,560
79	2,093	2,245	2,813	2,145	764	1,610
80	2,159	2,315	2,903	2,212	788	1,664
81	2,227	2,389	2,993	2,282	812	1,716
82	2,293	2,460	3,084	2,350	836	1,767
83	2,364	2,536	3,177	2,422	862	1,822
84	2,433	2,611	3,270	2,492	887	1,875
85	2,521	2,705	3,390	2,583	920	1,943
86	2,593	2,784	3,487	2,657	946	1,998
87	2,666	2,861	3,585	2,733	972	2,056
88	2,740	2,941	3,687	2,809	1,000	2,112
89	2,819	3,023	3,790	2,886	1,028	2,171
90	2,895	3,107	3,893	2,967	1,056	2,232
91	2,975	3,192	3,998	3,048	1,085	2,292
92	3,054	3,277	4,106	3,129	1,114	2,354
93	3,136	3,365	4,215	3,212	1,143	2,417
94	3,219	3,453	4,326	3,297	1,174	2,480
95	3,303	3,544	4,440	3,384	1,204	2,545
96	3,389	3,635	4,556	3,471	1,236	2,611
97	3,475	3,727	4,671	3,560	1,268	2,677
98	3,562	3,823	4,788	3,649	1,299	2,746
99+	3,652	3,917	4,908	3,741	1,332	2,814

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
65	1,632	1,753	2,194	1,674	596	1,190
66	1,632	1,753	2,194	1,674	596	1,190
67	1,632	1,753	2,194	1,674	596	1,190
68	1,650	1,770	2,219	1,691	602	1,233
69	1,687	1,810	2,269	1,728	617	1,283
70	1,733	1,860	2,328	1,776	632	1,331
71	1,784	1,914	2,398	1,828	652	1,378
72	1,840	1,975	2,475	1,886	671	1,426
73	1,900	2,038	2,554	1,947	693	1,474
74	1,967	2,110	2,644	2,015	718	1,524
75	2,036	2,183	2,736	2,085	742	1,573
76	2,107	2,261	2,831	2,159	770	1,623
77	2,180	2,340	2,932	2,236	796	1,678
78	2,255	2,420	3,032	2,312	822	1,733
79	2,325	2,495	3,128	2,384	849	1,789
80	2,398	2,573	3,224	2,458	875	1,850
81	2,475	2,655	3,326	2,535	903	1,906
82	2,548	2,734	3,426	2,609	929	1,964
83	2,628	2,820	3,532	2,691	958	2,024
84	2,704	2,900	3,634	2,769	985	2,083
85	2,800	3,005	3,766	2,870	1,022	2,159
86	2,881	3,092	3,875	2,952	1,051	2,220
87	2,963	3,180	3,983	3,036	1,080	2,285
88	3,047	3,269	4,095	3,121	1,111	2,348
89	3,132	3,358	4,210	3,208	1,142	2,412
90	3,218	3,451	4,325	3,296	1,174	2,480
91	3,305	3,546	4,443	3,387	1,206	2,547
92	3,394	3,642	4,562	3,477	1,238	2,616
93	3,484	3,738	4,684	3,571	1,271	2,685
94	3,575	3,837	4,808	3,663	1,305	2,756
95	3,669	3,938	4,933	3,761	1,339	2,829
96	3,765	4,040	5,061	3,856	1,373	2,900
97	3,861	4,142	5,189	3,956	1,408	2,975
98	3,958	4,248	5,321	4,055	1,443	3,051
99+	4,058	4,352	5,455	4,158	1,480	3,127

The above rates do not include the $20 one-time policy fee.

To calculate a household discount:

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

Modal premium **x** .93 **= 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: Rest of State

Male rates

Rates effective 5/1/2024

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
65	1,691	1,813	2,270	1,733	617	1,232
66	1,691	1,813	2,270	1,733	617	1,232
67	1,691	1,813	2,270	1,733	617	1,232
68	1,709	1,832	2,297	1,749	623	1,275
69	1,746	1,875	2,350	1,790	638	1,328
70	1,794	1,925	2,411	1,838	654	1,378
71	1,849	1,982	2,483	1,893	675	1,427
72	1,904	2,044	2,562	1,952	694	1,475
73	1,967	2,111	2,644	2,015	717	1,526
74	2,036	2,183	2,737	2,085	743	1,577
75	2,107	2,261	2,834	2,159	768	1,628
76	2,180	2,340	2,931	2,235	796	1,679
77	2,255	2,423	3,035	2,313	824	1,736
78	2,336	2,505	3,137	2,393	851	1,793
79	2,408	2,583	3,237	2,468	879	1,852
80	2,483	2,664	3,338	2,544	906	1,914
81	2,562	2,747	3,442	2,625	934	1,973
82	2,637	2,830	3,547	2,702	961	2,033
83	2,720	2,918	3,654	2,785	992	2,096
84	2,798	3,001	3,762	2,867	1,020	2,156
85	2,898	3,111	3,898	2,971	1,058	2,236
86	2,982	3,200	4,008	3,056	1,088	2,298
87	3,066	3,291	4,122	3,144	1,118	2,363
88	3,152	3,382	4,239	3,231	1,150	2,430
89	3,239	3,476	4,358	3,320	1,182	2,497
90	3,328	3,573	4,476	3,411	1,214	2,567
91	3,419	3,670	4,597	3,503	1,247	2,636
92	3,513	3,768	4,722	3,599	1,281	2,708
93	3,606	3,868	4,847	3,695	1,315	2,778
94	3,702	3,972	4,975	3,792	1,351	2,853
95	3,796	4,076	5,107	3,891	1,385	2,928
96	3,897	4,181	5,237	3,990	1,421	3,002
97	3,996	4,287	5,372	4,094	1,457	3,079
98	4,095	4,396	5,507	4,197	1,494	3,158
99+	4,198	4,505	5,645	4,302	1,531	3,236

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
65	1,878	2,017	2,522	1,925	686	1,369
66	1,878	2,017	2,522	1,925	686	1,369
67	1,878	2,017	2,522	1,925	686	1,369
68	1,899	2,036	2,551	1,945	692	1,418
69	1,941	2,083	2,611	1,988	710	1,475
70	1,993	2,137	2,679	2,043	727	1,530
71	2,051	2,202	2,760	2,103	750	1,585
72	2,116	2,272	2,846	2,168	772	1,640
73	2,184	2,345	2,938	2,239	797	1,695
74	2,263	2,426	3,041	2,318	826	1,753
75	2,340	2,511	3,147	2,397	853	1,808
76	2,423	2,600	3,255	2,482	885	1,867
77	2,507	2,692	3,372	2,571	916	1,929
78	2,594	2,784	3,487	2,659	945	1,993
79	2,675	2,869	3,597	2,741	977	2,057
80	2,760	2,960	3,708	2,826	1,006	2,127
81	2,846	3,052	3,825	2,916	1,038	2,193
82	2,931	3,145	3,939	3,002	1,068	2,258
83	3,020	3,243	4,060	3,095	1,102	2,328
84	3,110	3,335	4,178	3,184	1,134	2,396
85	3,221	3,455	4,332	3,301	1,176	2,484
86	3,313	3,557	4,455	3,395	1,209	2,554
87	3,408	3,657	4,579	3,491	1,243	2,627
88	3,503	3,758	4,710	3,588	1,277	2,700
89	3,601	3,864	4,843	3,690	1,313	2,774
90	3,698	3,971	4,974	3,791	1,351	2,853
91	3,799	4,077	5,109	3,895	1,386	2,930
92	3,902	4,188	5,247	3,999	1,424	3,008
93	4,006	4,299	5,387	4,105	1,462	3,088
94	4,110	4,412	5,528	4,213	1,501	3,169
95	4,220	4,528	5,675	4,324	1,539	3,253
96	4,331	4,646	5,821	4,435	1,579	3,335
97	4,440	4,763	5,968	4,550	1,620	3,420
98	4,551	4,885	6,119	4,663	1,660	3,509
99+	4,665	5,005	6,272	4,781	1,703	3,596

The above rates do not include the $20 one-time policy fee.

To calculate a household discount:

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

Modal premium **x** .93 **= 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 an Aetna Company Medicare supplement policy. The Medicare eligible adult must be either (a) your spouse or your civil union partner; and (b) someone with whom you have continuously resided for the past 12 months. The household discount will only be applicable if a policy for each applicant is issued. The discounted rate will be 7 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, G, HIGH DEDUCTIBLE 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

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

HIGH DEDUCTIBLE 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.

*****This high deductible plan pays the same benefits as Plan G after one has paid a calendar year $2,870 deductible. Benefits from High Deductible Plan G will not begin until out-of-pocket expenses are $2,870. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the policy. This does 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 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.

*****This high deductible plan pays the same benefits as Plan G after one has paid a calendar year $2,870 deductible. Benefits from High Deductible Plan G will not begin until out-of-pocket expenses are $2,870. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the policy. This does 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	$0	$257 (Unless Part B Deductible has been met)
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 (Unless Part B Deductible has been met)
Remainder of Medicare-Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

HIGH DEDUCTIBLE PLAN G

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	$0	$257 (Unless Part B Deductible has been met)
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 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