Outline of coverage

Medicare Supplement Insurance

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

Nebraska

Underwritten by

Continental Life Insurance Company of Brentwood, Tennessee

An Aetna Company

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CLIMS05026NE

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Rates effective: 08/2024 B

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: 690-693

Female rates

Rates effective 8/1/2024

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	2,033	2,040	2,464	546	1,983	1,405
66	2,033	2,040	2,464	546	1,983	1,405
67	2,033	2,040	2,464	546	1,983	1,405
68	2,049	2,058	2,484	550	1,999	1,451
69	2,091	2,098	2,535	562	2,038	1,505
70	2,143	2,153	2,602	577	2,092	1,563
71	2,208	2,218	2,680	594	2,154	1,618
72	2,281	2,293	2,766	615	2,225	1,675
73	2,355	2,365	2,856	633	2,298	1,731
74	2,435	2,445	2,952	655	2,375	1,788
75	2,520	2,532	3,056	678	2,458	1,844
76	2,614	2,624	3,166	703	2,548	1,905
77	2,703	2,712	3,275	727	2,635	1,967
78	2,793	2,805	3,387	752	2,725	2,033
79	2,885	2,895	3,498	776	2,811	2,102
80	2,975	2,984	3,608	800	2,902	2,172
81	3,069	3,080	3,719	825	2,993	2,239
82	3,165	3,177	3,837	851	3,087	2,310
83	3,261	3,277	3,955	877	3,181	2,381
84	3,362	3,375	4,074	905	3,279	2,455
85	3,465	3,480	4,199	932	3,377	2,530
86	3,578	3,595	4,338	962	3,488	2,612
87	3,678	3,695	4,461	990	3,590	2,687
88	3,782	3,799	4,589	1,018	3,690	2,762
89	3,887	3,903	4,715	1,046	3,793	2,839
90	3,995	4,010	4,845	1,075	3,897	2,917
91	4,105	4,120	4,975	1,104	4,004	2,996
92	4,214	4,232	5,110	1,134	4,108	3,076
93	4,327	4,345	5,246	1,164	4,218	3,159
94	4,440	4,460	5,385	1,195	4,331	3,243
95	4,557	4,577	5,525	1,226	4,445	3,328
96	4,675	4,695	5,668	1,258	4,558	3,413
97	4,796	4,813	5,813	1,291	4,675	3,500
98	4,914	4,937	5,959	1,323	4,795	3,589
99+	5,038	5,060	6,108	1,356	4,914	3,678

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	2,258	2,268	2,736	607	2,204	1,559
66	2,258	2,268	2,736	607	2,204	1,559
67	2,258	2,268	2,736	607	2,204	1,559
68	2,278	2,287	2,760	613	2,221	1,611
69	2,322	2,330	2,817	625	2,264	1,673
70	2,382	2,393	2,890	642	2,324	1,737
71	2,455	2,464	2,980	659	2,394	1,796
72	2,535	2,546	3,073	682	2,472	1,863
73	2,618	2,629	3,173	704	2,555	1,923
74	2,706	2,718	3,281	728	2,640	1,987
75	2,801	2,811	3,396	753	2,729	2,048
76	2,903	2,915	3,520	782	2,831	2,119
77	3,003	3,015	3,638	807	2,929	2,185
78	3,104	3,117	3,763	835	3,027	2,258
79	3,205	3,218	3,885	862	3,124	2,334
80	3,305	3,317	4,008	888	3,223	2,413
81	3,412	3,423	4,132	917	3,327	2,490
82	3,517	3,529	4,262	945	3,428	2,566
83	3,623	3,641	4,393	974	3,536	2,644
84	3,735	3,752	4,528	1,005	3,644	2,728
85	3,848	3,865	4,667	1,036	3,753	2,811
86	3,977	3,995	4,820	1,069	3,878	2,903
87	4,089	4,105	4,957	1,100	3,988	2,984
88	4,201	4,219	5,096	1,131	4,099	3,069
89	4,322	4,338	5,239	1,163	4,214	3,154
90	4,438	4,456	5,384	1,194	4,329	3,242
91	4,559	4,579	5,526	1,226	4,448	3,330
92	4,680	4,702	5,677	1,259	4,567	3,419
93	4,807	4,829	5,828	1,294	4,689	3,512
94	4,933	4,957	5,982	1,328	4,813	3,602
95	5,062	5,086	6,141	1,363	4,939	3,696
96	5,195	5,217	6,299	1,397	5,064	3,792
97	5,328	5,350	6,459	1,433	5,195	3,890
98	5,461	5,485	6,621	1,470	5,325	3,988
99+	5,597	5,623	6,787	1,506	5,460	4,088

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

To calculate the 7% 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: 690-693

Male rates

Rates effective 8/1/2024

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	2,335	2,347	2,833	628	2,281	1,615
66	2,335	2,347	2,833	628	2,281	1,615
67	2,335	2,347	2,833	628	2,281	1,615
68	2,359	2,366	2,856	633	2,298	1,668
69	2,405	2,411	2,915	646	2,342	1,731
70	2,467	2,478	2,991	663	2,406	1,796
71	2,539	2,552	3,079	683	2,480	1,860
72	2,624	2,635	3,181	706	2,559	1,928
73	2,709	2,720	3,284	729	2,643	1,990
74	2,801	2,811	3,396	754	2,729	2,056
75	2,899	2,911	3,516	780	2,826	2,121
76	3,004	3,016	3,644	809	2,931	2,192
77	3,107	3,118	3,767	835	3,028	2,263
78	3,212	3,226	3,896	863	3,132	2,339
79	3,316	3,330	4,022	894	3,233	2,418
80	3,419	3,435	4,147	920	3,336	2,498
81	3,529	3,544	4,277	948	3,441	2,578
82	3,637	3,655	4,409	980	3,550	2,657
83	3,752	3,768	4,547	1,009	3,658	2,739
84	3,865	3,883	4,687	1,041	3,769	2,823
85	3,985	4,002	4,832	1,071	3,884	2,909
86	4,116	4,134	4,989	1,106	4,011	3,004
87	4,231	4,250	5,132	1,138	4,128	3,089
88	4,349	4,368	5,273	1,171	4,243	3,177
89	4,472	4,492	5,421	1,202	4,362	3,265
90	4,595	4,613	5,567	1,236	4,480	3,354
91	4,720	4,739	5,721	1,270	4,604	3,447
92	4,846	4,868	5,875	1,304	4,726	3,537
93	4,976	4,995	6,030	1,339	4,853	3,634
94	5,106	5,128	6,192	1,373	4,983	3,729
95	5,240	5,263	6,355	1,410	5,113	3,827
96	5,376	5,397	6,520	1,448	5,244	3,925
97	5,513	5,538	6,684	1,483	5,376	4,026
98	5,651	5,676	6,854	1,522	5,513	4,126
99+	5,794	5,818	7,026	1,559	5,651	4,230

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	2,597	2,609	3,148	699	2,535	1,793
66	2,597	2,609	3,148	699	2,535	1,793
67	2,597	2,609	3,148	699	2,535	1,793
68	2,620	2,630	3,173	704	2,555	1,853
69	2,668	2,680	3,236	718	2,604	1,923
70	2,741	2,753	3,322	738	2,674	1,997
71	2,824	2,834	3,425	759	2,752	2,068
72	2,915	2,929	3,533	785	2,845	2,141
73	3,008	3,023	3,649	810	2,936	2,213
74	3,109	3,126	3,775	837	3,036	2,285
75	3,222	3,233	3,905	867	3,140	2,357
76	3,338	3,354	4,046	898	3,257	2,437
77	3,454	3,466	4,183	929	3,366	2,514
78	3,570	3,584	4,324	961	3,481	2,596
79	3,684	3,697	4,468	992	3,593	2,682
80	3,801	3,815	4,610	1,022	3,707	2,775
81	3,922	3,935	4,753	1,054	3,822	2,863
82	4,043	4,059	4,901	1,087	3,944	2,952
83	4,167	4,188	5,055	1,122	4,066	3,042
84	4,295	4,312	5,210	1,156	4,192	3,138
85	4,425	4,445	5,367	1,190	4,315	3,232
86	4,574	4,592	5,544	1,228	4,458	3,340
87	4,701	4,721	5,699	1,265	4,587	3,434
88	4,833	4,853	5,859	1,301	4,714	3,531
89	4,969	4,990	6,023	1,337	4,846	3,629
90	5,103	5,123	6,189	1,372	4,978	3,728
91	5,245	5,265	6,356	1,410	5,115	3,830
92	5,385	5,407	6,526	1,449	5,251	3,932
93	5,528	5,551	6,701	1,487	5,390	4,037
94	5,672	5,701	6,879	1,527	5,533	4,145
95	5,820	5,848	7,059	1,566	5,681	4,251
96	5,975	5,998	7,242	1,608	5,826	4,362
97	6,127	6,152	7,425	1,648	5,973	4,472
98	6,279	6,307	7,615	1,692	6,126	4,585
99+	6,436	6,466	7,804	1,732	6,278	4,702

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

To calculate the 7% 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 8/1/2024

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,865	1,872	2,261	501	1,819	1,289
66	1,865	1,872	2,261	501	1,819	1,289
67	1,865	1,872	2,261	501	1,819	1,289
68	1,880	1,888	2,279	505	1,834	1,331
69	1,918	1,925	2,326	516	1,870	1,381
70	1,966	1,975	2,387	529	1,919	1,434
71	2,026	2,035	2,459	545	1,976	1,484
72	2,093	2,104	2,538	564	2,041	1,537
73	2,161	2,170	2,620	581	2,108	1,588
74	2,234	2,243	2,708	601	2,179	1,640
75	2,312	2,323	2,804	622	2,255	1,692
76	2,398	2,407	2,905	645	2,338	1,748
77	2,480	2,488	3,005	667	2,417	1,805
78	2,562	2,573	3,107	690	2,500	1,865
79	2,647	2,656	3,209	712	2,579	1,928
80	2,729	2,738	3,310	734	2,662	1,993
81	2,816	2,826	3,412	757	2,746	2,054
82	2,904	2,915	3,520	781	2,832	2,119
83	2,992	3,006	3,628	805	2,918	2,184
84	3,084	3,096	3,738	830	3,008	2,252
85	3,179	3,193	3,852	855	3,098	2,321
86	3,283	3,298	3,980	883	3,200	2,396
87	3,374	3,390	4,093	908	3,294	2,465
88	3,470	3,485	4,210	934	3,385	2,534
89	3,566	3,581	4,326	960	3,480	2,605
90	3,665	3,679	4,445	986	3,575	2,676
91	3,766	3,780	4,564	1,013	3,673	2,749
92	3,866	3,883	4,688	1,040	3,769	2,822
93	3,970	3,986	4,813	1,068	3,870	2,898
94	4,073	4,092	4,940	1,096	3,973	2,975
95	4,181	4,199	5,069	1,125	4,078	3,053
96	4,289	4,307	5,200	1,154	4,182	3,131
97	4,400	4,416	5,333	1,184	4,289	3,211
98	4,508	4,529	5,467	1,214	4,399	3,293
99+	4,622	4,642	5,604	1,244	4,508	3,374

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	2,072	2,081	2,510	557	2,022	1,430
66	2,072	2,081	2,510	557	2,022	1,430
67	2,072	2,081	2,510	557	2,022	1,430
68	2,090	2,098	2,532	562	2,038	1,478
69	2,130	2,138	2,584	573	2,077	1,535
70	2,185	2,195	2,651	589	2,132	1,594
71	2,252	2,261	2,734	605	2,196	1,648
72	2,326	2,336	2,819	626	2,268	1,709
73	2,402	2,412	2,911	646	2,344	1,764
74	2,483	2,494	3,010	668	2,422	1,823
75	2,570	2,579	3,116	691	2,504	1,879
76	2,663	2,674	3,229	717	2,597	1,944
77	2,755	2,766	3,338	740	2,687	2,005
78	2,848	2,860	3,452	766	2,777	2,072
79	2,940	2,952	3,564	791	2,866	2,141
80	3,032	3,043	3,677	815	2,957	2,214
81	3,130	3,140	3,791	841	3,052	2,284
82	3,227	3,238	3,910	867	3,145	2,354
83	3,324	3,340	4,030	894	3,244	2,426
84	3,427	3,442	4,154	922	3,343	2,503
85	3,530	3,546	4,282	950	3,443	2,579
86	3,649	3,665	4,422	981	3,558	2,663
87	3,751	3,766	4,548	1,009	3,659	2,738
88	3,854	3,871	4,675	1,038	3,761	2,816
89	3,965	3,980	4,806	1,067	3,866	2,894
90	4,072	4,088	4,939	1,095	3,972	2,974
91	4,183	4,201	5,070	1,125	4,081	3,055
92	4,294	4,314	5,208	1,155	4,190	3,137
93	4,410	4,430	5,347	1,187	4,302	3,222
94	4,526	4,548	5,488	1,218	4,416	3,305
95	4,644	4,666	5,634	1,250	4,531	3,391
96	4,766	4,786	5,779	1,282	4,646	3,479
97	4,888	4,908	5,926	1,315	4,766	3,569
98	5,010	5,032	6,074	1,349	4,885	3,659
99+	5,135	5,159	6,227	1,382	5,009	3,750

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

To calculate the 7% Household discount:

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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 8/1/2024

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	2,142	2,153	2,599	576	2,093	1,482
66	2,142	2,153	2,599	576	2,093	1,482
67	2,142	2,153	2,599	576	2,093	1,482
68	2,164	2,171	2,620	581	2,108	1,530
69	2,206	2,212	2,674	593	2,149	1,588
70	2,263	2,273	2,744	608	2,207	1,648
71	2,329	2,341	2,825	627	2,275	1,706
72	2,407	2,417	2,918	648	2,348	1,769
73	2,485	2,495	3,013	669	2,425	1,826
74	2,570	2,579	3,116	692	2,504	1,886
75	2,660	2,671	3,226	716	2,593	1,946
76	2,756	2,767	3,343	742	2,689	2,011
77	2,850	2,861	3,456	766	2,778	2,076
78	2,947	2,960	3,574	792	2,873	2,146
79	3,042	3,055	3,690	820	2,966	2,218
80	3,137	3,151	3,805	844	3,061	2,292
81	3,238	3,251	3,924	870	3,157	2,365
82	3,337	3,353	4,045	899	3,257	2,438
83	3,442	3,457	4,172	926	3,356	2,513
84	3,546	3,562	4,300	955	3,458	2,590
85	3,656	3,672	4,433	983	3,563	2,669
86	3,776	3,793	4,577	1,015	3,680	2,756
87	3,882	3,899	4,708	1,044	3,787	2,834
88	3,990	4,007	4,838	1,074	3,893	2,915
89	4,103	4,121	4,973	1,103	4,002	2,995
90	4,216	4,232	5,107	1,134	4,110	3,077
91	4,330	4,348	5,249	1,165	4,224	3,162
92	4,446	4,466	5,390	1,196	4,336	3,245
93	4,565	4,583	5,532	1,228	4,452	3,334
94	4,684	4,705	5,681	1,260	4,572	3,421
95	4,807	4,828	5,830	1,294	4,691	3,511
96	4,932	4,951	5,982	1,328	4,811	3,601
97	5,058	5,081	6,132	1,361	4,932	3,694
98	5,184	5,207	6,288	1,396	5,058	3,785
99+	5,316	5,338	6,446	1,430	5,184	3,881

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	2,383	2,394	2,888	641	2,326	1,645
66	2,383	2,394	2,888	641	2,326	1,645
67	2,383	2,394	2,888	641	2,326	1,645
68	2,404	2,413	2,911	646	2,344	1,700
69	2,448	2,459	2,969	659	2,389	1,764
70	2,515	2,526	3,048	677	2,453	1,832
71	2,591	2,600	3,142	696	2,525	1,897
72	2,674	2,687	3,241	720	2,610	1,964
73	2,760	2,773	3,348	743	2,694	2,030
74	2,852	2,868	3,463	768	2,785	2,096
75	2,956	2,966	3,583	795	2,881	2,162
76	3,062	3,077	3,712	824	2,988	2,236
77	3,169	3,180	3,838	852	3,088	2,306
78	3,275	3,288	3,967	882	3,194	2,382
79	3,380	3,392	4,099	910	3,296	2,461
80	3,487	3,500	4,229	938	3,401	2,546
81	3,598	3,610	4,361	967	3,506	2,627
82	3,709	3,724	4,496	997	3,618	2,708
83	3,823	3,842	4,638	1,029	3,730	2,791
84	3,940	3,956	4,780	1,061	3,846	2,879
85	4,060	4,078	4,924	1,092	3,959	2,965
86	4,196	4,213	5,086	1,127	4,090	3,064
87	4,313	4,331	5,228	1,161	4,208	3,150
88	4,434	4,452	5,375	1,194	4,325	3,239
89	4,559	4,578	5,526	1,227	4,446	3,329
90	4,682	4,700	5,678	1,259	4,567	3,420
91	4,812	4,830	5,831	1,294	4,693	3,514
92	4,940	4,961	5,987	1,329	4,817	3,607
93	5,072	5,093	6,148	1,364	4,945	3,704
94	5,204	5,230	6,311	1,401	5,076	3,803
95	5,339	5,365	6,476	1,437	5,212	3,900
96	5,482	5,503	6,644	1,475	5,345	4,002
97	5,621	5,644	6,812	1,512	5,480	4,103
98	5,761	5,786	6,986	1,552	5,620	4,206
99+	5,905	5,932	7,160	1,589	5,760	4,314

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

To calculate the 7% 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 a Continental Life Insurance Company of Brentwood, Tennessee Medicare supplement policy. The Medicare eligible adult must be either (a) your spouse; (b) someone with whom you are in a civil union partnership; and (c) 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, 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