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: 03/2022A

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 2022[2]					**$6,620[2]**	**$3,310[2]**				

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

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

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

Continental Life Insurance Company of Brentwood, Tennessee

Annual Premiums

For Use in ZIP Codes: 480-485

Female Rates

Rates Effective 3/1/2022

Attained	Preferred					
Age	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
65	1,523	1,764	2,047	1,560	600	1,199
66	1,523	1,764	2,047	1,560	600	1,199
67	1,523	1,764	2,047	1,560	600	1,199
68	1,540	1,784	2,069	1,577	606	1,241
69	1,575	1,824	2,117	1,613	621	1,292
70	1,615	1,873	2,173	1,656	637	1,341
71	1,665	1,929	2,237	1,706	656	1,388
72	1,717	1,990	2,308	1,758	676	1,436
73	1,773	2,053	2,383	1,815	698	1,485
74	1,834	2,125	2,466	1,879	723	1,535
75	1,900	2,201	2,552	1,945	748	1,585
76	1,964	2,278	2,641	2,013	775	1,635
77	2,034	2,358	2,734	2,085	802	1,690
78	2,103	2,438	2,828	2,156	828	1,746
79	2,169	2,513	2,916	2,223	855	1,802
80	2,237	2,591	3,009	2,292	882	1,863
81	2,308	2,674	3,102	2,366	909	1,920
82	2,377	2,754	3,195	2,435	936	1,978
83	2,450	2,839	3,293	2,510	965	2,040
84	2,522	2,922	3,389	2,583	993	2,098
85	2,613	3,028	3,514	2,677	1,030	2,175
86	2,688	3,116	3,614	2,754	1,059	2,236
87	2,763	3,203	3,715	2,832	1,088	2,301
88	2,840	3,292	3,821	2,911	1,119	2,364
89	2,921	3,383	3,927	2,991	1,150	2,430
90	3,000	3,477	4,035	3,074	1,182	2,499
91	3,083	3,572	4,143	3,159	1,214	2,566
92	3,165	3,667	4,255	3,243	1,247	2,635
93	3,250	3,766	4,369	3,329	1,280	2,705
94	3,335	3,865	4,484	3,417	1,314	2,776
95	3,423	3,966	4,601	3,508	1,348	2,849
96	3,512	4,069	4,721	3,597	1,383	2,922
97	3,601	4,171	4,841	3,689	1,419	2,996
98	3,692	4,279	4,963	3,782	1,454	3,073
99+	3,784	4,385	5,086	3,877	1,491	3,150

Attained	Standard					
Age	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
65	1,691	1,962	2,274	1,735	667	1,332
66	1,691	1,962	2,274	1,735	667	1,332
67	1,691	1,962	2,274	1,735	667	1,332
68	1,710	1,981	2,300	1,752	673	1,380
69	1,748	2,026	2,352	1,791	691	1,436
70	1,796	2,081	2,413	1,840	708	1,490
71	1,850	2,142	2,485	1,895	730	1,542
72	1,907	2,211	2,566	1,954	752	1,596
73	1,969	2,281	2,646	2,018	776	1,649
74	2,039	2,362	2,740	2,089	804	1,706
75	2,111	2,444	2,835	2,161	831	1,760
76	2,184	2,530	2,934	2,237	861	1,817
77	2,259	2,619	3,039	2,317	891	1,878
78	2,338	2,708	3,143	2,396	920	1,940
79	2,410	2,793	3,242	2,471	950	2,002
80	2,485	2,880	3,342	2,547	980	2,070
81	2,566	2,972	3,447	2,628	1,010	2,134
82	2,641	3,060	3,550	2,705	1,039	2,198
83	2,723	3,156	3,660	2,789	1,072	2,266
84	2,802	3,246	3,766	2,869	1,103	2,331
85	2,902	3,364	3,903	2,974	1,144	2,417
86	2,985	3,461	4,016	3,059	1,176	2,485
87	3,071	3,559	4,127	3,146	1,209	2,557
88	3,157	3,659	4,244	3,234	1,243	2,628
89	3,245	3,759	4,363	3,325	1,279	2,700
90	3,334	3,863	4,482	3,416	1,314	2,776
91	3,425	3,969	4,604	3,510	1,349	2,851
92	3,517	4,076	4,728	3,604	1,386	2,928
93	3,610	4,183	4,854	3,700	1,423	3,005
94	3,705	4,294	4,982	3,797	1,460	3,084
95	3,803	4,408	5,113	3,897	1,498	3,166
96	3,902	4,521	5,245	3,997	1,537	3,246
97	4,002	4,636	5,378	4,099	1,576	3,329
98	4,102	4,754	5,514	4,202	1,615	3,415
99+	4,205	4,871	5,653	4,309	1,657	3,500

Modal Factors: Semi-Annual: 0.5200 Quarterly: 0.2650 Monthly: 0.0833

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 Period, use Preferred rates.

Continental Life Insurance Company of Brentwood, Tennessee

Annual Premiums

For Use in ZIP Codes: 480-485

Male Rates

Rates Effective 3/1/2022

Attained	Preferred					
Age	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
65	1,752	2,029	2,353	1,796	691	1,379
66	1,752	2,029	2,353	1,796	691	1,379
67	1,752	2,029	2,353	1,796	691	1,379
68	1,771	2,051	2,380	1,813	698	1,427
69	1,809	2,098	2,435	1,854	714	1,486
70	1,859	2,155	2,499	1,904	732	1,542
71	1,915	2,218	2,573	1,962	755	1,597
72	1,974	2,288	2,655	2,023	777	1,651
73	2,039	2,363	2,740	2,089	803	1,708
74	2,111	2,444	2,837	2,161	832	1,765
75	2,184	2,530	2,937	2,237	860	1,823
76	2,259	2,619	3,038	2,316	891	1,879
77	2,338	2,712	3,145	2,397	922	1,943
78	2,420	2,804	3,251	2,479	953	2,007
79	2,495	2,891	3,355	2,557	983	2,073
80	2,573	2,982	3,459	2,636	1,014	2,142
81	2,655	3,074	3,567	2,721	1,046	2,208
82	2,733	3,167	3,676	2,800	1,076	2,275
83	2,818	3,266	3,787	2,887	1,110	2,346
84	2,900	3,359	3,898	2,971	1,142	2,413
85	3,004	3,482	4,039	3,079	1,185	2,502
86	3,090	3,582	4,154	3,167	1,218	2,572
87	3,178	3,683	4,272	3,257	1,252	2,645
88	3,267	3,786	4,393	3,348	1,287	2,719
89	3,357	3,891	4,516	3,440	1,322	2,795
90	3,449	3,999	4,638	3,534	1,359	2,873
91	3,544	4,108	4,764	3,631	1,396	2,950
92	3,640	4,218	4,893	3,730	1,434	3,030
93	3,737	4,330	5,024	3,830	1,471	3,110
94	3,836	4,446	5,156	3,930	1,512	3,193
95	3,935	4,562	5,292	4,033	1,551	3,277
96	4,038	4,680	5,428	4,136	1,591	3,360
97	4,141	4,798	5,567	4,243	1,631	3,447
98	4,244	4,920	5,707	4,349	1,673	3,534
99+	4,351	5,042	5,850	4,459	1,714	3,622

Attained	Standard					
Age	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
65	1,946	2,257	2,614	1,995	767	1,532
66	1,946	2,257	2,614	1,995	767	1,532
67	1,946	2,257	2,614	1,995	767	1,532
68	1,968	2,279	2,644	2,015	775	1,587
69	2,012	2,331	2,706	2,061	794	1,651
70	2,065	2,392	2,777	2,117	814	1,713
71	2,126	2,464	2,860	2,179	839	1,774
72	2,192	2,542	2,950	2,247	864	1,836
73	2,264	2,624	3,044	2,320	892	1,897
74	2,345	2,716	3,151	2,402	925	1,962
75	2,425	2,811	3,261	2,484	955	2,024
76	2,511	2,910	3,373	2,572	991	2,090
77	2,599	3,013	3,495	2,664	1,025	2,159
78	2,689	3,116	3,614	2,755	1,058	2,230
79	2,772	3,211	3,728	2,841	1,093	2,302
80	2,860	3,314	3,843	2,929	1,126	2,380
81	2,950	3,416	3,964	3,022	1,161	2,455
82	3,038	3,520	4,082	3,111	1,196	2,528
83	3,131	3,630	4,208	3,207	1,233	2,606
84	3,223	3,733	4,330	3,300	1,269	2,682
85	3,338	3,867	4,490	3,421	1,316	2,780
86	3,433	3,981	4,616	3,518	1,353	2,858
87	3,532	4,093	4,746	3,619	1,391	2,940
88	3,631	4,207	4,881	3,719	1,430	3,022
89	3,732	4,325	5,019	3,823	1,470	3,105
90	3,833	4,444	5,155	3,928	1,512	3,193
91	3,937	4,563	5,295	4,036	1,552	3,279
92	4,044	4,687	5,438	4,144	1,593	3,367
93	4,152	4,812	5,583	4,254	1,636	3,456
94	4,260	4,939	5,729	4,366	1,680	3,547
95	4,374	5,068	5,880	4,481	1,723	3,640
96	4,488	5,200	6,032	4,597	1,768	3,733
97	4,601	5,331	6,184	4,715	1,813	3,828
98	4,717	5,468	6,342	4,832	1,858	3,927
99+	4,835	5,602	6,500	4,954	1,906	4,025

Modal Factors: Semi-Annual: 0.5200 Quarterly: 0.2650 Monthly: 0.0833

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 Period, use Preferred rates.

Continental Life Insurance Company of Brentwood, Tennessee

Annual Premiums

For Use in ZIP Codes: 486-489 and 492

Female Rates

Rates Effective 3/1/2022

Attained Age	Preferred					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
65	1,298	1,504	1,745	1,330	512	1,022
66	1,298	1,504	1,745	1,330	512	1,022
67	1,298	1,504	1,745	1,330	512	1,022
68	1,312	1,520	1,764	1,345	517	1,058
69	1,343	1,555	1,804	1,375	529	1,101
70	1,377	1,596	1,852	1,411	543	1,143
71	1,420	1,644	1,907	1,454	560	1,184
72	1,463	1,696	1,968	1,499	576	1,224
73	1,511	1,750	2,031	1,548	595	1,266
74	1,563	1,812	2,102	1,602	617	1,308
75	1,619	1,876	2,176	1,658	638	1,351
76	1,674	1,942	2,252	1,716	660	1,394
77	1,734	2,010	2,331	1,777	683	1,440
78	1,793	2,078	2,411	1,838	706	1,488
79	1,849	2,142	2,486	1,895	729	1,536
80	1,907	2,209	2,565	1,954	752	1,588
81	1,968	2,280	2,645	2,017	775	1,637
82	2,026	2,347	2,724	2,076	798	1,686
83	2,088	2,420	2,807	2,139	823	1,739
84	2,150	2,491	2,889	2,202	847	1,789
85	2,228	2,581	2,995	2,282	878	1,854
86	2,291	2,656	3,080	2,347	903	1,906
87	2,356	2,730	3,167	2,414	928	1,961
88	2,421	2,806	3,257	2,481	954	2,016
89	2,490	2,884	3,348	2,550	981	2,072
90	2,557	2,964	3,439	2,621	1,008	2,130
91	2,628	3,045	3,532	2,693	1,035	2,187
92	2,698	3,126	3,628	2,764	1,063	2,246
93	2,771	3,210	3,724	2,838	1,091	2,306
94	2,843	3,295	3,822	2,913	1,120	2,366
95	2,918	3,381	3,922	2,990	1,149	2,428
96	2,994	3,468	4,025	3,066	1,179	2,491
97	3,070	3,556	4,127	3,145	1,210	2,554
98	3,147	3,647	4,231	3,224	1,240	2,620
99+	3,226	3,738	4,336	3,305	1,271	2,685

Attained Age	Standard					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
65	1,441	1,672	1,939	1,479	569	1,136
66	1,441	1,672	1,939	1,479	569	1,136
67	1,441	1,672	1,939	1,479	569	1,136
68	1,458	1,689	1,960	1,493	574	1,176
69	1,490	1,727	2,005	1,527	589	1,224
70	1,531	1,774	2,057	1,568	603	1,270
71	1,577	1,826	2,118	1,615	622	1,315
72	1,626	1,884	2,187	1,666	641	1,360
73	1,679	1,945	2,256	1,720	661	1,406
74	1,738	2,013	2,336	1,780	685	1,454
75	1,799	2,083	2,417	1,842	708	1,501
76	1,862	2,157	2,501	1,907	734	1,549
77	1,926	2,233	2,591	1,975	759	1,601
78	1,993	2,309	2,679	2,043	784	1,654
79	2,054	2,381	2,763	2,106	810	1,707
80	2,118	2,455	2,849	2,172	835	1,765
81	2,187	2,533	2,938	2,240	861	1,819
82	2,252	2,608	3,026	2,306	886	1,874
83	2,321	2,690	3,120	2,377	914	1,931
84	2,389	2,767	3,210	2,446	940	1,987
85	2,474	2,867	3,327	2,536	976	2,060
86	2,545	2,950	3,424	2,607	1,003	2,118
87	2,618	3,034	3,518	2,682	1,031	2,180
88	2,692	3,119	3,618	2,757	1,060	2,240
89	2,766	3,204	3,719	2,834	1,090	2,302
90	2,842	3,293	3,821	2,912	1,120	2,366
91	2,919	3,383	3,925	2,992	1,150	2,430
92	2,998	3,475	4,030	3,072	1,181	2,496
93	3,077	3,566	4,138	3,154	1,213	2,562
94	3,158	3,661	4,247	3,236	1,245	2,629
95	3,242	3,758	4,359	3,322	1,277	2,699
96	3,326	3,854	4,471	3,407	1,310	2,767
97	3,411	3,952	4,584	3,494	1,344	2,838
98	3,496	4,053	4,701	3,582	1,377	2,911
99+	3,585	4,153	4,819	3,673	1,412	2,984

Modal Factors: Semi-Annual: 0.5200 Quarterly: 0.2650 Monthly: 0.0833

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 Period, use Preferred rates.

Continental Life Insurance Company of Brentwood, Tennessee

Annual Premiums
For Use in ZIP Codes: 486-489 and 492
Male Rates

Rates Effective 3/1/2022

Attained	Preferred					
Age	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
65	1,493	1,730	2,006	1,531	589	1,175
66	1,493	1,730	2,006	1,531	589	1,175
67	1,493	1,730	2,006	1,531	589	1,175
68	1,510	1,748	2,029	1,545	595	1,217
69	1,542	1,789	2,076	1,581	608	1,267
70	1,585	1,837	2,130	1,623	624	1,315
71	1,633	1,891	2,193	1,672	644	1,361
72	1,683	1,950	2,263	1,724	662	1,407
73	1,738	2,014	2,336	1,780	684	1,456
74	1,799	2,083	2,418	1,842	709	1,505
75	1,862	2,157	2,503	1,907	733	1,554
76	1,926	2,233	2,590	1,974	759	1,602
77	1,993	2,312	2,681	2,044	786	1,657
78	2,063	2,390	2,772	2,113	812	1,711
79	2,127	2,465	2,860	2,180	838	1,767
80	2,193	2,542	2,948	2,247	864	1,826
81	2,263	2,621	3,041	2,319	891	1,882
82	2,330	2,700	3,134	2,387	917	1,940
83	2,402	2,784	3,228	2,461	946	2,000
84	2,472	2,863	3,323	2,532	973	2,057
85	2,560	2,968	3,443	2,625	1,010	2,133
86	2,634	3,053	3,541	2,700	1,038	2,192
87	2,709	3,140	3,642	2,777	1,067	2,255
88	2,785	3,227	3,745	2,854	1,097	2,318
89	2,862	3,317	3,850	2,933	1,127	2,383
90	2,940	3,409	3,954	3,013	1,159	2,449
91	3,021	3,502	4,061	3,095	1,190	2,515
92	3,103	3,595	4,171	3,179	1,222	2,583
93	3,186	3,691	4,283	3,265	1,254	2,651
94	3,270	3,790	4,395	3,350	1,289	2,722
95	3,354	3,889	4,512	3,438	1,322	2,793
96	3,442	3,989	4,627	3,526	1,356	2,864
97	3,530	4,090	4,746	3,617	1,390	2,938
98	3,618	4,194	4,865	3,708	1,426	3,013
99+	3,709	4,298	4,987	3,801	1,461	3,088

Attained	Standard					
Age	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
65	1,659	1,924	2,229	1,700	654	1,306
66	1,659	1,924	2,229	1,700	654	1,306
67	1,659	1,924	2,229	1,700	654	1,306
68	1,678	1,943	2,254	1,718	660	1,353
69	1,715	1,987	2,307	1,757	677	1,407
70	1,761	2,039	2,367	1,804	694	1,460
71	1,813	2,101	2,438	1,857	716	1,512
72	1,869	2,167	2,515	1,916	736	1,565
73	1,930	2,237	2,595	1,978	760	1,617
74	1,999	2,315	2,686	2,048	788	1,672
75	2,068	2,396	2,780	2,117	814	1,725
76	2,140	2,480	2,876	2,192	844	1,782
77	2,215	2,569	2,980	2,271	874	1,841
78	2,292	2,656	3,080	2,348	902	1,901
79	2,363	2,737	3,178	2,422	932	1,962
80	2,438	2,825	3,276	2,497	960	2,029
81	2,515	2,912	3,379	2,576	990	2,092
82	2,590	3,000	3,480	2,652	1,019	2,155
83	2,669	3,094	3,587	2,734	1,051	2,221
84	2,748	3,182	3,691	2,813	1,082	2,286
85	2,845	3,297	3,827	2,916	1,122	2,370
86	2,927	3,394	3,935	2,999	1,153	2,437
87	3,011	3,489	4,046	3,085	1,186	2,506
88	3,095	3,586	4,161	3,170	1,219	2,576
89	3,181	3,687	4,279	3,259	1,253	2,647
90	3,268	3,789	4,394	3,349	1,289	2,722
91	3,356	3,890	4,514	3,440	1,323	2,796
92	3,448	3,996	4,635	3,533	1,358	2,870
93	3,539	4,102	4,759	3,626	1,395	2,946
94	3,632	4,210	4,884	3,722	1,432	3,023
95	3,728	4,320	5,013	3,820	1,468	3,103
96	3,826	4,432	5,142	3,919	1,507	3,182
97	3,922	4,545	5,272	4,020	1,545	3,264
98	4,021	4,661	5,406	4,119	1,584	3,348
99+	4,122	4,776	5,541	4,223	1,624	3,431

Modal Factors: Semi-Annual: 0.5200 Quarterly: 0.2650 Monthly: 0.0833

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 Period, use Preferred rates.

Continental Life Insurance Company of Brentwood, Tennessee

Annual Premiums

For Use in: Rest of State

Female Rates

Rates Effective 3/1/2022

Attained	Preferred					
Age	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
65	1,248	1,446	1,678	1,279	492	983
66	1,248	1,446	1,678	1,279	492	983
67	1,248	1,446	1,678	1,279	492	983
68	1,262	1,462	1,696	1,293	497	1,017
69	1,291	1,495	1,735	1,322	509	1,059
70	1,324	1,535	1,781	1,357	522	1,099
71	1,365	1,581	1,834	1,398	538	1,138
72	1,407	1,631	1,892	1,441	554	1,177
73	1,453	1,683	1,953	1,488	572	1,217
74	1,503	1,742	2,021	1,540	593	1,258
75	1,557	1,804	2,092	1,594	613	1,299
76	1,610	1,867	2,165	1,650	635	1,340
77	1,667	1,933	2,241	1,709	657	1,385
78	1,724	1,998	2,318	1,767	679	1,431
79	1,778	2,060	2,390	1,822	701	1,477
80	1,834	2,124	2,466	1,879	723	1,527
81	1,892	2,192	2,543	1,939	745	1,574
82	1,948	2,257	2,619	1,996	767	1,621
83	2,008	2,327	2,699	2,057	791	1,672
84	2,067	2,395	2,778	2,117	814	1,720
85	2,142	2,482	2,880	2,194	844	1,783
86	2,203	2,554	2,962	2,257	868	1,833
87	2,265	2,625	3,045	2,321	892	1,886
88	2,328	2,698	3,132	2,386	917	1,938
89	2,394	2,773	3,219	2,452	943	1,992
90	2,459	2,850	3,307	2,520	969	2,048
91	2,527	2,928	3,396	2,589	995	2,103
92	2,594	3,006	3,488	2,658	1,022	2,160
93	2,664	3,087	3,581	2,729	1,049	2,217
94	2,734	3,168	3,675	2,801	1,077	2,275
95	2,806	3,251	3,771	2,875	1,105	2,335
96	2,879	3,335	3,870	2,948	1,134	2,395
97	2,952	3,419	3,968	3,024	1,163	2,456
98	3,026	3,507	4,068	3,100	1,192	2,519
99+	3,102	3,594	4,169	3,178	1,222	2,582

Attained	Standard					
Age	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
65	1,386	1,608	1,864	1,422	547	1,092
66	1,386	1,608	1,864	1,422	547	1,092
67	1,386	1,608	1,864	1,422	547	1,092
68	1,402	1,624	1,885	1,436	552	1,131
69	1,433	1,661	1,928	1,468	566	1,177
70	1,472	1,706	1,978	1,508	580	1,221
71	1,516	1,756	2,037	1,553	598	1,264
72	1,563	1,812	2,103	1,602	616	1,308
73	1,614	1,870	2,169	1,654	636	1,352
74	1,671	1,936	2,246	1,712	659	1,398
75	1,730	2,003	2,324	1,771	681	1,443
76	1,790	2,074	2,405	1,834	706	1,489
77	1,852	2,147	2,491	1,899	730	1,539
78	1,916	2,220	2,576	1,964	754	1,590
79	1,975	2,289	2,657	2,025	779	1,641
80	2,037	2,361	2,739	2,088	803	1,697
81	2,103	2,436	2,825	2,154	828	1,749
82	2,165	2,508	2,910	2,217	852	1,802
83	2,232	2,587	3,000	2,286	879	1,857
84	2,297	2,661	3,087	2,352	904	1,911
85	2,379	2,757	3,199	2,438	938	1,981
86	2,447	2,837	3,292	2,507	964	2,037
87	2,517	2,917	3,383	2,579	991	2,096
88	2,588	2,999	3,479	2,651	1,019	2,154
89	2,660	3,081	3,576	2,725	1,048	2,213
90	2,733	3,166	3,674	2,800	1,077	2,275
91	2,807	3,253	3,774	2,877	1,106	2,337
92	2,883	3,341	3,875	2,954	1,136	2,400
93	2,959	3,429	3,979	3,033	1,166	2,463
94	3,037	3,520	4,084	3,112	1,197	2,528
95	3,117	3,613	4,191	3,194	1,228	2,595
96	3,198	3,706	4,299	3,276	1,260	2,661
97	3,280	3,800	4,408	3,360	1,292	2,729
98	3,362	3,897	4,520	3,444	1,324	2,799
99+	3,447	3,993	4,634	3,532	1,358	2,869

Modal Factors: Semi-Annual: 0.5200 Quarterly: 0.2650 Monthly: 0.0833

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 Period, use Preferred rates.

Continental Life Insurance Company of Brentwood, Tennessee

Annual Premiums
For Use in: Rest of State
Male Rates

Rates Effective 3/1/2022

Attained Age	Preferred					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
65	1,436	1,663	1,929	1,472	566	1,130
66	1,436	1,663	1,929	1,472	566	1,130
67	1,436	1,663	1,929	1,472	566	1,130
68	1,452	1,681	1,951	1,486	572	1,170
69	1,483	1,720	1,996	1,520	585	1,218
70	1,524	1,766	2,048	1,561	600	1,264
71	1,570	1,818	2,109	1,608	619	1,309
72	1,618	1,875	2,176	1,658	637	1,353
73	1,671	1,937	2,246	1,712	658	1,400
74	1,730	2,003	2,325	1,771	682	1,447
75	1,790	2,074	2,407	1,834	705	1,494
76	1,852	2,147	2,490	1,898	730	1,540
77	1,916	2,223	2,578	1,965	756	1,593
78	1,984	2,298	2,665	2,032	781	1,645
79	2,045	2,370	2,750	2,096	806	1,699
80	2,109	2,444	2,835	2,161	831	1,756
81	2,176	2,520	2,924	2,230	857	1,810
82	2,240	2,596	3,013	2,295	882	1,865
83	2,310	2,677	3,104	2,366	910	1,923
84	2,377	2,753	3,195	2,435	936	1,978
85	2,462	2,854	3,311	2,524	971	2,051
86	2,533	2,936	3,405	2,596	998	2,108
87	2,605	3,019	3,502	2,670	1,026	2,168
88	2,678	3,103	3,601	2,744	1,055	2,229
89	2,752	3,189	3,702	2,820	1,084	2,291
90	2,827	3,278	3,802	2,897	1,114	2,355
91	2,905	3,367	3,905	2,976	1,144	2,418
92	2,984	3,457	4,011	3,057	1,175	2,484
93	3,063	3,549	4,118	3,139	1,206	2,549
94	3,144	3,644	4,226	3,221	1,239	2,617
95	3,225	3,739	4,338	3,306	1,271	2,686
96	3,310	3,836	4,449	3,390	1,304	2,754
97	3,394	3,933	4,563	3,478	1,337	2,825
98	3,479	4,033	4,678	3,565	1,371	2,897
99+	3,566	4,133	4,795	3,655	1,405	2,969

Attained Age	Standard					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
65	1,595	1,850	2,143	1,635	629	1,256
66	1,595	1,850	2,143	1,635	629	1,256
67	1,595	1,850	2,143	1,635	629	1,256
68	1,613	1,868	2,167	1,652	635	1,301
69	1,649	1,911	2,218	1,689	651	1,353
70	1,693	1,961	2,276	1,735	667	1,404
71	1,743	2,020	2,344	1,786	688	1,454
72	1,797	2,084	2,418	1,842	708	1,505
73	1,856	2,151	2,495	1,902	731	1,555
74	1,922	2,226	2,583	1,969	758	1,608
75	1,988	2,304	2,673	2,036	783	1,659
76	2,058	2,385	2,765	2,108	812	1,713
77	2,130	2,470	2,865	2,184	840	1,770
78	2,204	2,554	2,962	2,258	867	1,828
79	2,272	2,632	3,056	2,329	896	1,887
80	2,344	2,716	3,150	2,401	923	1,951
81	2,418	2,800	3,249	2,477	952	2,012
82	2,490	2,885	3,346	2,550	980	2,072
83	2,566	2,975	3,449	2,629	1,011	2,136
84	2,642	3,060	3,549	2,705	1,040	2,198
85	2,736	3,170	3,680	2,804	1,079	2,279
86	2,814	3,263	3,784	2,884	1,109	2,343
87	2,895	3,355	3,890	2,966	1,140	2,410
88	2,976	3,448	4,001	3,048	1,172	2,477
89	3,059	3,545	4,114	3,134	1,205	2,545
90	3,142	3,643	4,225	3,220	1,239	2,617
91	3,227	3,740	4,340	3,308	1,272	2,688
92	3,315	3,842	4,457	3,397	1,306	2,760
93	3,403	3,944	4,576	3,487	1,341	2,833
94	3,492	4,048	4,696	3,579	1,377	2,907
95	3,585	4,154	4,820	3,673	1,412	2,984
96	3,679	4,262	4,944	3,768	1,449	3,060
97	3,771	4,370	5,069	3,865	1,486	3,138
98	3,866	4,482	5,198	3,961	1,523	3,219
99+	3,963	4,592	5,328	4,061	1,562	3,299

Modal Factors: Semi-Annual: 0.5200 Quarterly: 0.2650 Monthly: 0.0833

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 Period, use Preferred rates.

PREMIUM INFORMATION

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

Premiums payable other than annually will be determined according to the following factors:

Semi-annual: 0.5200 Quarterly: 0.2650 Monthly EFT: 0.0833.

HOUSEHOLD DISCOUNT

In order to be eligible for the household discount under a Continental Life Insurance Company of Brentwood, Tennessee Medicare supplement plan, you must apply for a Medicare supplement plan at the same time as another Medicare eligible adult or the other Medicare eligible adult must currently be covered by 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 rates 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 $1,556	$0	$1,556 (Part A Deductible)
61st thru 90th day	All but $389 a day	$389 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $778 a day	$778 a day	$0
•Once lifetime reserve days are used:			
•Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
•Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $194.50 a day	$0	Up to $194.50 a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

PLAN A

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

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

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

PARTS A & B

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

PLAN B

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

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

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

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

PLAN B

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

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

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

PARTS A & B

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

PLAN F

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

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

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

PARTS A & B

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

PLAN F

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

PLAN G

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

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

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

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

PLAN G

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

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

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

PARTS A & B

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

PLAN G

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

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 $2,490 deductible. Benefits from high deductible plan G will not begin until out-of-pocket expenses are $2,490. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid bythe policy. This does not include the plan's separate foreign travel emergency deductible.**

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,490 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2,490 DEDUCTIBLE*** YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,556	$1,556 (Part A Deductible)	$0
61st thru 90th day	All but $389 a day	$389 a day	$0
91st day and after			
*While using 60 lifetime reserve days	All but $778 a day	$778 a day	$0
*Once lifetime reserve days are used:			
*Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
*Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $194.50 a day	Up to $194.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare andwill pay whatever amo Medicare would have paid for up to 365 days as provided in the policy's "Core Benefits." During this time the hospital is pr ohibited from bil 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 $233 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

*****This high deductible plan pays the same benefits as Plan G after one has paid a calendar year $2,490 deductible. Benefits from high deductible plan G will not begin until out-of-pocket expenses are $2,490. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid bythe policy. This does not include the plan's separate foreign travel emergency deductible.**

SERVICES 3	MEDICARE PAYS	AFTER YOU PAY $2,490 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2,490 DEDUCTIBLE*** YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $233 of Medicare-Approved amounts*	$0	$0	$233 (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 $233 of Medicare-Approved amounts*	$0	$0	$233 (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 $2,490 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2,490 DEDUCTIBLE*** YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
*Medically necessary skilled care services and medical supplies	100%	$0	$0
*Durable medical equipment			
First $233 of Medicare Approved amounts	$0	$0	$233 (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 $2,370 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2,370 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 $1,556	$1,556 (Part A Deductible)	$0
61st thru 90th day	All but $389 a day	$389 a day	$0
91st day and after			
*While using 60 lifetime reserve days	All but $778 a day	$778 a day	$0
*Once lifetime reserve days are used:			
*Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
*Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $194.50 a day	Up to $194.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness services	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare co-payment/ coinsurance	$0

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

PLAN N

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $233 of Medicare-Approved amounts*	$0	$0	$233 (Part B Deductible)
Remainder of Medicare-Approved amounts	Generally 80%	Balance, other than up to $20 per office visit and up to $50 per emergency room visit. The co-payment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Up to $20 per office visit and up to $50 per emergency room visit. The 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.
Part B Excess Charges (Above Medicare-Approved amounts)	$0	0%	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $233 of Medicare-Approved amounts*	$0	$0	$233 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN N

PARTS A & B

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

OTHER BENEFITS – NOT COVERED BY MEDICARE

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