

# **Continental Life Insurance Company of Brentwood, Tennessee**

An Aetna Company

800 Crescent Centre Dr.  
Suite 200  
Franklin, TN 37067  
800 264.4000  
aetnaseniorproducts.com

## **Outline of Coverage Medicare Supplement Insurance**

**BENEFIT PLANS A, B, F, HIGH DEDUCTIBLE F, G, N**

Underwritten by

An Aetna Company

**Continental Life Insurance Company  
of Brentwood, Tennessee**

**CALIFORNIA**



**CONTINENTAL LIFE INSURANCE COMPANY OF BRENTWOOD, TENNESSEE**  
**OUTLINE OF MEDICARE SUPPLEMENT COVERAGE COVER PAGE: Page 1 of 2**  
**BENEFIT PLANS AVAILABLE: A, B, F, HIGH DEDUCTIBLE F, G, N**

These charts show the benefits included in each of the standard Medicare supplement plans. Every company must make available Plan "A"  
Some plans may not be available in your state.

**See Outlines of Coverage Sections for details about ALL Plans**

**Basic Benefits:**

Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.

Medical Expenses: Part B coinsurance (generally 20% of Medicare-Approved expenses) or, co-payments for hospital outpatient services. Plans K, L, and N require insureds to pay a portion of coinsurance or copayments

Blood: First three pints of blood each year.

Hospice: Part A coinsurance

<b>A</b>	<b>B</b>	<b>C</b>	<b>D</b>	<b>F/F*</b>	<b>G</b>	<b>K</b>	<b>L</b>	<b>M</b>	<b>N</b>
Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance, except up to \$20 copayment for office visit, and up to \$50 copayment for ER
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Part B Deductible		Part B Deductible					
				Part B Excess (100%)	Part B Excess (100%)				
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency			Foreign Travel Emergency	Foreign Travel Emergency
						Out-of-pocket limit \$4960; paid at 100% after limit reached	Out-of-pocket limit \$2480; paid at 100% after limit reached		

\*Plan F also has an option called a high deductible plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year \$2180 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed \$2180. 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.

# Continental Life Insurance Company of Brentwood, Tennessee

Annual Attained Age Premiums

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

Rates Effective 9/1/2016

Attained	Preferred						Standard						
	Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	Under 65	2,388	3,021	3,545	n/a	n/a	2,487	2,651	3,352	3,934	n/a	n/a	2,761
65	65	1,255	1,587	1,864	586	1,631	1,241	1,394	1,762	2,068	650	1,808	1,377
66	66	1,304	1,649	1,936	609	1,694	1,291	1,449	1,831	2,149	675	1,879	1,434
67	67	1,355	1,713	2,012	633	1,760	1,345	1,504	1,902	2,232	702	1,953	1,493
68	68	1,408	1,780	2,090	657	1,829	1,400	1,563	1,976	2,320	730	2,029	1,554
69	69	1,463	1,850	2,172	683	1,899	1,456	1,624	2,053	2,409	758	2,108	1,617
70	70	1,519	1,922	2,256	710	1,973	1,516	1,687	2,134	2,503	788	2,190	1,683
71	71	1,579	1,998	2,345	736	2,051	1,580	1,754	2,218	2,603	818	2,277	1,755
72	72	1,642	2,077	2,436	767	2,131	1,649	1,823	2,306	2,705	851	2,366	1,831
73	73	1,706	2,158	2,534	795	2,216	1,721	1,895	2,397	2,812	883	2,460	1,909
74	74	1,774	2,244	2,634	828	2,303	1,795	1,969	2,491	2,922	920	2,556	1,993
75	75	1,846	2,334	2,738	861	2,395	1,870	2,047	2,588	3,038	956	2,658	2,076
76	76	1,897	2,399	2,816	885	2,463	1,930	2,106	2,663	3,126	982	2,734	2,142
77	77	1,951	2,467	2,895	911	2,533	1,994	2,165	2,737	3,213	1,011	2,811	2,214
78	78	2,006	2,538	2,978	937	2,605	2,059	2,227	2,816	3,305	1,039	2,890	2,284
79	79	2,063	2,609	3,062	963	2,677	2,123	2,290	2,895	3,399	1,070	2,971	2,356
80	80	2,121	2,681	3,147	990	2,752	2,190	2,354	2,977	3,493	1,099	3,056	2,432
81	81	2,146	2,714	3,186	1,003	2,786	2,219	2,383	3,012	3,536	1,113	3,093	2,463
82	82	2,172	2,747	3,224	1,016	2,819	2,248	2,411	3,050	3,579	1,127	3,131	2,496
83	83	2,198	2,779	3,262	1,024	2,853	2,277	2,439	3,086	3,621	1,137	3,167	2,526
84	84	2,225	2,813	3,302	1,037	2,888	2,307	2,468	3,121	3,664	1,152	3,206	2,561
85	85	2,250	2,846	3,340	1,052	2,922	2,336	2,498	3,160	3,708	1,167	3,243	2,594
86	86	2,278	2,882	3,380	1,063	2,957	2,366	2,528	3,199	3,753	1,180	3,284	2,627
87	87	2,305	2,915	3,421	1,076	2,993	2,396	2,558	3,235	3,797	1,195	3,322	2,659
88	88	2,333	2,950	3,462	1,089	3,029	2,427	2,588	3,274	3,843	1,208	3,362	2,693
89	89	2,360	2,985	3,504	1,102	3,064	2,458	2,619	3,314	3,889	1,223	3,402	2,727
90	90	2,388	3,021	3,545	1,114	3,102	2,487	2,651	3,352	3,934	1,237	3,442	2,761
91	91	2,416	3,057	3,588	1,128	3,139	2,520	2,682	3,393	3,982	1,253	3,484	2,798
92	92	2,447	3,094	3,631	1,142	3,176	2,552	2,715	3,434	4,029	1,266	3,526	2,833
93	93	2,475	3,131	3,675	1,156	3,214	2,583	2,748	3,475	4,078	1,283	3,566	2,869
94	94	2,505	3,168	3,720	1,170	3,254	2,618	2,781	3,516	4,128	1,300	3,610	2,906
95	95	2,536	3,207	3,764	1,183	3,292	2,651	2,815	3,559	4,179	1,314	3,655	2,943
96	96	2,566	3,245	3,809	1,200	3,332	2,687	2,847	3,602	4,228	1,331	3,699	2,983
97	97	2,597	3,284	3,856	1,213	3,373	2,720	2,884	3,647	4,280	1,346	3,744	3,018
98	98	2,629	3,324	3,902	1,227	3,413	2,754	2,917	3,690	4,331	1,363	3,788	3,058
99	99	2,660	3,364	3,948	1,241	3,453	2,789	2,952	3,733	4,382	1,377	3,832	3,098

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

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

To calculate a Household discount:

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

Modal premium x .95 = discounted premium

If applying during Open Enrollment or Guaranteed Issue Period, use Preferred rates.

# Continental Life Insurance Company of Brentwood, Tennessee

Annual Attained Age Premiums

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

Rates Effective 9/1/2016

Attained Age	Preferred					Standard				
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan A	Plan B	Plan F	Plan HF	Plan G
Under 65	2,627	3,323	3,900	n/a	n/a	2,916	3,687	4,327	n/a	n/a
65	1,381	1,746	2,050	645	1,794	1,533	1,938	2,275	715	1,989
66	1,434	1,814	2,130	670	1,863	1,594	2,014	2,364	743	2,067
67	1,491	1,884	2,213	696	1,936	1,654	2,092	2,455	772	2,148
68	1,549	1,958	2,299	723	2,012	1,719	2,174	2,552	803	2,232
69	1,609	2,035	2,389	751	2,089	1,786	2,258	2,650	834	2,319
70	1,671	2,114	2,482	781	2,170	1,856	2,347	2,753	867	2,409
71	1,737	2,198	2,580	810	2,256	1,929	2,440	2,863	900	2,505
72	1,806	2,285	2,680	844	2,344	2,005	2,537	2,976	936	2,603
73	1,877	2,374	2,787	875	2,438	2,085	2,637	3,093	971	2,706
74	1,951	2,468	2,897	911	2,533	2,166	2,740	3,214	1,012	2,812
75	2,031	2,567	3,012	947	2,635	2,252	2,847	3,342	1,052	2,924
76	2,087	2,639	3,098	974	2,709	2,317	2,929	3,439	1,080	3,007
77	2,146	2,714	3,185	1,002	2,786	2,382	3,011	3,534	1,112	3,092
78	2,207	2,792	3,276	1,031	2,866	2,450	3,098	3,636	1,143	3,179
79	2,269	2,870	3,368	1,059	2,945	2,519	3,185	3,739	1,177	3,268
80	2,333	2,949	3,462	1,089	3,027	2,589	3,275	3,842	1,209	3,362
81	2,361	2,985	3,505	1,103	3,065	2,621	3,313	3,890	1,224	3,402
82	2,389	3,022	3,546	1,118	3,101	2,652	3,355	3,937	1,240	3,444
83	2,418	3,057	3,588	1,126	3,138	2,683	3,395	3,983	1,251	3,484
84	2,448	3,094	3,632	1,141	3,177	2,715	3,433	4,030	1,267	3,527
85	2,475	3,131	3,674	1,157	3,214	2,748	3,476	4,079	1,284	3,567
86	2,506	3,170	3,718	1,169	3,253	2,781	3,519	4,128	1,298	3,612
87	2,536	3,207	3,763	1,184	3,292	2,814	3,559	4,177	1,315	3,654
88	2,566	3,245	3,808	1,198	3,332	2,847	3,601	4,227	1,329	3,698
89	2,596	3,284	3,854	1,212	3,370	2,881	3,645	4,278	1,345	3,742
90	2,627	3,323	3,900	1,225	3,412	2,916	3,687	4,327	1,361	3,786
91	2,658	3,363	3,947	1,241	3,453	2,950	3,732	4,380	1,378	3,832
92	2,692	3,403	3,994	1,256	3,494	2,987	3,777	4,432	1,393	3,879
93	2,723	3,444	4,043	1,272	3,535	3,023	3,823	4,486	1,411	3,923
94	2,756	3,485	4,092	1,287	3,579	3,059	3,868	4,541	1,430	3,971
95	2,790	3,528	4,140	1,301	3,621	3,097	3,915	4,597	1,445	4,021
96	2,823	3,570	4,190	1,320	3,665	3,132	3,962	4,651	1,464	4,069
97	2,857	3,612	4,242	1,334	3,710	3,172	4,012	4,708	1,481	4,118
98	2,892	3,656	4,292	1,350	3,754	3,209	4,059	4,764	1,499	4,167
99	2,926	3,700	4,343	1,365	3,798	3,247	4,106	4,820	1,515	4,215

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

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

To calculate a Household discount:

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

Modal premium x .95 = discounted premium

If applying during Open Enrollment or Guaranteed Issue Period, use Preferred rates.

# Continental Life Insurance Company of Brentwood, Tennessee

Annual Attained Age Premiums

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

Rates Effective 9/1/2016

Attained	Preferred						Standard						
	Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65		2,794	3,535	4,148	n/a	n/a	2,910	3,102	3,922	4,603	n/a	n/a	3,230
65		1,468	1,857	2,181	686	1,908	1,452	1,631	2,062	2,420	761	2,115	1,611
66		1,526	1,929	2,265	713	1,982	1,510	1,695	2,142	2,514	790	2,198	1,678
67		1,585	2,004	2,354	741	2,059	1,574	1,760	2,225	2,611	821	2,285	1,747
68		1,647	2,083	2,445	769	2,140	1,638	1,829	2,312	2,714	854	2,374	1,818
69		1,712	2,165	2,541	799	2,222	1,704	1,900	2,402	2,819	887	2,466	1,892
70		1,777	2,249	2,640	831	2,308	1,774	1,974	2,497	2,929	922	2,562	1,969
71		1,847	2,338	2,744	861	2,400	1,849	2,052	2,595	3,046	957	2,664	2,053
72		1,921	2,430	2,850	897	2,493	1,929	2,133	2,698	3,165	996	2,768	2,142
73		1,996	2,525	2,965	930	2,593	2,014	2,217	2,804	3,290	1,033	2,878	2,234
74		2,076	2,625	3,082	969	2,695	2,100	2,304	2,914	3,419	1,076	2,991	2,332
75		2,160	2,731	3,203	1,007	2,802	2,188	2,395	3,028	3,554	1,119	3,110	2,429
76		2,219	2,807	3,295	1,035	2,882	2,258	2,464	3,116	3,657	1,149	3,199	2,506
77		2,283	2,886	3,387	1,066	2,964	2,333	2,533	3,202	3,759	1,183	3,289	2,590
78		2,347	2,969	3,484	1,096	3,048	2,409	2,606	3,295	3,867	1,216	3,381	2,672
79		2,414	3,053	3,583	1,127	3,132	2,484	2,679	3,387	3,977	1,252	3,476	2,757
80		2,482	3,137	3,682	1,158	3,220	2,562	2,754	3,483	4,087	1,286	3,576	2,845
81		2,511	3,175	3,728	1,174	3,260	2,596	2,788	3,524	4,137	1,302	3,619	2,882
82		2,541	3,214	3,772	1,189	3,298	2,630	2,821	3,569	4,187	1,319	3,663	2,920
83		2,572	3,251	3,817	1,198	3,338	2,664	2,854	3,611	4,237	1,330	3,705	2,955
84		2,603	3,291	3,863	1,213	3,379	2,699	2,888	3,652	4,287	1,348	3,751	2,996
85		2,633	3,330	3,908	1,231	3,419	2,733	2,923	3,697	4,338	1,365	3,794	3,035
86		2,665	3,372	3,955	1,244	3,460	2,768	2,958	3,743	4,391	1,381	3,842	3,074
87		2,697	3,411	4,003	1,259	3,502	2,803	2,993	3,785	4,442	1,398	3,887	3,111
88		2,730	3,452	4,051	1,274	3,544	2,840	3,028	3,831	4,496	1,413	3,934	3,151
89		2,761	3,492	4,100	1,289	3,585	2,876	3,064	3,877	4,550	1,431	3,980	3,191
90		2,794	3,535	4,148	1,303	3,629	2,910	3,102	3,922	4,603	1,447	4,027	3,230
91		2,827	3,577	4,198	1,320	3,673	2,948	3,138	3,970	4,659	1,466	4,076	3,274
92		2,863	3,620	4,248	1,336	3,716	2,986	3,177	4,018	4,714	1,481	4,125	3,315
93		2,896	3,663	4,300	1,353	3,760	3,022	3,215	4,066	4,771	1,501	4,172	3,357
94		2,931	3,707	4,352	1,369	3,807	3,063	3,254	4,114	4,830	1,521	4,224	3,400
95		2,967	3,752	4,404	1,384	3,852	3,102	3,294	4,164	4,889	1,537	4,276	3,443
96		3,002	3,797	4,457	1,404	3,898	3,144	3,331	4,214	4,947	1,557	4,328	3,490
97		3,038	3,842	4,512	1,419	3,946	3,182	3,374	4,267	5,008	1,575	4,380	3,531
98		3,076	3,889	4,565	1,436	3,993	3,222	3,413	4,317	5,067	1,595	4,432	3,578
99		3,112	3,936	4,619	1,452	4,040	3,263	3,454	4,368	5,127	1,611	4,483	3,625

Modal Factors: Quarterly: 0.2650 Monthly: 0.0833

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

To calculate a Household discount:

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

Modal premium x .95 = discounted premium

If applying during Open Enrollment or Guaranteed Issue Period, use Preferred rates.

Continental Life Insurance Company of Brentwood, Tennessee

Annual Attained Age Premiums

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

Rates Effective 9/1/2016

Attained	Preferred						Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	2,913	3,686	4,325	n/a	n/a	3,034	3,234	4,089	4,799	n/a	n/a	3,368
65	1,531	1,936	2,274	715	1,990	1,514	1,701	2,150	2,523	793	2,206	1,680
66	1,591	2,012	2,362	743	2,067	1,575	1,768	2,234	2,622	824	2,292	1,749
67	1,653	2,090	2,455	772	2,147	1,641	1,835	2,320	2,723	856	2,383	1,821
68	1,718	2,172	2,550	802	2,231	1,708	1,907	2,411	2,830	891	2,475	1,896
69	1,785	2,257	2,650	833	2,317	1,776	1,981	2,505	2,939	925	2,572	1,973
70	1,853	2,345	2,752	866	2,407	1,850	2,058	2,603	3,054	961	2,672	2,053
71	1,926	2,438	2,861	898	2,502	1,928	2,140	2,706	3,176	998	2,778	2,141
72	2,003	2,534	2,972	936	2,600	2,012	2,224	2,813	3,300	1,038	2,887	2,234
73	2,081	2,633	3,091	970	2,704	2,100	2,312	2,924	3,431	1,077	3,001	2,329
74	2,164	2,738	3,213	1,010	2,810	2,190	2,402	3,039	3,565	1,122	3,118	2,431
75	2,252	2,847	3,340	1,050	2,922	2,281	2,497	3,157	3,706	1,166	3,243	2,533
76	2,314	2,927	3,436	1,080	3,005	2,355	2,569	3,249	3,814	1,198	3,335	2,613
77	2,380	3,010	3,532	1,111	3,090	2,433	2,641	3,339	3,920	1,233	3,429	2,701
78	2,447	3,096	3,633	1,143	3,178	2,512	2,717	3,436	4,032	1,268	3,526	2,786
79	2,517	3,183	3,736	1,175	3,266	2,590	2,794	3,532	4,147	1,305	3,625	2,874
80	2,588	3,271	3,839	1,208	3,357	2,672	2,872	3,632	4,261	1,341	3,728	2,967
81	2,618	3,311	3,887	1,224	3,399	2,707	2,907	3,675	4,314	1,358	3,773	3,005
82	2,650	3,351	3,933	1,240	3,439	2,743	2,941	3,721	4,366	1,375	3,820	3,045
83	2,682	3,390	3,980	1,249	3,481	2,778	2,976	3,765	4,418	1,387	3,864	3,082
84	2,715	3,432	4,028	1,265	3,523	2,815	3,011	3,808	4,470	1,405	3,911	3,124
85	2,745	3,472	4,075	1,283	3,565	2,850	3,048	3,855	4,524	1,424	3,956	3,165
86	2,779	3,516	4,124	1,297	3,608	2,887	3,084	3,903	4,579	1,440	4,006	3,205
87	2,812	3,556	4,174	1,313	3,651	2,923	3,121	3,947	4,632	1,458	4,053	3,244
88	2,846	3,599	4,224	1,329	3,695	2,961	3,157	3,994	4,688	1,474	4,102	3,285
89	2,879	3,642	4,275	1,344	3,738	2,999	3,195	4,043	4,745	1,492	4,150	3,327
90	2,913	3,686	4,325	1,359	3,784	3,034	3,234	4,089	4,799	1,509	4,199	3,368
91	2,948	3,730	4,377	1,376	3,830	3,074	3,272	4,139	4,858	1,529	4,250	3,414
92	2,985	3,775	4,430	1,393	3,875	3,113	3,312	4,189	4,915	1,545	4,302	3,456
93	3,020	3,820	4,484	1,410	3,921	3,151	3,353	4,240	4,975	1,565	4,351	3,500
94	3,056	3,865	4,538	1,427	3,970	3,194	3,393	4,290	5,036	1,586	4,404	3,545
95	3,094	3,913	4,592	1,443	4,016	3,234	3,434	4,342	5,098	1,603	4,459	3,590
96	3,131	3,959	4,647	1,464	4,065	3,278	3,473	4,394	5,158	1,624	4,513	3,639
97	3,168	4,006	4,704	1,480	4,115	3,318	3,518	4,449	5,222	1,642	4,568	3,682
98	3,207	4,055	4,760	1,497	4,164	3,360	3,559	4,502	5,284	1,663	4,621	3,731
99	3,245	4,104	4,817	1,514	4,213	3,403	3,601	4,554	5,346	1,680	4,675	3,780

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

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

To calculate a Household discount:

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

Modal premium x .95 = discounted premium

If applying during Open Enrollment or Guaranteed Issue Period, use Preferred rates.

# Continental Life Insurance Company of Brentwood, Tennessee

Annual Attained Age Premiums

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

Rates Effective 9/1/2016

Attained	Preferred						Standard						
	Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65		3,272	4,139	4,857	n/a	n/a	3,407	Under 65	3,632	4,592	5,390	n/a	3,783
65		1,719	2,174	2,554	803	2,234	1,700	65	1,910	2,414	2,833	891	2,477
66		1,786	2,259	2,652	834	2,321	1,769	66	1,985	2,508	2,944	925	2,574
67		1,856	2,347	2,756	867	2,411	1,843	67	2,060	2,606	3,058	962	2,676
68		1,929	2,439	2,863	900	2,506	1,918	68	2,141	2,707	3,178	1,000	2,780
69		2,004	2,535	2,976	936	2,602	1,995	69	2,225	2,813	3,300	1,038	2,888
70		2,081	2,633	3,091	973	2,703	2,077	70	2,311	2,924	3,429	1,080	3,000
71		2,163	2,737	3,213	1,008	2,810	2,165	71	2,403	3,039	3,566	1,121	3,119
72		2,250	2,845	3,337	1,051	2,919	2,259	72	2,498	3,159	3,706	1,166	3,241
73		2,337	2,956	3,472	1,089	3,036	2,358	73	2,596	3,284	3,852	1,210	3,370
74		2,430	3,074	3,609	1,134	3,155	2,459	74	2,698	3,413	4,003	1,260	3,502
75		2,529	3,198	3,751	1,180	3,281	2,562	75	2,804	3,546	4,162	1,310	3,641
76		2,599	3,287	3,858	1,212	3,374	2,644	76	2,885	3,648	4,283	1,345	3,746
77		2,673	3,380	3,966	1,248	3,470	2,732	77	2,966	3,750	4,402	1,385	3,851
78		2,748	3,477	4,080	1,284	3,569	2,821	78	3,051	3,858	4,528	1,423	3,959
79		2,826	3,574	4,195	1,319	3,667	2,909	79	3,137	3,966	4,657	1,466	4,070
80		2,906	3,673	4,311	1,356	3,770	3,000	80	3,225	4,078	4,785	1,506	4,187
81		2,940	3,718	4,365	1,374	3,817	3,040	81	3,265	4,126	4,844	1,525	4,237
82		2,976	3,763	4,417	1,392	3,862	3,080	82	3,303	4,179	4,903	1,544	4,289
83		3,011	3,807	4,469	1,403	3,909	3,119	83	3,341	4,228	4,961	1,558	4,339
84		3,048	3,854	4,524	1,421	3,957	3,161	84	3,381	4,276	5,020	1,578	4,392
85		3,083	3,899	4,576	1,441	4,003	3,200	85	3,422	4,329	5,080	1,599	4,443
86		3,121	3,948	4,631	1,456	4,051	3,241	86	3,463	4,383	5,142	1,617	4,499
87		3,158	3,994	4,687	1,474	4,100	3,283	87	3,504	4,432	5,202	1,637	4,551
88		3,196	4,042	4,743	1,492	4,150	3,325	88	3,546	4,485	5,265	1,655	4,606
89		3,233	4,089	4,800	1,510	4,198	3,367	89	3,588	4,540	5,328	1,676	4,661
90		3,272	4,139	4,857	1,526	4,250	3,407	90	3,632	4,592	5,390	1,695	4,716
91		3,310	4,188	4,916	1,545	4,300	3,452	91	3,674	4,648	5,455	1,717	4,773
92		3,352	4,239	4,974	1,565	4,351	3,496	92	3,720	4,705	5,520	1,734	4,831
93		3,391	4,289	5,035	1,584	4,403	3,539	93	3,765	4,761	5,587	1,758	4,885
94		3,432	4,340	5,096	1,603	4,458	3,587	94	3,810	4,817	5,655	1,781	4,946
95		3,474	4,394	5,157	1,621	4,510	3,632	95	3,857	4,876	5,725	1,800	5,007
96		3,515	4,446	5,218	1,644	4,565	3,681	96	3,900	4,935	5,792	1,823	5,068
97		3,558	4,499	5,283	1,662	4,621	3,726	97	3,951	4,996	5,864	1,844	5,129
98		3,602	4,554	5,346	1,681	4,676	3,773	98	3,996	5,055	5,933	1,867	5,190
99		3,644	4,609	5,409	1,700	4,731	3,821	99	4,044	5,114	6,003	1,886	5,250

Modal Factors: Quarterly: 0.2650 Monthly: 0.0833

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

To calculate a Household discount:

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

Modal premium x .95 = discounted premium

If applying during Open Enrollment or Guaranteed Issue Period, use Preferred rates.



# Continental Life Insurance Company of Brentwood, Tennessee

Annual Attained Age Premiums

For Use in ZIP Codes: Rest of State

Rates Effective 9/1/2016

Attained	Preferred						Standard						
	Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65		2,269	2,870	3,368	n/a	n/a	2,363	2,518	3,184	3,737	n/a	n/a	2,623
65		1,192	1,508	1,771	557	1,549	1,179	1,324	1,674	1,965	618	1,718	1,308
66		1,239	1,567	1,839	579	1,609	1,226	1,377	1,739	2,042	641	1,785	1,362
67		1,287	1,627	1,911	601	1,672	1,278	1,429	1,807	2,120	667	1,855	1,418
68		1,338	1,691	1,986	624	1,738	1,330	1,485	1,877	2,204	694	1,928	1,476
69		1,390	1,758	2,063	649	1,804	1,383	1,543	1,950	2,289	720	2,003	1,536
70		1,443	1,826	2,143	675	1,874	1,440	1,603	2,027	2,378	749	2,081	1,599
71		1,500	1,898	2,228	699	1,948	1,501	1,666	2,107	2,473	777	2,163	1,667
72		1,560	1,973	2,314	729	2,024	1,567	1,732	2,191	2,570	808	2,248	1,739
73		1,621	2,050	2,407	755	2,105	1,635	1,800	2,277	2,671	839	2,337	1,814
74		1,685	2,132	2,502	787	2,188	1,705	1,871	2,366	2,776	874	2,428	1,893
75		1,754	2,217	2,601	818	2,275	1,777	1,945	2,459	2,886	908	2,525	1,972
76		1,802	2,279	2,675	841	2,340	1,834	2,001	2,530	2,970	933	2,597	2,035
77		1,853	2,344	2,750	865	2,406	1,894	2,057	2,600	3,052	960	2,670	2,103
78		1,906	2,411	2,829	890	2,475	1,956	2,116	2,675	3,140	987	2,746	2,170
79		1,960	2,479	2,909	915	2,543	2,017	2,176	2,750	3,229	1,017	2,822	2,238
80		2,015	2,547	2,990	941	2,614	2,081	2,236	2,828	3,318	1,044	2,903	2,310
81		2,039	2,578	3,027	953	2,647	2,108	2,264	2,861	3,359	1,057	2,938	2,340
82		2,063	2,610	3,063	965	2,678	2,136	2,290	2,898	3,400	1,071	2,974	2,371
83		2,088	2,640	3,099	973	2,710	2,163	2,317	2,932	3,440	1,080	3,009	2,400
84		2,114	2,672	3,137	985	2,744	2,192	2,345	2,965	3,481	1,094	3,046	2,433
85		2,138	2,704	3,173	999	2,776	2,219	2,373	3,002	3,523	1,109	3,081	2,464
86		2,164	2,738	3,211	1,010	2,809	2,248	2,402	3,039	3,565	1,121	3,120	2,496
87		2,190	2,769	3,250	1,022	2,843	2,276	2,430	3,073	3,607	1,135	3,156	2,526
88		2,216	2,803	3,289	1,035	2,878	2,306	2,459	3,110	3,651	1,148	3,194	2,558
89		2,242	2,836	3,329	1,047	2,911	2,335	2,488	3,148	3,695	1,162	3,232	2,591
90		2,269	2,870	3,368	1,058	2,947	2,363	2,518	3,184	3,737	1,175	3,270	2,623
91		2,295	2,904	3,409	1,072	2,982	2,394	2,548	3,223	3,783	1,190	3,310	2,658
92		2,325	2,939	3,449	1,085	3,017	2,424	2,579	3,262	3,828	1,203	3,350	2,691
93		2,351	2,974	3,491	1,098	3,053	2,454	2,611	3,301	3,874	1,219	3,388	2,726
94		2,380	3,010	3,534	1,112	3,091	2,487	2,642	3,340	3,922	1,235	3,430	2,761
95		2,409	3,047	3,576	1,124	3,127	2,518	2,674	3,381	3,970	1,248	3,472	2,796
96		2,438	3,083	3,619	1,140	3,165	2,553	2,705	3,422	4,017	1,264	3,514	2,834
97		2,467	3,120	3,663	1,152	3,204	2,584	2,740	3,465	4,066	1,279	3,557	2,867
98		2,498	3,158	3,707	1,166	3,242	2,616	2,771	3,506	4,114	1,295	3,599	2,905
99		2,527	3,196	3,751	1,179	3,280	2,650	2,804	3,546	4,163	1,308	3,640	2,943

Modal Factors: Semi-Annual: 0.5200

Quarterly: 0.2650

Monthly: 0.0833

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

To calculate a Household discount:

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

Modal premium x .95 = discounted premium

If applying during Open Enrollment or Guaranteed Issue 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.

## **HOUSEHOLD DISCOUNT**

In order to be eligible for the Household discount under a Continental Life Insurance Company of Brentwood, Tennessee Medicare supplement plan, you must apply for a Medicare supplement plan at the same time as another Medicare eligible adult or the other Medicare eligible adult must currently be covered by a Continental Life Insurance Company of Brentwood, Tennessee Medicare supplement policy. The Medicare eligible adult must be either (a) your spouse; (b) be someone with whom you are in a civil union partnership; or (c) be a permanent resident in your home. The household discount will only be applicable if a policy for each applicant is issued. The discounted rate will be 5 percent lower than the individual rates and will apply as long as both policies remain in force.

## **DISCLOSURES**

Use this outline to compare benefits and premium among policies.

## **READ YOUR POLICY VERY CAREFULLY**

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

## **RIGHT TO RETURN POLICY**

If you find that you are not satisfied with your policy, you may return it to Continental Life Insurance Company of Brentwood, Tennessee, P.O. Box 14770, Lexington, KY 40512-4770. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all your payments.

## **POLICY REPLACEMENT**

If you are replacing another health insurance policy, do **NOT** cancel it until you have actually received your new policy and are sure you want to keep it.

## **NOTICE**

The policy may not cover all of your medical costs.

Neither Continental Life Insurance Company of Brentwood, Tennessee nor its agents are connected with Medicare.

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult *Medicare & You* for more details.

## **COMPLETE ANSWERS ARE VERY IMPORTANT**

When you fill out the application for the new policy, be sure to answer truthfully and completely any questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information.

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

**THE FOLLOWING CHARTS DESCRIBE PLANS A, B, F, HIGH DEDUCTIBLE F, G and N OFFERED BY CONTINENTAL LIFE INSURANCE COMPANY OF BRENTWOOD, TENNESSEE.**

## PLAN A

### MEDICARE (PART A) – HOSPITAL SERVICES – PER CALENDAR YEAR

\*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
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days  61st thru 90th day 91st day and after •While using 60 lifetime reserve days •Once lifetime reserve days are used: •Additional 365 days  •Beyond the Additional 365 days	All but \$1288  All but \$322 a day  All but \$644 a day  \$0  \$0	\$0  \$322 a day  \$644 a day  100% of Medicare Eligible Expenses \$0	\$1288 (Part A Deductible) \$0  \$0  \$0**  All costs
<b>SKILLED NURSING FACILITY CARE*</b> 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 21st thru 100th day 101st day and after	All approved amounts All but \$161 a day \$0	\$0 \$0 \$0	\$0 Up to \$161 a day All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> 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 \$166 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
<b>MEDICAL EXPENSES –</b> 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 \$166 of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0  Generally 80%	\$0  Generally 20%	\$166 (Part B Deductible)  \$0
<b>Part B Excess Charges</b> (Above Medicare-Approved amounts)	\$0	\$0	All costs
<b>BLOOD</b> First 3 pints Next \$166 of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0 \$0  80%	All costs \$0  20%	\$0 \$166 (Part B Deductible)  \$0
<b>CLINICAL LABORATORY SERVICES –</b> TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

## PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE –</b> MEDICARE APPROVED SERVICES •Medically necessary skilled care services and medical supplies  •Durable medical equipment •First \$166 of Medicare Approved amounts*  •Remainder of Medicare Approved amounts	100%  \$0  80%	\$0  \$0  20%	\$0  \$166 (Part B Deductible)  \$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
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days  61st thru 90th day 91st day and after •While using 60 lifetime reserve days •Once lifetime reserve days are used: •Additional 365 days  •Beyond the Additional 365 days	All but \$1288  All but \$322 a day  All but \$644 a day  \$0  \$0	\$1288 (Part A Deductible) \$322 a day  \$644 a day  100% of Medicare Eligible Expenses \$0	\$0  \$0  \$0  \$0**  All costs
<b>SKILLED NURSING FACILITY CARE*</b> 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  21st thru 100th day 101st day and after	All approved amounts All but \$161 a day \$0	\$0  \$0 \$0	\$0  Up to \$161 a day All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> 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 \$166 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
<b>MEDICAL EXPENSES –</b> 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 \$166 of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0  Generally 80%	\$0  Generally 20%	\$166 (Part B Deductible)  \$0
<b>Part B Excess Charges</b> (Above Medicare-Approved amounts)	\$0	\$0	All costs
<b>BLOOD</b> First 3 pints Next \$166 of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0 \$0  80%	All costs \$0  20%	\$0 \$166 (Part B Deductible)  \$0
<b>CLINICAL LABORATORY SERVICES –</b> TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

## PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE –</b> MEDICARE APPROVED SERVICES •Medically necessary skilled care services and medical supplies  •Durable medical equipment •First \$166 of Medicare Approved amounts*  •Remainder of Medicare Approved amounts	100%  \$0  80%	\$0  \$0  20%	\$0  \$166 (Part B Deductible)  \$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
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days  61st thru 90th day 91st day and after •While using 60 lifetime reserve days •Once lifetime reserve days are used: •Additional 365 days  •Beyond the Additional 365 days	All but \$1288  All but \$322 a day  All but \$644 a day  \$0  \$0	\$1288 (Part A Deductible) \$322 a day  \$644 a day  100% of Medicare Eligible Expenses \$0	\$0  \$0  \$0  \$0**  All costs
<b>SKILLED NURSING FACILITY CARE*</b> 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  21st thru 100th day 101st day and after	All approved amounts All but \$161 a day \$0	\$0  Up to \$161 a day \$0	\$0  \$0 All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> 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 F

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

\*Once you have been billed \$166 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
<b>MEDICAL EXPENSES –</b> 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 \$166 of Medicare-Approved amounts*	\$0	\$166 (Part B Deductible)	\$0
Remainder of Medicare-Approved amounts	Generally 80%	Generally 20%	\$0
<b>Part B Excess Charges</b> (Above Medicare-Approved amounts)	\$0	100%	\$0
<b>BLOOD</b> First 3 pints	\$0	All costs	\$0
Next \$166 of Medicare-Approved amounts*	\$0	\$166 (Part B Deductible)	\$0
Remainder of Medicare-Approved amounts	80%	20%	\$0
<b>CLINICAL LABORATORY SERVICES –</b> TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

### PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE –</b> MEDICARE APPROVED SERVICES			
•Medically necessary skilled care services and medical supplies	100%	\$0	\$0
•Durable medical equipment			
•First \$166 of Medicare Approved amounts*	\$0	\$166 (Part B Deductible)	\$0
•Remainder of Medicare Approved amounts	80%	20%	\$0



**PLAN F**

**OTHER BENEFITS – NOT COVERED BY MEDICARE**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</b> Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of charges	     \$0 \$0	     \$0 80% to a lifetime maximum benefit of \$50,000	     \$250 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 \$2180 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses are \$2180. 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 \$2180 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO \$2180 DEDUCTIBLE*** YOU PAY
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days  61st thru 90th day 91st day and after •While using 60 lifetime reserve days •Once lifetime reserve days are used: •Additional 365 days  •Beyond the Additional 365 days	All but \$1288  All but \$322 a day  All but \$644 a day  \$0  \$0	\$1288 (Part A Deductible) \$322 a day  \$644 a day  100% of Medicare Eligible Expenses \$0	\$0  \$0  \$0  \$0**  All costs
<b>SKILLED NURSING FACILITY CARE*</b> 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  21st thru 100th day 101st day and after	All approved amounts All but \$161 a day \$0	\$0  Up to \$161 a day \$0	\$0  \$0 All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0

<b>HOSPICE CARE</b> 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.

## HIGH DEDUCTIBLE PLAN F

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

\*Once you have been billed \$166 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 \$2180 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses are \$2180. 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 \$2180 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO \$2180 DEDUCTIBLE*** YOU PAY
<b>MEDICAL EXPENSES –</b> 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 \$166 of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0  Generally 80%	\$166 (Part B Deductible)  Generally 20%	\$0  \$0
<b>Part B Excess Charges</b> (Above Medicare-Approved amounts)	\$0	100%	\$0
<b>BLOOD</b> First 3 pints Next \$166 of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0 \$0  80%	All costs \$166 (Part B Deductible)  20%	\$0 \$0  \$0
<b>CLINICAL LABORATORY            SERVICES –</b> TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

## HIGH DEDUCTIBLE PLAN F

### PARTS A & B

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$2180 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO \$2180 DEDUCTIBLE*** YOU PAY
<b>HOME HEALTH CARE – MEDICARE APPROVED SERVICES</b>			
•Medically necessary skilled care services and medical supplies	100%	\$0	\$0
•Durable medical equipment			
•First \$166 of Medicare Approved amounts*	\$0	\$166 (Part B Deductible)	\$0
•Remainder of Medicare Approved amounts	80%	20%	\$0

### OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$2180 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO \$2180 DEDUCTIBLE** YOU PAY
<b>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</b>			
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
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days  61st thru 90th day 91st day and after •While using 60 lifetime reserve days •Once lifetime reserve days are used: •Additional 365 days  •Beyond the Additional 365 days	All but \$1288  All but \$322 a day  All but \$644 a day  \$0  \$0	\$1288 (Part A Deductible) \$322 a day  \$644 a day  100% of Medicare Eligible Expenses \$0	\$0  \$0  \$0  \$0**  All costs
<b>SKILLED NURSING FACILITY CARE*</b> 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  21st thru 100th day 101st day and after	All approved amounts All but \$161 a day \$0	\$0  Up to \$161 a day \$0	\$0  \$0 All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> 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 \$166 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
<b>MEDICAL EXPENSES –</b> 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 \$166 of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	 \$0 Generally 80%	 \$0 Generally 20%	 \$166 (Part B Deductible) \$0
<b>Part B Excess Charges</b> (Above Medicare-Approved amounts)	\$0	100%	\$0
<b>BLOOD</b> First 3 pints Next \$166 of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$166 (Part B Deductible) \$0
<b>CLINICAL LABORATORY SERVICES –</b> TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

### PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE –</b> MEDICARE APPROVED SERVICES •Medically necessary skilled care services and medical supplies •Durable medical equipment •First \$166 of Medicare Approved amounts* •Remainder of Medicare Approved amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$166 (Part B Deductible) \$0

## PLAN G

### OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</b> Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of charges	\$0 \$0	\$0 80% to a lifetime maximum benefit of \$50,000	\$250 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
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days  61st thru 90th day 91st day and after •While using 60 lifetime reserve days •Once lifetime reserve days are used: •Additional 365 days  •Beyond the Additional 365 days	All but \$1288  All but \$322 a day  All but \$644 a day  \$0  \$0	\$1288 (Part A Deductible) \$322 a day  \$644 a day  100% of Medicare Eligible Expenses \$0	\$0  \$0  \$0  \$0**  All costs
<b>SKILLED NURSING FACILITY CARE*</b> 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  21st thru 100th day 101st day and after	All approved amounts All but \$161 a day \$0	\$0  Up to \$161 a day \$0	\$0  \$0 All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> 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 \$166 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
<b>MEDICAL EXPENSES –</b> 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 \$166 of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0  Generally 80%	\$0  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.	\$166 (Part B Deductible) 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.
<b>Part B Excess Charges</b> (Above Medicare-Approved amounts)	\$0	0%	All costs
<b>BLOOD</b> First 3 pints Next \$166 of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	\$0 \$0  80%	All costs \$0  20%	\$0 \$166 (Part B Deductible)  \$0
<b>CLINICAL LABORATORY SERVICES –</b> TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

## PLAN N

### PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE – MEDICARE APPROVED SERVICES</b> <ul style="list-style-type: none"> <li>•Medically necessary skilled care services and medical supplies</li> <li>•Durable medical equipment</li> <li>•First \$166 of Medicare Approved amounts*</li> <li>•Remainder of Medicare Approved amounts</li> </ul>	100%  \$0  80%	\$0  \$0  20%	\$0  \$166 (Part B Deductible)  \$0

### OTHER BENEFITS – NOT COVERED BY MEDICARE

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

