Outline of coverage

Medicare Supplement Insurance

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

Alabama

Underwritten by

Continental Life Insurance Company of Brentwood, Tennessee

An Aetna Company

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CLIMS04877AL

Rates effective: 04/2024 A

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. 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 2024[2]					**$7,060[2]**	**$3,530[2]**				

[1] Plans F and G also have a high deductible option, which require first paying a plan deductible of **$2,800** 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: 350-352

Female rates

Rates effective 4/1/2024

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
65	1,773	1,878	2,342	2,029	739	1,099
66	1,773	1,878	2,342	2,029	739	1,099
67	1,773	1,878	2,342	2,029	739	1,099
68	1,791	1,897	2,368	2,052	747	1,139
69	1,833	1,940	2,422	2,098	764	1,185
70	1,879	1,993	2,487	2,153	784	1,231
71	1,936	2,052	2,562	2,217	807	1,274
72	1,997	2,116	2,641	2,287	833	1,318
73	2,061	2,187	2,727	2,362	860	1,362
74	2,133	2,262	2,823	2,445	890	1,408
75	2,208	2,340	2,921	2,531	921	1,453
76	2,286	2,423	3,024	2,618	954	1,500
77	2,367	2,507	3,129	2,711	986	1,550
78	2,446	2,592	3,235	2,804	1,020	1,602
79	2,523	2,674	3,337	2,892	1,051	1,653
80	2,604	2,758	3,443	2,981	1,085	1,709
81	2,685	2,845	3,550	3,076	1,120	1,762
82	2,764	2,929	3,656	3,166	1,151	1,815
83	2,849	3,022	3,770	3,266	1,189	1,870
84	2,932	3,109	3,878	3,361	1,223	1,926
85	3,040	3,221	4,018	3,482	1,268	1,994
86	3,126	3,313	4,134	3,582	1,303	2,052
87	3,216	3,407	4,251	3,683	1,340	2,110
88	3,303	3,503	4,371	3,787	1,377	2,170
89	3,397	3,600	4,492	3,892	1,417	2,229
90	3,491	3,698	4,617	3,999	1,455	2,292
91	3,587	3,800	4,743	4,108	1,494	2,354
92	3,682	3,902	4,868	4,219	1,535	2,417
93	3,779	4,007	4,998	4,330	1,576	2,481
94	3,880	4,113	5,132	4,445	1,617	2,547
95	3,982	4,219	5,267	4,562	1,659	2,614
96	4,084	4,328	5,401	4,679	1,702	2,680
97	4,189	4,439	5,539	4,799	1,747	2,749
98	4,294	4,549	5,681	4,919	1,791	2,819
99+	4,402	4,665	5,821	5,042	1,835	2,889

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
65	1,970	2,086	2,604	2,254	820	1,222
66	1,970	2,086	2,604	2,254	820	1,222
67	1,970	2,086	2,604	2,254	820	1,222
68	1,989	2,106	2,630	2,280	831	1,266
69	2,035	2,157	2,688	2,331	849	1,318
70	2,088	2,214	2,763	2,392	871	1,367
71	2,150	2,280	2,845	2,463	897	1,415
72	2,217	2,352	2,937	2,541	925	1,464
73	2,291	2,427	3,028	2,625	955	1,513
74	2,371	2,513	3,136	2,715	989	1,564
75	2,452	2,599	3,245	2,814	1,024	1,615
76	2,540	2,694	3,361	2,911	1,059	1,666
77	2,628	2,788	3,477	3,011	1,097	1,722
78	2,719	2,882	3,595	3,115	1,133	1,781
79	2,804	2,971	3,709	3,211	1,167	1,837
80	2,892	3,063	3,824	3,313	1,206	1,898
81	2,984	3,161	3,947	3,418	1,244	1,957
82	3,070	3,254	4,062	3,519	1,280	2,016
83	3,165	3,355	4,189	3,627	1,319	2,078
84	3,258	3,454	4,310	3,734	1,358	2,139
85	3,378	3,578	4,466	3,870	1,408	2,216
86	3,475	3,682	4,596	3,980	1,449	2,280
87	3,572	3,787	4,725	4,092	1,489	2,344
88	3,671	3,892	4,858	4,207	1,531	2,410
89	3,774	4,000	4,993	4,325	1,573	2,477
90	3,876	4,109	5,131	4,444	1,616	2,546
91	3,984	4,221	5,268	4,563	1,660	2,615
92	4,092	4,336	5,410	4,686	1,705	2,686
93	4,201	4,451	5,554	4,814	1,750	2,757
94	4,311	4,569	5,703	4,938	1,798	2,830
95	4,424	4,688	5,851	5,069	1,844	2,904
96	4,538	4,808	6,003	5,200	1,892	2,979
97	4,653	4,931	6,156	5,329	1,941	3,054
98	4,772	5,056	6,310	5,466	1,989	3,132
99+	4,891	5,182	6,468	5,603	2,040	3,210

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

To calculate a 7% household discount:

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

Modal premium **x** .93 **= discounted premium**

If applying during Open Enrollment or Guaranteed Issue periods, use preferred rates.

Modal factors

Semi-annual 0.5200

Quarterly 0.2650

Monthly 0.0833

Continental Life Insurance Company of Brentwood, Tennessee

Annual premiums

For use in Zip Codes: 350-352

Male rates

Rates effective 4/1/2024

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
65	2,037	2,159	2,694	2,332	850	1,264
66	2,037	2,159	2,694	2,332	850	1,264
67	2,037	2,159	2,694	2,332	850	1,264
68	2,059	2,180	2,723	2,359	859	1,310
69	2,107	2,232	2,784	2,413	878	1,363
70	2,161	2,291	2,860	2,476	902	1,415
71	2,227	2,358	2,944	2,549	928	1,464
72	2,295	2,433	3,039	2,630	957	1,515
73	2,371	2,513	3,136	2,715	988	1,566
74	2,454	2,601	3,246	2,810	1,024	1,619
75	2,540	2,691	3,358	2,911	1,059	1,671
76	2,628	2,788	3,477	3,011	1,097	1,724
77	2,721	2,885	3,598	3,118	1,135	1,783
78	2,814	2,981	3,720	3,225	1,174	1,843
79	2,904	3,076	3,836	3,324	1,208	1,901
80	2,995	3,172	3,957	3,430	1,248	1,965
81	3,088	3,270	4,084	3,537	1,287	2,026
82	3,178	3,369	4,205	3,641	1,325	2,087
83	3,277	3,474	4,336	3,755	1,367	2,150
84	3,372	3,575	4,460	3,863	1,407	2,215
85	3,494	3,703	4,622	4,007	1,459	2,294
86	3,596	3,809	4,754	4,118	1,501	2,359
87	3,696	3,919	4,891	4,236	1,541	2,426
88	3,801	4,027	5,026	4,354	1,584	2,495
89	3,905	4,138	5,167	4,476	1,628	2,564
90	4,013	4,254	5,310	4,599	1,674	2,635
91	4,123	4,369	5,451	4,723	1,719	2,706
92	4,234	4,488	5,598	4,852	1,764	2,780
93	4,347	4,607	5,748	4,981	1,813	2,853
94	4,461	4,729	5,902	5,113	1,861	2,929
95	4,580	4,853	6,058	5,245	1,907	3,006
96	4,697	4,979	6,212	5,381	1,957	3,083
97	4,817	5,104	6,370	5,518	2,009	3,162
98	4,939	5,233	6,533	5,657	2,059	3,242
99+	5,061	5,365	6,694	5,799	2,110	3,323

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
65	2,266	2,399	2,995	2,592	944	1,405
66	2,266	2,399	2,995	2,592	944	1,405
67	2,266	2,399	2,995	2,592	944	1,405
68	2,288	2,423	3,025	2,623	955	1,455
69	2,340	2,479	3,093	2,681	975	1,515
70	2,402	2,546	3,176	2,753	1,001	1,573
71	2,474	2,623	3,271	2,833	1,031	1,627
72	2,549	2,702	3,376	2,921	1,063	1,684
73	2,632	2,791	3,485	3,016	1,098	1,740
74	2,727	2,889	3,608	3,122	1,138	1,799
75	2,822	2,989	3,732	3,233	1,176	1,857
76	2,921	3,097	3,865	3,347	1,218	1,915
77	3,023	3,205	3,998	3,462	1,262	1,981
78	3,126	3,313	4,132	3,582	1,303	2,048
79	3,224	3,416	4,265	3,695	1,344	2,113
80	3,327	3,522	4,399	3,809	1,387	2,183
81	3,432	3,636	4,539	3,929	1,432	2,251
82	3,531	3,741	4,670	4,047	1,472	2,319
83	3,640	3,859	4,817	4,173	1,518	2,390
84	3,747	3,971	4,956	4,294	1,563	2,460
85	3,885	4,115	5,136	4,450	1,619	2,548
86	3,996	4,234	5,283	4,575	1,667	2,623
87	4,108	4,354	5,432	4,705	1,712	2,695
88	4,223	4,476	5,586	4,839	1,761	2,772
89	4,340	4,600	5,743	4,971	1,809	2,849
90	4,459	4,726	5,901	5,112	1,860	2,928
91	4,582	4,854	6,059	5,248	1,911	3,007
92	4,704	4,986	6,222	5,389	1,961	3,089
93	4,832	5,119	6,387	5,534	2,014	3,171
94	4,957	5,255	6,557	5,679	2,068	3,254
95	5,088	5,390	6,729	5,831	2,120	3,340
96	5,218	5,531	6,903	5,979	2,175	3,425
97	5,352	5,670	7,076	6,130	2,233	3,512
98	5,488	5,815	7,256	6,286	2,287	3,602
99+	5,624	5,961	7,437	6,444	2,345	3,692

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

To calculate a 7% household discount:

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

Modal premium **x** .93 **= discounted premium**

If applying during Open Enrollment or Guaranteed Issue periods, use preferred rates.

Modal factors

Semi-annual 0.5200

Quarterly 0.2650

Monthly 0.0833

Continental Life Insurance Company of Brentwood, Tennessee

Annual premiums

For use in: Rest of State

Female rates

Rates effective 4/1/2024

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
65	1,569	1,662	2,073	1,796	654	973
66	1,569	1,662	2,073	1,796	654	973
67	1,569	1,662	2,073	1,796	654	973
68	1,585	1,679	2,096	1,816	661	1,008
69	1,622	1,717	2,143	1,857	676	1,049
70	1,663	1,764	2,201	1,905	694	1,089
71	1,713	1,816	2,267	1,962	714	1,127
72	1,767	1,873	2,337	2,024	737	1,166
73	1,824	1,935	2,413	2,090	761	1,205
74	1,888	2,002	2,498	2,164	788	1,246
75	1,954	2,071	2,585	2,240	815	1,286
76	2,023	2,144	2,676	2,317	844	1,327
77	2,095	2,219	2,769	2,399	873	1,372
78	2,165	2,294	2,863	2,481	903	1,418
79	2,233	2,366	2,953	2,559	930	1,463
80	2,304	2,441	3,047	2,638	960	1,512
81	2,376	2,518	3,142	2,722	991	1,559
82	2,446	2,592	3,235	2,802	1,019	1,606
83	2,521	2,674	3,336	2,890	1,052	1,655
84	2,595	2,751	3,432	2,974	1,082	1,704
85	2,690	2,850	3,556	3,081	1,122	1,765
86	2,766	2,932	3,658	3,170	1,153	1,816
87	2,846	3,015	3,762	3,259	1,186	1,867
88	2,923	3,100	3,868	3,351	1,219	1,920
89	3,006	3,186	3,975	3,444	1,254	1,973
90	3,089	3,273	4,086	3,539	1,288	2,028
91	3,174	3,363	4,197	3,635	1,322	2,083
92	3,258	3,453	4,308	3,734	1,358	2,139
93	3,344	3,546	4,423	3,832	1,395	2,196
94	3,434	3,640	4,542	3,934	1,431	2,254
95	3,524	3,734	4,661	4,037	1,468	2,313
96	3,614	3,830	4,780	4,141	1,506	2,372
97	3,707	3,928	4,902	4,247	1,546	2,433
98	3,800	4,026	5,027	4,353	1,585	2,495
99+	3,896	4,128	5,151	4,462	1,624	2,557

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
65	1,743	1,846	2,304	1,995	726	1,081
66	1,743	1,846	2,304	1,995	726	1,081
67	1,743	1,846	2,304	1,995	726	1,081
68	1,760	1,864	2,327	2,018	735	1,120
69	1,801	1,909	2,379	2,063	751	1,166
70	1,848	1,959	2,445	2,117	771	1,210
71	1,903	2,018	2,518	2,180	794	1,252
72	1,962	2,081	2,599	2,249	819	1,296
73	2,027	2,148	2,680	2,323	845	1,339
74	2,098	2,224	2,775	2,403	875	1,384
75	2,170	2,300	2,872	2,490	906	1,429
76	2,248	2,384	2,974	2,576	937	1,474
77	2,326	2,467	3,077	2,665	971	1,524
78	2,406	2,550	3,181	2,757	1,003	1,576
79	2,481	2,629	3,282	2,842	1,033	1,626
80	2,559	2,711	3,384	2,932	1,067	1,680
81	2,641	2,797	3,493	3,025	1,101	1,732
82	2,717	2,880	3,595	3,114	1,133	1,784
83	2,801	2,969	3,707	3,210	1,167	1,839
84	2,883	3,057	3,814	3,304	1,202	1,893
85	2,989	3,166	3,952	3,425	1,246	1,961
86	3,075	3,258	4,067	3,522	1,282	2,018
87	3,161	3,351	4,181	3,621	1,318	2,074
88	3,249	3,444	4,299	3,723	1,355	2,133
89	3,340	3,540	4,419	3,827	1,392	2,192
90	3,430	3,636	4,541	3,933	1,430	2,253
91	3,526	3,735	4,662	4,038	1,469	2,314
92	3,621	3,837	4,788	4,147	1,509	2,377
93	3,718	3,939	4,915	4,260	1,549	2,440
94	3,815	4,043	5,047	4,370	1,591	2,504
95	3,915	4,149	5,178	4,486	1,632	2,570
96	4,016	4,255	5,312	4,602	1,674	2,636
97	4,118	4,364	5,448	4,716	1,718	2,703
98	4,223	4,474	5,584	4,837	1,760	2,772
99+	4,328	4,586	5,724	4,958	1,805	2,841

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

To calculate a 7% household discount:

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

Modal premium **x** .93 **= discounted premium**

If applying during Open Enrollment or Guaranteed Issue periods, use preferred rates.

Modal factors

Semi-annual 0.5200

Quarterly 0.2650

Monthly 0.0833

Continental Life Insurance Company of Brentwood, Tennessee

Annual premiums

For use in: Rest of State

Male rates

Rates effective 4/1/2024

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
65	1,803	1,911	2,384	2,064	752	1,119
66	1,803	1,911	2,384	2,064	752	1,119
67	1,803	1,911	2,384	2,064	752	1,119
68	1,822	1,929	2,410	2,088	760	1,159
69	1,865	1,975	2,464	2,135	777	1,206
70	1,912	2,027	2,531	2,191	798	1,252
71	1,971	2,087	2,605	2,256	821	1,296
72	2,031	2,153	2,689	2,327	847	1,341
73	2,098	2,224	2,775	2,403	874	1,386
74	2,172	2,302	2,873	2,487	906	1,433
75	2,248	2,381	2,972	2,576	937	1,479
76	2,326	2,467	3,077	2,665	971	1,526
77	2,408	2,553	3,184	2,759	1,004	1,578
78	2,490	2,638	3,292	2,854	1,039	1,631
79	2,570	2,722	3,395	2,942	1,069	1,682
80	2,650	2,807	3,502	3,035	1,104	1,739
81	2,733	2,894	3,614	3,130	1,139	1,793
82	2,812	2,981	3,721	3,222	1,173	1,847
83	2,900	3,074	3,837	3,323	1,210	1,903
84	2,984	3,164	3,947	3,419	1,245	1,960
85	3,092	3,277	4,090	3,546	1,291	2,030
86	3,182	3,371	4,207	3,644	1,328	2,088
87	3,271	3,468	4,328	3,749	1,364	2,147
88	3,364	3,564	4,448	3,853	1,402	2,208
89	3,456	3,662	4,573	3,961	1,441	2,269
90	3,551	3,765	4,699	4,070	1,481	2,332
91	3,649	3,866	4,824	4,180	1,521	2,395
92	3,747	3,972	4,954	4,294	1,561	2,460
93	3,847	4,077	5,087	4,408	1,604	2,525
94	3,948	4,185	5,223	4,525	1,647	2,592
95	4,053	4,295	5,361	4,642	1,688	2,660
96	4,157	4,406	5,497	4,762	1,732	2,728
97	4,263	4,517	5,637	4,883	1,778	2,798
98	4,371	4,631	5,781	5,006	1,822	2,869
99+	4,479	4,748	5,924	5,132	1,867	2,941

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
65	2,005	2,123	2,650	2,294	835	1,243
66	2,005	2,123	2,650	2,294	835	1,243
67	2,005	2,123	2,650	2,294	835	1,243
68	2,025	2,144	2,677	2,321	845	1,288
69	2,071	2,194	2,737	2,373	863	1,341
70	2,126	2,253	2,811	2,436	886	1,392
71	2,189	2,321	2,895	2,507	912	1,440
72	2,256	2,391	2,988	2,585	941	1,490
73	2,329	2,470	3,084	2,669	972	1,540
74	2,413	2,557	3,193	2,763	1,007	1,592
75	2,497	2,645	3,303	2,861	1,041	1,643
76	2,585	2,741	3,420	2,962	1,078	1,695
77	2,675	2,836	3,538	3,064	1,117	1,753
78	2,766	2,932	3,657	3,170	1,153	1,812
79	2,853	3,023	3,774	3,270	1,189	1,870
80	2,944	3,117	3,893	3,371	1,227	1,932
81	3,037	3,218	4,017	3,477	1,267	1,992
82	3,125	3,311	4,133	3,581	1,303	2,052
83	3,221	3,415	4,263	3,693	1,343	2,115
84	3,316	3,514	4,386	3,800	1,383	2,177
85	3,438	3,642	4,545	3,938	1,433	2,255
86	3,536	3,747	4,675	4,049	1,475	2,321
87	3,635	3,853	4,807	4,164	1,515	2,385
88	3,737	3,961	4,943	4,282	1,558	2,453
89	3,841	4,071	5,082	4,399	1,601	2,521
90	3,946	4,182	5,222	4,524	1,646	2,591
91	4,055	4,296	5,362	4,644	1,691	2,661
92	4,163	4,412	5,506	4,769	1,735	2,734
93	4,276	4,530	5,652	4,897	1,782	2,806
94	4,387	4,650	5,803	5,026	1,830	2,880
95	4,503	4,770	5,955	5,160	1,876	2,956
96	4,618	4,895	6,109	5,291	1,925	3,031
97	4,736	5,018	6,262	5,425	1,976	3,108
98	4,857	5,146	6,421	5,563	2,024	3,188
99+	4,977	5,275	6,581	5,703	2,075	3,267

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

To calculate a 7% household discount:

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

Modal premium **x** .93 **= discounted premium**

If applying during Open Enrollment or Guaranteed Issue periods, use preferred rates.

Modal factors

Semi-annual 0.5200

Quarterly 0.2650

Monthly 0.0833

PREMIUM INFORMATION

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

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

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

HOUSEHOLD DISCOUNT

In order to be eligible for the household discount under a Continental Life Insurance Company of Brentwood, Tennessee Medicare supplement plan, you must apply for a Medicare supplement plan at the same time as another Medicare eligible adult or the other Medicare eligible adult must currently have a Medicare supplement policy with an Aetna company. The Medicare eligible adult must be either (a) your spouse or someone with whom you are in a civil union partnership; 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 $1,632	$0	$1,632 (Part A Deductible)
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after While using 60 lifetime reserve days	All but $816 a day	$816 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 $204 a day	$0	Up to $204 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 $240 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 $240 of Medicare-Approved amounts*	$0	$0	$240 (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 $240 of Medicare-Approved amounts*	$0	$0	$240 (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 $240 of Medicare-Approved amounts*	$0	$0	$240 (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 $1,632	$1,632 (Part A Deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after While using 60 lifetime reserve days	All but $816 a day	$816 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 $204 a day	$0	Up to $204 a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

PLAN B

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

*Once you have been billed $240 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 $240 of Medicare-Approved amounts*	$0	$0	$240 (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 $240 of Medicare-Approved amounts*	$0	$0	$240 (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 $240 of Medicare-Approved amounts*	$0	$0	$240 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	$0

PLAN F

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,632	$1,632 (Part A Deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after While using 60 lifetime reserve days	All but $816 a day	$816 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 $204 a day	Up to $204 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

PLAN F

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

*Once you have been billed $240 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 $240 of Medicare-Approved amounts*	$0	$240 (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 $240 of Medicare-Approved amounts*	$0	$240 (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 $240 of Medicare-Approved amounts*	$0	$240 (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 $1,632	$1,632 (Part A Deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after While using 60 lifetime reserve days	All but $816 a day	$816 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 $204 a day	Up to $204 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

PLAN G

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

*Once you have been billed $240 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 $240 of Medicare-Approved amounts*	$0	$0	$240 (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 $240 of Medicare-Approved amounts*	$0	$0	$240 (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 $240 of Medicare-Approved amounts*	$0	$0	$240 (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 $2,800 deductible. Benefits from High Deductible Plan G will not begin until out-of-pocket expenses are $2,800. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.**

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,800 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2,800 DEDUCTIBLE*** YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,632	$1,632 (Part A Deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after While using 60 lifetime reserve days	All but $816 a day	$816 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 $204 a day	Up to $204 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

HIGH DEDUCTIBLE PLAN G

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

*Once you have been billed $240 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 $2,800 deductible. Benefits from High Deductible Plan G will not begin until out-of-pocket expenses are $2,800. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.**

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,800 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2,800 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 $240 of Medicare-Approved amounts*	$0	$0	$240 (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 $240 of Medicare-Approved amounts*	$0	$0	$240 (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 $2,800 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2,800 DEDUCTIBLE*** YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
First $240 of Medicare-Approved amounts*	$0	$0	$240 (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 $2,800 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2,800 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 $1,632	$1,632 (Part A Deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after While using 60 lifetime reserve days	All but $816 a day	$816 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 $204 a day	Up to $204 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

PLAN N

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

*Once you have been billed $240 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 $240 of Medicare-Approved amounts*	$0	$0	$240 (Part B Deductible)
Remainder of Medicare-Approved amounts	Generally 80%	Balance, other than up to $20 per office visit and up to $50 per emergency room visit. The co-payment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
PART B EXCESS CHARGES (Above Medicare-Approved amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $240 of Medicare-Approved amounts*	$0	$0	$240 (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 $240 of Medicare-Approved amounts*	$0	$0	$240 (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