Outline of coverage

Medicare Supplement Insurance

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

Nebraska

Underwritten by

Continental Life Insurance Company of Brentwood, Tennessee

An Aetna Company

AetnaSeniorProducts.com

CLIMS05026NE

Rates effective: 08/2023 B

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

This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plan "A" available. Some plans may not be available. Only applicants **first** eligible for Medicare before 2020 may purchase Plans C, F, and High Deductible F.

Note: A ✓ means 100% of the benefit is paid.

Benefits	Plans Available to All Applicants								Medicare first eligible before 2020 only	
	A	B	D	G[1]	K	L	M	N	C	F[1]
Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Medicare Part B coinsurance or copayment	✓	✓	✓	✓	50%	75%	✓	✓ copays apply[3]	✓	✓
Blood (first three pints)	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Part A hospice care coinsurance or copayment	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Skilled nursing facility coinsurance			✓	✓	50%	75%	✓	✓	✓	✓
Medicare Part A deductible		✓	✓	✓	50%	75%	50%	✓	✓	✓
Medicare Part B deductible									✓	✓
Medicare Part B excess charges				✓						✓
Foreign travel emergency (up to plan limits)			✓	✓			✓	✓	✓	✓
Out-of-pocket limit in 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: 690-693

Female rates

Rates effective 8/1/2023

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,694	1,700	2,054	546	1,652	1,171
66	1,694	1,700	2,054	546	1,652	1,171
67	1,694	1,700	2,054	546	1,652	1,171
68	1,708	1,715	2,070	550	1,666	1,209
69	1,742	1,748	2,112	562	1,698	1,255
70	1,785	1,794	2,168	577	1,743	1,303
71	1,840	1,849	2,233	594	1,795	1,348
72	1,901	1,911	2,305	615	1,854	1,396
73	1,963	1,971	2,379	633	1,915	1,442
74	2,030	2,037	2,460	655	1,979	1,490
75	2,100	2,110	2,547	678	2,048	1,537
76	2,178	2,187	2,639	703	2,123	1,588
77	2,253	2,260	2,729	727	2,195	1,639
78	2,327	2,337	2,822	752	2,270	1,694
79	2,405	2,412	2,915	776	2,342	1,752
80	2,479	2,487	3,006	800	2,418	1,810
81	2,558	2,567	3,099	825	2,494	1,866
82	2,638	2,648	3,197	851	2,572	1,925
83	2,717	2,730	3,295	877	2,651	1,984
84	2,801	2,812	3,395	905	2,733	2,046
85	2,887	2,900	3,499	932	2,814	2,108
86	2,982	2,995	3,616	962	2,907	2,177
87	3,065	3,079	3,718	990	2,992	2,239
88	3,152	3,165	3,824	1,018	3,075	2,302
89	3,239	3,253	3,929	1,046	3,161	2,366
90	3,329	3,342	4,037	1,075	3,247	2,431
91	3,420	3,434	4,145	1,104	3,336	2,497
92	3,512	3,527	4,259	1,134	3,424	2,564
93	3,606	3,621	4,372	1,164	3,515	2,632
94	3,699	3,717	4,488	1,195	3,609	2,702
95	3,798	3,814	4,604	1,226	3,704	2,773
96	3,896	3,912	4,723	1,258	3,799	2,844
97	3,997	4,011	4,844	1,291	3,896	2,917
98	4,095	4,114	4,966	1,323	3,996	2,991
99+	4,199	4,216	5,090	1,356	4,095	3,065

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,882	1,890	2,280	607	1,837	1,299
66	1,882	1,890	2,280	607	1,837	1,299
67	1,882	1,890	2,280	607	1,837	1,299
68	1,899	1,905	2,300	613	1,851	1,343
69	1,935	1,942	2,347	625	1,887	1,394
70	1,985	1,994	2,408	642	1,937	1,448
71	2,046	2,054	2,483	659	1,995	1,497
72	2,112	2,122	2,560	682	2,060	1,552
73	2,182	2,191	2,644	704	2,129	1,602
74	2,255	2,265	2,734	728	2,200	1,656
75	2,335	2,342	2,831	753	2,275	1,707
76	2,419	2,429	2,933	782	2,359	1,766
77	2,503	2,512	3,032	807	2,441	1,821
78	2,587	2,597	3,136	835	2,522	1,882
79	2,671	2,681	3,237	862	2,603	1,945
80	2,754	2,764	3,340	888	2,686	2,011
81	2,843	2,853	3,443	917	2,772	2,074
82	2,931	2,941	3,551	945	2,857	2,139
83	3,019	3,033	3,660	974	2,946	2,204
84	3,113	3,126	3,774	1,005	3,037	2,274
85	3,207	3,221	3,889	1,036	3,127	2,342
86	3,315	3,329	4,017	1,069	3,232	2,419
87	3,407	3,420	4,131	1,100	3,323	2,487
88	3,501	3,516	4,247	1,131	3,416	2,558
89	3,601	3,616	4,365	1,163	3,512	2,629
90	3,698	3,714	4,486	1,194	3,608	2,701
91	3,800	3,816	4,605	1,226	3,707	2,775
92	3,900	3,919	4,731	1,259	3,806	2,849
93	4,006	4,024	4,857	1,294	3,908	2,927
94	4,111	4,131	4,985	1,328	4,011	3,002
95	4,218	4,238	5,118	1,363	4,116	3,080
96	4,329	4,347	5,249	1,397	4,220	3,160
97	4,440	4,458	5,382	1,433	4,329	3,242
98	4,551	4,570	5,518	1,470	4,437	3,323
99+	4,664	4,686	5,656	1,506	4,550	3,406

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

To calculate the 7% Household discount:

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

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

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

Modal factors

Semi-annual 0.5200

Quarterly 0.2650

Monthly 0.0833

Continental Life Insurance Company of Brentwood, Tennessee

Annual premiums

For Use in ZIP Codes: 690-693

Male rates

Rates effective 8/1/2023

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,946	1,955	2,361	628	1,901	1,346
66	1,946	1,955	2,361	628	1,901	1,346
67	1,946	1,955	2,361	628	1,901	1,346
68	1,965	1,972	2,379	633	1,915	1,390
69	2,003	2,009	2,429	646	1,952	1,442
70	2,056	2,064	2,493	663	2,005	1,497
71	2,116	2,127	2,566	683	2,067	1,550
72	2,187	2,195	2,651	706	2,133	1,607
73	2,257	2,266	2,737	729	2,203	1,659
74	2,335	2,342	2,831	754	2,275	1,713
75	2,417	2,426	2,930	780	2,355	1,768
76	2,504	2,514	3,037	809	2,443	1,827
77	2,589	2,599	3,139	835	2,523	1,886
78	2,677	2,689	3,246	863	2,609	1,949
79	2,763	2,775	3,352	894	2,694	2,014
80	2,849	2,862	3,456	920	2,781	2,082
81	2,941	2,953	3,564	948	2,868	2,148
82	3,031	3,045	3,674	980	2,958	2,215
83	3,126	3,140	3,790	1,009	3,049	2,282
84	3,221	3,235	3,905	1,041	3,141	2,352
85	3,321	3,335	4,026	1,071	3,236	2,424
86	3,430	3,445	4,157	1,106	3,343	2,504
87	3,526	3,541	4,276	1,138	3,440	2,575
88	3,624	3,640	4,395	1,171	3,536	2,648
89	3,727	3,743	4,517	1,202	3,635	2,721
90	3,829	3,844	4,639	1,236	3,733	2,795
91	3,933	3,949	4,768	1,270	3,837	2,872
92	4,038	4,057	4,896	1,304	3,938	2,947
93	4,146	4,163	5,025	1,339	4,044	3,028
94	4,254	4,274	5,160	1,373	4,153	3,108
95	4,367	4,385	5,295	1,410	4,261	3,189
96	4,480	4,497	5,434	1,448	4,370	3,271
97	4,594	4,615	5,570	1,483	4,480	3,355
98	4,709	4,730	5,712	1,522	4,594	3,438
99+	4,829	4,848	5,855	1,559	4,709	3,525

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	2,165	2,175	2,624	699	2,112	1,494
66	2,165	2,175	2,624	699	2,112	1,494
67	2,165	2,175	2,624	699	2,112	1,494
68	2,183	2,192	2,644	704	2,129	1,545
69	2,224	2,233	2,697	718	2,170	1,602
70	2,285	2,294	2,769	738	2,228	1,664
71	2,353	2,362	2,854	759	2,293	1,723
72	2,429	2,441	2,944	785	2,371	1,784
73	2,507	2,519	3,041	810	2,447	1,844
74	2,591	2,605	3,146	837	2,530	1,904
75	2,685	2,694	3,255	867	2,617	1,964
76	2,782	2,795	3,371	898	2,714	2,031
77	2,879	2,889	3,486	929	2,805	2,095
78	2,975	2,987	3,604	961	2,902	2,164
79	3,071	3,081	3,723	992	2,994	2,236
80	3,168	3,180	3,841	1,022	3,089	2,313
81	3,268	3,279	3,961	1,054	3,185	2,386
82	3,369	3,382	4,084	1,087	3,286	2,460
83	3,473	3,490	4,213	1,122	3,388	2,535
84	3,578	3,594	4,341	1,156	3,493	2,615
85	3,687	3,704	4,472	1,190	3,596	2,693
86	3,812	3,827	4,619	1,228	3,715	2,783
87	3,917	3,934	4,749	1,265	3,823	2,861
88	4,028	4,044	4,882	1,301	3,928	2,942
89	4,141	4,158	5,019	1,337	4,038	3,024
90	4,253	4,270	5,158	1,372	4,149	3,107
91	4,371	4,387	5,296	1,410	4,263	3,192
92	4,488	4,506	5,438	1,449	4,375	3,277
93	4,607	4,626	5,584	1,487	4,492	3,365
94	4,727	4,750	5,732	1,527	4,611	3,454
95	4,849	4,873	5,883	1,566	4,734	3,543
96	4,979	4,999	6,035	1,608	4,855	3,635
97	5,106	5,126	6,188	1,648	4,978	3,727
98	5,233	5,256	6,346	1,692	5,104	3,820
99+	5,364	5,388	6,504	1,732	5,232	3,919

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

To calculate the 7% Household discount:

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

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

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

Modal factors

Semi-annual 0.5200

Quarterly 0.2650

Monthly 0.0833

Continental Life Insurance Company of Brentwood, Tennessee

Annual premiums

For Use in: Rest of State

Female rates

Rates effective 8/1/2023

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,554	1,560	1,884	501	1,516	1,074
66	1,554	1,560	1,884	501	1,516	1,074
67	1,554	1,560	1,884	501	1,516	1,074
68	1,567	1,573	1,899	505	1,528	1,109
69	1,598	1,604	1,938	516	1,558	1,151
70	1,638	1,646	1,989	529	1,599	1,195
71	1,688	1,696	2,049	545	1,647	1,237
72	1,744	1,753	2,115	564	1,701	1,281
73	1,801	1,808	2,183	581	1,757	1,323
74	1,862	1,869	2,257	601	1,816	1,367
75	1,927	1,936	2,337	622	1,879	1,410
76	1,998	2,006	2,421	645	1,948	1,457
77	2,067	2,073	2,504	667	2,014	1,504
78	2,135	2,144	2,589	690	2,083	1,554
79	2,206	2,213	2,674	712	2,149	1,607
80	2,274	2,282	2,758	734	2,218	1,661
81	2,347	2,355	2,843	757	2,288	1,712
82	2,420	2,429	2,933	781	2,360	1,766
83	2,493	2,505	3,023	805	2,432	1,820
84	2,570	2,580	3,115	830	2,507	1,877
85	2,649	2,661	3,210	855	2,582	1,934
86	2,736	2,748	3,317	883	2,667	1,997
87	2,812	2,825	3,411	908	2,745	2,054
88	2,892	2,904	3,508	934	2,821	2,112
89	2,972	2,984	3,605	960	2,900	2,171
90	3,054	3,066	3,704	986	2,979	2,230
91	3,138	3,150	3,803	1,013	3,061	2,291
92	3,222	3,236	3,907	1,040	3,141	2,352
93	3,308	3,322	4,011	1,068	3,225	2,415
94	3,394	3,410	4,117	1,096	3,311	2,479
95	3,484	3,499	4,224	1,125	3,398	2,544
96	3,574	3,589	4,333	1,154	3,485	2,609
97	3,667	3,680	4,444	1,184	3,574	2,676
98	3,757	3,774	4,556	1,214	3,666	2,744
99+	3,852	3,868	4,670	1,244	3,757	2,812

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,727	1,734	2,092	557	1,685	1,192
66	1,727	1,734	2,092	557	1,685	1,192
67	1,727	1,734	2,092	557	1,685	1,192
68	1,742	1,748	2,110	562	1,698	1,232
69	1,775	1,782	2,153	573	1,731	1,279
70	1,821	1,829	2,209	589	1,777	1,328
71	1,877	1,884	2,278	605	1,830	1,373
72	1,938	1,947	2,349	626	1,890	1,424
73	2,002	2,010	2,426	646	1,953	1,470
74	2,069	2,078	2,508	668	2,018	1,519
75	2,142	2,149	2,597	691	2,087	1,566
76	2,219	2,228	2,691	717	2,164	1,620
77	2,296	2,305	2,782	740	2,239	1,671
78	2,373	2,383	2,877	766	2,314	1,727
79	2,450	2,460	2,970	791	2,388	1,784
80	2,527	2,536	3,064	815	2,464	1,845
81	2,608	2,617	3,159	841	2,543	1,903
82	2,689	2,698	3,258	867	2,621	1,962
83	2,770	2,783	3,358	894	2,703	2,022
84	2,856	2,868	3,462	922	2,786	2,086
85	2,942	2,955	3,568	950	2,869	2,149
86	3,041	3,054	3,685	981	2,965	2,219
87	3,126	3,138	3,790	1,009	3,049	2,282
88	3,212	3,226	3,896	1,038	3,134	2,347
89	3,304	3,317	4,005	1,067	3,222	2,412
90	3,393	3,407	4,116	1,095	3,310	2,478
91	3,486	3,501	4,225	1,125	3,401	2,546
92	3,578	3,595	4,340	1,155	3,492	2,614
93	3,675	3,692	4,456	1,187	3,585	2,685
94	3,772	3,790	4,573	1,218	3,680	2,754
95	3,870	3,888	4,695	1,250	3,776	2,826
96	3,972	3,988	4,816	1,282	3,872	2,899
97	4,073	4,090	4,938	1,315	3,972	2,974
98	4,175	4,193	5,062	1,349	4,071	3,049
99+	4,279	4,299	5,189	1,382	4,174	3,125

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

To calculate the 7% Household discount:

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

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

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

Modal factors

Semi-annual 0.5200

Quarterly 0.2650

Monthly 0.0833

Continental Life Insurance Company of Brentwood, Tennessee

Annual premiums

For Use in: Rest of State

Male rates

Rates effective 8/1/2023

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,785	1,794	2,166	576	1,744	1,235
66	1,785	1,794	2,166	576	1,744	1,235
67	1,785	1,794	2,166	576	1,744	1,235
68	1,803	1,809	2,183	581	1,757	1,275
69	1,838	1,843	2,228	593	1,791	1,323
70	1,886	1,894	2,287	608	1,839	1,373
71	1,941	1,951	2,354	627	1,896	1,422
72	2,006	2,014	2,432	648	1,957	1,474
73	2,071	2,079	2,511	669	2,021	1,522
74	2,142	2,149	2,597	692	2,087	1,572
75	2,217	2,226	2,688	716	2,161	1,622
76	2,297	2,306	2,786	742	2,241	1,676
77	2,375	2,384	2,880	766	2,315	1,730
78	2,456	2,467	2,978	792	2,394	1,788
79	2,535	2,546	3,075	820	2,472	1,848
80	2,614	2,626	3,171	844	2,551	1,910
81	2,698	2,709	3,270	870	2,631	1,971
82	2,781	2,794	3,371	899	2,714	2,032
83	2,868	2,881	3,477	926	2,797	2,094
84	2,955	2,968	3,583	955	2,882	2,158
85	3,047	3,060	3,694	983	2,969	2,224
86	3,147	3,161	3,814	1,015	3,067	2,297
87	3,235	3,249	3,923	1,044	3,156	2,362
88	3,325	3,339	4,032	1,074	3,244	2,429
89	3,419	3,434	4,144	1,103	3,335	2,496
90	3,513	3,527	4,256	1,134	3,425	2,564
91	3,608	3,623	4,374	1,165	3,520	2,635
92	3,705	3,722	4,492	1,196	3,613	2,704
93	3,804	3,819	4,610	1,228	3,710	2,778
94	3,903	3,921	4,734	1,260	3,810	2,851
95	4,006	4,023	4,858	1,294	3,909	2,926
96	4,110	4,126	4,985	1,328	4,009	3,001
97	4,215	4,234	5,110	1,361	4,110	3,078
98	4,320	4,339	5,240	1,396	4,215	3,154
99+	4,430	4,448	5,372	1,430	4,320	3,234

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,986	1,995	2,407	641	1,938	1,371
66	1,986	1,995	2,407	641	1,938	1,371
67	1,986	1,995	2,407	641	1,938	1,371
68	2,003	2,011	2,426	646	1,953	1,417
69	2,040	2,049	2,474	659	1,991	1,470
70	2,096	2,105	2,540	677	2,044	1,527
71	2,159	2,167	2,618	696	2,104	1,581
72	2,228	2,239	2,701	720	2,175	1,637
73	2,300	2,311	2,790	743	2,245	1,692
74	2,377	2,390	2,886	768	2,321	1,747
75	2,463	2,472	2,986	795	2,401	1,802
76	2,552	2,564	3,093	824	2,490	1,863
77	2,641	2,650	3,198	852	2,573	1,922
78	2,729	2,740	3,306	882	2,662	1,985
79	2,817	2,827	3,416	910	2,747	2,051
80	2,906	2,917	3,524	938	2,834	2,122
81	2,998	3,008	3,634	967	2,922	2,189
82	3,091	3,103	3,747	997	3,015	2,257
83	3,186	3,202	3,865	1,029	3,108	2,326
84	3,283	3,297	3,983	1,061	3,205	2,399
85	3,383	3,398	4,103	1,092	3,299	2,471
86	3,497	3,511	4,238	1,127	3,408	2,553
87	3,594	3,609	4,357	1,161	3,507	2,625
88	3,695	3,710	4,479	1,194	3,604	2,699
89	3,799	3,815	4,605	1,227	3,705	2,774
90	3,902	3,917	4,732	1,259	3,806	2,850
91	4,010	4,025	4,859	1,294	3,911	2,928
92	4,117	4,134	4,989	1,329	4,014	3,006
93	4,227	4,244	5,123	1,364	4,121	3,087
94	4,337	4,358	5,259	1,401	4,230	3,169
95	4,449	4,471	5,397	1,437	4,343	3,250
96	4,568	4,586	5,537	1,475	4,454	3,335
97	4,684	4,703	5,677	1,512	4,567	3,419
98	4,801	4,822	5,822	1,552	4,683	3,505
99+	4,921	4,943	5,967	1,589	4,800	3,595

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

To calculate the 7% Household discount:

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

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

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

Modal factors

Semi-annual 0.5200

Quarterly 0.2650

Monthly 0.0833

PREMIUM INFORMATION

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

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

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

HOUSEHOLD DISCOUNT

In order to be eligible for the Household discount under a Continental Life Insurance Company of Brentwood, Tennessee Medicare supplement plan, you must apply for a Medicare supplement plan at the same time as another Medicare eligible adult or the other Medicare eligible adult must currently be covered by a Continental Life Insurance Company of Brentwood, Tennessee Medicare supplement policy. The Medicare eligible adult must be either (a) your spouse; (b) someone with whom you are in a civil union partnership; and (c) someone with whom you have continuously resided for the past 12 months. The household discount will only be applicable if a policy for each applicant is issued. The discounted rate will be 7 percent lower than the individual rates and will apply as long as both policies remain in force.

DISCLOSURES

Use this outline to compare benefits and premium among policies.

READ YOUR POLICY VERY CAREFULLY

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

RIGHT TO RETURN POLICY

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

POLICY REPLACEMENT

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

NOTICE

The policy may not cover all of your medical costs.

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

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

COMPLETE ANSWERS ARE VERY IMPORTANT

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

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

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

PLAN A

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,632	$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

HIGH DEDUCTIBLE PLAN F

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

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

*****This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2,800 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses are $2,800. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.**

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,800 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 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.

*****This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2,800 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses are $2,800. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.**

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,800 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	$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

HIGH DEDUCTIBLE PLAN F

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	$240 (Part B Deductible)	$0
Remainder of Medicare-Approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,800 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 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

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