



Outline of Coverage

Medicare Supplement Insurance Plan

Continental Life Insurance Company
of Brentwood, Tennessee

Benefit plans: A, F, G, High Deductible G, N

New Mexico



CONTINENTAL LIFE INSURANCE COMPANY OF BRENTWOOD, TENNESSEE
OUTLINE OF MEDICARE SUPPLEMENT COVERAGE COVER PAGE
BENEFIT PLANS AVAILABLE: A, 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)			80%	80%			80%	80%	80%	80%
Out-of-pocket limit in 2024 ²						\$7,060²	\$3,530²			

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 ALL ZIP CODES
Female rates
Rates effective 3/1/2023

ATTAINED AGE	PREFERRED				
	Plan A	Plan F	Plan G	Plan HG	Plan N
65	1,390	1,931	1,598	342	938
66	1,390	1,931	1,598	342	938
67	1,390	1,931	1,598	342	938
68	1,457	1,931	1,598	359	983
69	1,523	1,931	1,598	375	1,027
70	1,584	1,931	1,598	390	1,068
71	1,649	1,979	1,638	406	1,113
72	1,714	2,034	1,683	422	1,156
73	1,776	2,093	1,732	437	1,198
74	1,836	2,156	1,784	452	1,239
75	1,891	2,220	1,838	466	1,276
76	1,948	2,287	1,893	480	1,314
77	2,007	2,356	1,950	494	1,354
78	2,070	2,430	2,011	510	1,397
79	2,135	2,506	2,074	526	1,440
80	2,202	2,585	2,139	543	1,486
81	2,268	2,663	2,203	559	1,530
82	2,336	2,743	2,270	576	1,576
83	2,410	2,829	2,341	594	1,626
84	2,486	2,918	2,415	612	1,677
85	2,571	3,018	2,498	634	1,735
86	2,648	3,109	2,573	653	1,787
87	2,728	3,202	2,650	672	1,840
88	2,810	3,298	2,729	692	1,895
89	2,894	3,397	2,811	713	1,952
90	2,981	3,499	2,896	735	2,011
91	3,070	3,604	2,983	757	2,071
92	3,162	3,712	3,072	779	2,133
93	3,257	3,824	3,164	803	2,197
94	3,355	3,938	3,259	827	2,263
95	3,456	4,057	3,357	851	2,331
96	3,559	4,178	3,458	877	2,401
97	3,666	4,303	3,561	903	2,473
98	3,776	4,433	3,668	930	2,547
99+	3,889	4,565	3,778	958	2,624

ATTAINED AGE	STANDARD				
	Plan A	Plan F	Plan G	Plan HG	Plan N
65	1,544	2,146	1,776	380	1,042
66	1,544	2,146	1,776	380	1,042
67	1,544	2,146	1,776	380	1,042
68	1,619	2,146	1,776	399	1,092
69	1,692	2,146	1,776	417	1,141
70	1,760	2,146	1,776	433	1,187
71	1,832	2,199	1,820	451	1,237
72	1,904	2,260	1,870	469	1,284
73	1,973	2,326	1,924	486	1,331
74	2,040	2,396	1,982	502	1,377
75	2,101	2,467	2,042	518	1,418
76	2,164	2,541	2,103	533	1,460
77	2,230	2,618	2,167	549	1,504
78	2,300	2,700	2,234	567	1,552
79	2,372	2,784	2,304	584	1,600
80	2,447	2,872	2,377	603	1,651
81	2,520	2,959	2,448	621	1,700
82	2,596	3,048	2,522	640	1,751
83	2,678	3,143	2,601	660	1,807
84	2,762	3,242	2,683	680	1,863
85	2,857	3,353	2,776	704	1,928
86	2,942	3,454	2,859	726	1,986
87	3,031	3,558	2,944	747	2,044
88	3,122	3,664	3,032	769	2,106
89	3,216	3,774	3,123	792	2,169
90	3,312	3,888	3,218	817	2,234
91	3,411	4,004	3,314	841	2,301
92	3,513	4,124	3,413	866	2,370
93	3,619	4,249	3,516	892	2,441
94	3,728	4,376	3,621	919	2,514
95	3,840	4,508	3,730	946	2,590
96	3,954	4,642	3,842	974	2,668
97	4,073	4,781	3,957	1,003	2,748
98	4,196	4,926	4,076	1,033	2,830
99+	4,321	5,072	4,198	1,064	2,916

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

To calculate a household discount:

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

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

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

Modal factors

Semi-annual0.5200
 Quarterly0.2650
 Monthly.....0.0833

Continental Life Insurance Company of Brentwood, Tennessee

Annual premiums
For use in ALL ZIP CODES
Male rates
Rates effective 3/1/2023

ATTAINED AGE	PREFERRED				
	Plan A	Plan F	Plan G	Plan HG	Plan N
65	1,599	2,221	1,838	393	1,079
66	1,599	2,221	1,838	393	1,079
67	1,599	2,221	1,838	393	1,079
68	1,676	2,221	1,838	413	1,130
69	1,751	2,221	1,838	431	1,181
70	1,822	2,221	1,838	449	1,228
71	1,896	2,276	1,884	467	1,280
72	1,971	2,339	1,935	485	1,329
73	2,042	2,407	1,992	503	1,378
74	2,111	2,479	2,052	520	1,425
75	2,175	2,553	2,114	536	1,467
76	2,240	2,630	2,177	552	1,511
77	2,308	2,709	2,243	568	1,557
78	2,381	2,795	2,313	587	1,607
79	2,455	2,882	2,385	605	1,656
80	2,532	2,973	2,460	624	1,709
81	2,608	3,062	2,533	643	1,760
82	2,686	3,154	2,611	662	1,812
83	2,772	3,253	2,692	683	1,870
84	2,859	3,356	2,777	704	1,929
85	2,957	3,471	2,873	729	1,995
86	3,045	3,575	2,959	751	2,055
87	3,137	3,682	3,048	773	2,116
88	3,232	3,793	3,138	796	2,179
89	3,328	3,907	3,233	820	2,245
90	3,428	4,024	3,330	845	2,313
91	3,531	4,145	3,430	871	2,382
92	3,636	4,269	3,533	896	2,453
93	3,746	4,398	3,639	923	2,527
94	3,858	4,529	3,748	951	2,602
95	3,974	4,666	3,861	979	2,681
96	4,093	4,805	3,977	1,009	2,761
97	4,216	4,948	4,095	1,038	2,844
98	4,342	5,098	4,218	1,070	2,929
99+	4,472	5,250	4,345	1,102	3,018

ATTAINED AGE	STANDARD				
	Plan A	Plan F	Plan G	Plan HG	Plan N
65	1,776	2,468	2,042	437	1,198
66	1,776	2,468	2,042	437	1,198
67	1,776	2,468	2,042	437	1,198
68	1,862	2,468	2,042	459	1,256
69	1,946	2,468	2,042	480	1,312
70	2,024	2,468	2,042	498	1,365
71	2,107	2,529	2,093	519	1,423
72	2,190	2,599	2,151	539	1,477
73	2,269	2,675	2,213	559	1,531
74	2,346	2,755	2,279	577	1,584
75	2,416	2,837	2,348	596	1,631
76	2,489	2,922	2,418	613	1,679
77	2,565	3,011	2,492	631	1,730
78	2,645	3,105	2,569	652	1,785
79	2,728	3,202	2,650	672	1,840
80	2,814	3,303	2,734	693	1,899
81	2,898	3,403	2,815	714	1,955
82	2,985	3,505	2,900	736	2,014
83	3,080	3,614	2,991	759	2,078
84	3,176	3,728	3,085	782	2,142
85	3,286	3,856	3,192	810	2,217
86	3,383	3,972	3,288	835	2,284
87	3,486	4,092	3,386	859	2,351
88	3,590	4,214	3,487	884	2,422
89	3,698	4,340	3,591	911	2,494
90	3,809	4,471	3,701	940	2,569
91	3,923	4,605	3,811	967	2,646
92	4,040	4,743	3,925	996	2,726
93	4,162	4,886	4,043	1,026	2,807
94	4,287	5,032	4,164	1,057	2,891
95	4,416	5,184	4,290	1,088	2,979
96	4,547	5,338	4,418	1,120	3,068
97	4,684	5,498	4,551	1,153	3,160
98	4,825	5,665	4,687	1,188	3,255
99+	4,969	5,833	4,828	1,224	3,353

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

To calculate a household discount:

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

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

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

Modal factors

Semi-annual0.5200
 Quarterly0.2650
 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 Aetna Company Medicare supplement policy. 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 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, 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 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