



Outline of coverage

Medicare Supplement Insurance

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

Tennessee

Underwritten by

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

An Aetna Company

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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					\$7,060²	\$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 4/1/2024

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	6,063	6,990	8,610	7,229	2,503	5,466
65	1,345	1,552	1,911	1,604	555	1,145
66	1,345	1,552	1,911	1,604	555	1,145
67	1,345	1,552	1,911	1,604	555	1,145
68	1,359	1,567	1,930	1,621	560	1,186
69	1,391	1,603	1,975	1,658	573	1,233
70	1,428	1,645	2,028	1,701	590	1,281
71	1,470	1,696	2,088	1,753	607	1,325
72	1,517	1,748	2,153	1,807	626	1,371
73	1,566	1,805	2,224	1,865	646	1,417
74	1,621	1,869	2,301	1,931	669	1,466
75	1,678	1,934	2,384	1,999	691	1,513
76	1,735	2,001	2,466	2,070	716	1,561
77	1,797	2,072	2,552	2,142	741	1,613
78	1,858	2,143	2,638	2,215	766	1,667
79	1,917	2,209	2,721	2,284	790	1,720
80	1,976	2,279	2,807	2,358	815	1,778
81	2,038	2,350	2,894	2,431	841	1,834
82	2,099	2,421	2,981	2,503	867	1,889
83	2,165	2,495	3,074	2,579	893	1,946
84	2,228	2,568	3,163	2,656	919	2,003
85	2,309	2,662	3,278	2,751	952	2,075
86	2,375	2,738	3,370	2,830	979	2,136
87	2,442	2,814	3,468	2,909	1,007	2,195
88	2,509	2,894	3,564	2,993	1,036	2,258
89	2,580	2,975	3,665	3,076	1,065	2,321
90	2,651	3,056	3,764	3,160	1,093	2,385
91	2,723	3,138	3,866	3,245	1,123	2,448
92	2,797	3,223	3,971	3,334	1,153	2,516
93	2,872	3,309	4,077	3,423	1,185	2,583
94	2,946	3,396	4,185	3,512	1,215	2,651
95	3,023	3,485	4,292	3,605	1,248	2,720
96	3,101	3,575	4,405	3,698	1,280	2,789
97	3,181	3,668	4,517	3,792	1,311	2,862
98	3,261	3,761	4,631	3,887	1,345	2,934
99+	3,342	3,854	4,748	3,984	1,379	3,007

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	6,736	7,766	9,568	8,031	2,781	6,073
65	1,493	1,722	2,123	1,782	617	1,271
66	1,493	1,722	2,123	1,782	617	1,271
67	1,493	1,722	2,123	1,782	617	1,271
68	1,510	1,743	2,146	1,800	622	1,318
69	1,545	1,781	2,193	1,842	638	1,371
70	1,587	1,828	2,254	1,891	655	1,424
71	1,634	1,884	2,321	1,946	675	1,474
72	1,686	1,942	2,391	2,007	697	1,523
73	1,740	2,006	2,471	2,072	717	1,574
74	1,801	2,078	2,557	2,147	743	1,628
75	1,863	2,147	2,648	2,220	768	1,680
76	1,929	2,223	2,738	2,299	796	1,734
77	1,996	2,302	2,836	2,378	823	1,793
78	2,064	2,381	2,932	2,460	852	1,851
79	2,130	2,455	3,023	2,538	879	1,912
80	2,196	2,532	3,118	2,617	906	1,975
81	2,265	2,612	3,218	2,699	935	2,037
82	2,333	2,689	3,313	2,780	962	2,098
83	2,406	2,773	3,415	2,867	991	2,163
84	2,474	2,854	3,513	2,950	1,020	2,226
85	2,564	2,958	3,642	3,059	1,057	2,306
86	2,640	3,042	3,745	3,145	1,088	2,373
87	2,712	3,127	3,853	3,234	1,119	2,441
88	2,789	3,216	3,960	3,325	1,151	2,509
89	2,867	3,305	4,070	3,417	1,184	2,578
90	2,946	3,396	4,183	3,511	1,214	2,649
91	3,026	3,488	4,296	3,606	1,248	2,721
92	3,108	3,581	4,411	3,705	1,282	2,795
93	3,190	3,678	4,530	3,803	1,317	2,869
94	3,274	3,775	4,649	3,902	1,351	2,945
95	3,358	3,872	4,769	4,005	1,386	3,021
96	3,447	3,971	4,894	4,108	1,422	3,099
97	3,534	4,076	5,019	4,214	1,457	3,180
98	3,625	4,178	5,146	4,319	1,494	3,260
99+	3,715	4,283	5,276	4,428	1,533	3,341

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 4/1/2024

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	6,973	8,040	9,902	8,311	2,878	6,286
65	1,546	1,783	2,199	1,844	638	1,317
66	1,546	1,783	2,199	1,844	638	1,317
67	1,546	1,783	2,199	1,844	638	1,317
68	1,562	1,802	2,220	1,863	645	1,364
69	1,599	1,844	2,272	1,905	659	1,418
70	1,642	1,893	2,333	1,957	677	1,474
71	1,691	1,950	2,401	2,015	699	1,524
72	1,745	2,011	2,474	2,078	720	1,576
73	1,800	2,078	2,557	2,146	743	1,628
74	1,863	2,148	2,645	2,223	768	1,686
75	1,929	2,223	2,740	2,299	795	1,740
76	1,996	2,301	2,835	2,379	823	1,795
77	2,068	2,383	2,935	2,464	853	1,854
78	2,136	2,463	3,035	2,547	882	1,916
79	2,204	2,540	3,128	2,628	909	1,978
80	2,273	2,619	3,229	2,710	937	2,045
81	2,345	2,703	3,328	2,795	967	2,110
82	2,415	2,784	3,428	2,877	995	2,172
83	2,490	2,870	3,535	2,967	1,027	2,239
84	2,562	2,954	3,638	3,054	1,056	2,304
85	2,655	3,061	3,770	3,164	1,094	2,388
86	2,730	3,149	3,877	3,256	1,126	2,456
87	2,808	3,236	3,988	3,347	1,159	2,524
88	2,886	3,328	4,099	3,440	1,191	2,597
89	2,967	3,419	4,213	3,538	1,224	2,668
90	3,049	3,515	4,328	3,634	1,257	2,742
91	3,130	3,609	4,445	3,733	1,292	2,815
92	3,216	3,706	4,566	3,834	1,328	2,892
93	3,303	3,805	4,688	3,936	1,363	2,970
94	3,389	3,905	4,812	4,040	1,397	3,049
95	3,477	4,009	4,938	4,144	1,436	3,127
96	3,565	4,110	5,065	4,252	1,473	3,208
97	3,658	4,217	5,194	4,361	1,509	3,291
98	3,751	4,323	5,326	4,471	1,547	3,375
99+	3,844	4,433	5,460	4,582	1,586	3,459

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	7,748	8,931	11,002	9,237	3,197	6,985
65	1,718	1,982	2,442	2,049	710	1,463
66	1,718	1,982	2,442	2,049	710	1,463
67	1,718	1,982	2,442	2,049	710	1,463
68	1,735	2,003	2,469	2,070	716	1,515
69	1,778	2,048	2,522	2,117	735	1,576
70	1,826	2,100	2,591	2,176	753	1,637
71	1,878	2,167	2,668	2,240	776	1,694
72	1,939	2,233	2,750	2,309	801	1,752
73	2,001	2,309	2,843	2,384	826	1,810
74	2,072	2,388	2,940	2,469	856	1,874
75	2,143	2,470	3,045	2,555	884	1,931
76	2,218	2,556	3,150	2,643	916	1,995
77	2,296	2,648	3,262	2,736	947	2,062
78	2,374	2,738	3,370	2,830	980	2,129
79	2,450	2,822	3,476	2,918	1,010	2,199
80	2,527	2,911	3,586	3,011	1,041	2,270
81	2,604	3,003	3,699	3,104	1,075	2,342
82	2,682	3,092	3,810	3,196	1,107	2,413
83	2,769	3,192	3,926	3,297	1,139	2,486
84	2,848	3,282	4,042	3,394	1,174	2,560
85	2,947	3,401	4,188	3,515	1,216	2,652
86	3,036	3,498	4,306	3,618	1,251	2,728
87	3,118	3,596	4,431	3,718	1,286	2,805
88	3,208	3,698	4,553	3,824	1,323	2,886
89	3,297	3,801	4,680	3,931	1,360	2,966
90	3,389	3,905	4,809	4,038	1,396	3,045
91	3,480	4,012	4,940	4,145	1,436	3,128
92	3,575	4,119	5,074	4,261	1,475	3,213
93	3,669	4,229	5,210	4,374	1,514	3,299
94	3,766	4,339	5,348	4,489	1,554	3,388
95	3,863	4,453	5,486	4,605	1,595	3,474
96	3,963	4,567	5,628	4,726	1,636	3,564
97	4,064	4,686	5,772	4,846	1,676	3,657
98	4,169	4,805	5,918	4,968	1,719	3,749
99+	4,273	4,926	6,067	5,094	1,764	3,842

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.

Standard/Preferred rating classes are used, but all applicants in their open enrollment period or a specified guarantee issue period will receive Preferred rates.

Modal factors

Semi-annual	0.5200
Quarterly	0.2650
Monthly	0.0833

PREMIUM INFORMATION

Continental Life Insurance Company of Brentwood, Tennessee will increase premiums due to the increase in your age on each annual anniversary of your Effective Date. The renewal premium for this policy will be the renewal premium then in effect for your attained age. The premium may also change for other reasons. Any change in premium will apply to all covered persons in your same class based on the issue state of your policy. For any premium change under this paragraph, we will give you at least 30 days advance notice in writing of such premium change.

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 of Medicare-Approved amounts*	\$0	\$0	(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