# Outline of coverage

## Medicare Supplement Insurance

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

**Virginia**

Underwritten by

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

An Aetna Company

**AetnaSeniorProducts.com**

CLIMS04884VA



Rates effective: 01/2024 A

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

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

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

| Benefits | Plans Available to All Applicants | | | | | | | | Medicare first eligible before 2020 only | |
|---|---|---|---|---|---|---|---|---|---|---|
| | A | B | D | G[1] | K | L | M | N | C | F[1] |
| Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up) | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Medicare Part B coinsurance or copayment | ✓ | ✓ | ✓ | ✓ | 50% | 75% | ✓ | ✓ copays apply[3] | ✓ | ✓ |
| Blood (first three pints) | ✓ | ✓ | ✓ | ✓ | 50% | 75% | ✓ | ✓ | ✓ | ✓ |
| Part A hospice care coinsurance or copayment | ✓ | ✓ | ✓ | ✓ | 50% | 75% | ✓ | ✓ | ✓ | ✓ |
| Skilled nursing facility coinsurance | | | ✓ | ✓ | 50% | 75% | ✓ | ✓ | ✓ | ✓ |
| Medicare Part A deductible | | ✓ | ✓ | ✓ | 50% | 75% | 50% | ✓ | ✓ | ✓ |
| Medicare Part B deductible | | | | | | | | | ✓ | ✓ |
| Medicare Part B excess charges | | | | ✓ | | | | | | ✓ |
| Foreign travel emergency (up to plan limits) | | | ✓ | ✓ | | | ✓ | ✓ | ✓ | ✓ |
| Out-of-pocket limit in 2024[2] | | | | | **$7,060[2]** | **$3,530[2]** | | | | |

[1] Plans F and G also have a high deductible option, which require first paying a plan deductible of **$2,800** before the plan begins to pay. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High deductible plan G does not cover the Medicare Part B deductible. However, high deductible plans F and G count your payment of the Medicare Part B deductible toward meeting the plan deductible. High deductible plan G is the same as high deductible plan F except that where the annual out-of-pocket expenses are met with Medicare Part A expenses only, any subsequent Medicare Part B deductible expense incurred by the beneficiary after the required annual out-of-pocket expenses is met may not be paid for by the high deductible plan G.

[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: 201, 205, 220-225, 232-237

Female rates

Rates effective 1/1/2024

| ATTAINED AGE | PREFERRED | | | | | |
|---|---|---|---|---|---|---|
| | Plan A | Plan B | Plan F | Plan G | Plan HG | Plan N |
| Under 65 | 1,522 | - | - | - | - | - |
| 65 | 1,522 | 1,698 | 2,007 | 1,759 | 563 | 1,166 |
| 66 | 1,522 | 1,698 | 2,007 | 1,759 | 563 | 1,166 |
| 67 | 1,522 | 1,698 | 2,007 | 1,759 | 563 | 1,166 |
| 68 | 1,538 | 1,716 | 2,030 | 1,779 | 567 | 1,206 |
| 69 | 1,574 | 1,756 | 2,078 | 1,820 | 581 | 1,256 |
| 70 | 1,615 | 1,803 | 2,132 | 1,869 | 598 | 1,304 |
| 71 | 1,665 | 1,857 | 2,195 | 1,924 | 615 | 1,350 |
| 72 | 1,716 | 1,914 | 2,264 | 1,983 | 634 | 1,395 |
| 73 | 1,773 | 1,977 | 2,338 | 2,050 | 655 | 1,442 |
| 74 | 1,834 | 2,046 | 2,420 | 2,121 | 679 | 1,493 |
| 75 | 1,898 | 2,118 | 2,506 | 2,195 | 702 | 1,540 |
| 76 | 1,965 | 2,193 | 2,593 | 2,272 | 727 | 1,589 |
| 77 | 2,034 | 2,270 | 2,685 | 2,353 | 751 | 1,643 |
| 78 | 2,104 | 2,346 | 2,775 | 2,432 | 778 | 1,698 |
| 79 | 2,170 | 2,420 | 2,863 | 2,507 | 801 | 1,752 |
| 80 | 2,237 | 2,495 | 2,952 | 2,586 | 826 | 1,811 |
| 81 | 2,306 | 2,574 | 3,046 | 2,668 | 853 | 1,869 |
| 82 | 2,376 | 2,651 | 3,135 | 2,747 | 878 | 1,923 |
| 83 | 2,449 | 2,731 | 3,232 | 2,831 | 905 | 1,982 |
| 84 | 2,520 | 2,812 | 3,326 | 2,916 | 932 | 2,040 |
| 85 | 2,612 | 2,915 | 3,449 | 3,021 | 964 | 2,114 |
| 86 | 2,686 | 2,997 | 3,547 | 3,107 | 993 | 2,176 |
| 87 | 2,764 | 3,083 | 3,647 | 3,197 | 1,020 | 2,236 |
| 88 | 2,841 | 3,169 | 3,749 | 3,285 | 1,049 | 2,299 |
| 89 | 2,920 | 3,257 | 3,853 | 3,377 | 1,078 | 2,363 |
| 90 | 3,001 | 3,347 | 3,959 | 3,470 | 1,108 | 2,428 |
| 91 | 3,081 | 3,439 | 4,066 | 3,565 | 1,139 | 2,495 |
| 92 | 3,164 | 3,530 | 4,175 | 3,661 | 1,169 | 2,562 |
| 93 | 3,249 | 3,624 | 4,288 | 3,757 | 1,200 | 2,629 |
| 94 | 3,336 | 3,721 | 4,400 | 3,856 | 1,231 | 2,698 |
| 95 | 3,421 | 3,818 | 4,516 | 3,958 | 1,264 | 2,768 |
| 96 | 3,509 | 3,917 | 4,631 | 4,060 | 1,297 | 2,841 |
| 97 | 3,600 | 4,016 | 4,750 | 4,165 | 1,329 | 2,915 |
| 98 | 3,691 | 4,118 | 4,870 | 4,269 | 1,364 | 2,987 |
| 99+ | 3,784 | 4,220 | 4,991 | 4,375 | 1,398 | 3,063 |

| ATTAINED AGE | STANDARD | | | | | |
|---|---|---|---|---|---|---|
| | Plan A | Plan B | Plan F | Plan G | Plan HG | Plan N |
| Under 65 | 1,690 | - | - | - | - | - |
| 65 | 1,690 | 1,886 | 2,231 | 1,955 | 626 | 1,296 |
| 66 | 1,690 | 1,886 | 2,231 | 1,955 | 626 | 1,296 |
| 67 | 1,690 | 1,886 | 2,231 | 1,955 | 626 | 1,296 |
| 68 | 1,710 | 1,907 | 2,258 | 1,977 | 630 | 1,342 |
| 69 | 1,747 | 1,952 | 2,307 | 2,022 | 645 | 1,395 |
| 70 | 1,793 | 2,003 | 2,369 | 2,076 | 663 | 1,450 |
| 71 | 1,849 | 2,062 | 2,441 | 2,138 | 684 | 1,500 |
| 72 | 1,907 | 2,126 | 2,514 | 2,205 | 704 | 1,551 |
| 73 | 1,969 | 2,197 | 2,597 | 2,277 | 728 | 1,604 |
| 74 | 2,039 | 2,274 | 2,690 | 2,357 | 754 | 1,658 |
| 75 | 2,109 | 2,352 | 2,784 | 2,438 | 780 | 1,710 |
| 76 | 2,183 | 2,436 | 2,880 | 2,524 | 808 | 1,765 |
| 77 | 2,261 | 2,523 | 2,983 | 2,614 | 835 | 1,827 |
| 78 | 2,335 | 2,608 | 3,082 | 2,702 | 864 | 1,885 |
| 79 | 2,412 | 2,689 | 3,180 | 2,787 | 889 | 1,947 |
| 80 | 2,487 | 2,772 | 3,279 | 2,875 | 917 | 2,013 |
| 81 | 2,563 | 2,860 | 3,383 | 2,965 | 946 | 2,075 |
| 82 | 2,639 | 2,946 | 3,482 | 3,052 | 975 | 2,138 |
| 83 | 2,721 | 3,036 | 3,591 | 3,148 | 1,006 | 2,203 |
| 84 | 2,800 | 3,125 | 3,695 | 3,240 | 1,036 | 2,269 |
| 85 | 2,903 | 3,239 | 3,831 | 3,358 | 1,072 | 2,349 |
| 86 | 2,987 | 3,330 | 3,940 | 3,453 | 1,102 | 2,418 |
| 87 | 3,069 | 3,424 | 4,054 | 3,550 | 1,135 | 2,485 |
| 88 | 3,156 | 3,521 | 4,165 | 3,649 | 1,166 | 2,556 |
| 89 | 3,244 | 3,619 | 4,282 | 3,751 | 1,198 | 2,626 |
| 90 | 3,335 | 3,720 | 4,398 | 3,855 | 1,231 | 2,698 |
| 91 | 3,423 | 3,820 | 4,518 | 3,959 | 1,266 | 2,772 |
| 92 | 3,515 | 3,924 | 4,639 | 4,068 | 1,298 | 2,848 |
| 93 | 3,609 | 4,027 | 4,763 | 4,175 | 1,335 | 2,921 |
| 94 | 3,705 | 4,133 | 4,888 | 4,285 | 1,369 | 3,000 |
| 95 | 3,802 | 4,241 | 5,019 | 4,398 | 1,404 | 3,077 |
| 96 | 3,899 | 4,351 | 5,146 | 4,511 | 1,441 | 3,156 |
| 97 | 3,999 | 4,462 | 5,277 | 4,626 | 1,477 | 3,239 |
| 98 | 4,101 | 4,575 | 5,411 | 4,743 | 1,516 | 3,319 |
| 99+ | 4,204 | 4,690 | 5,547 | 4,861 | 1,554 | 3,403 |

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-annual ..... 0.5200

Quarterly ..... 0.2650

Monthly ..... 0.0833

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

Annual premiums

For Use in ZIP Codes: 201, 205, 220-225, 232-237

Male rates

Rates effective 1/1/2024

| ATTAINED AGE | PREFERRED | | | | | |
|---|---|---|---|---|---|---|
| | Plan A | Plan B | Plan F | Plan G | Plan HG | Plan N |
| Under 65 | 1,750 | - | - | - | - | - |
| 65 | 1,750 | 1,954 | 2,310 | 2,024 | 649 | 1,342 |
| 66 | 1,750 | 1,954 | 2,310 | 2,024 | 649 | 1,342 |
| 67 | 1,750 | 1,954 | 2,310 | 2,024 | 649 | 1,342 |
| 68 | 1,770 | 1,972 | 2,337 | 2,047 | 653 | 1,388 |
| 69 | 1,809 | 2,018 | 2,389 | 2,093 | 668 | 1,444 |
| 70 | 1,859 | 2,073 | 2,453 | 2,149 | 686 | 1,500 |
| 71 | 1,915 | 2,134 | 2,525 | 2,214 | 708 | 1,554 |
| 72 | 1,975 | 2,201 | 2,603 | 2,282 | 730 | 1,607 |
| 73 | 2,039 | 2,274 | 2,689 | 2,358 | 753 | 1,659 |
| 74 | 2,110 | 2,352 | 2,784 | 2,438 | 780 | 1,717 |
| 75 | 2,183 | 2,435 | 2,880 | 2,524 | 806 | 1,771 |
| 76 | 2,259 | 2,522 | 2,980 | 2,612 | 835 | 1,828 |
| 77 | 2,339 | 2,610 | 3,088 | 2,706 | 864 | 1,890 |
| 78 | 2,418 | 2,698 | 3,191 | 2,798 | 893 | 1,952 |
| 79 | 2,495 | 2,782 | 3,291 | 2,885 | 921 | 2,015 |
| 80 | 2,574 | 2,870 | 3,394 | 2,975 | 950 | 2,082 |
| 81 | 2,654 | 2,958 | 3,502 | 3,067 | 980 | 2,148 |
| 82 | 2,732 | 3,047 | 3,606 | 3,161 | 1,010 | 2,212 |
| 83 | 2,816 | 3,142 | 3,717 | 3,257 | 1,041 | 2,280 |
| 84 | 2,898 | 3,234 | 3,826 | 3,353 | 1,072 | 2,346 |
| 85 | 3,004 | 3,353 | 3,965 | 3,475 | 1,110 | 2,431 |
| 86 | 3,092 | 3,447 | 4,076 | 3,574 | 1,142 | 2,501 |
| 87 | 3,177 | 3,547 | 4,194 | 3,676 | 1,174 | 2,570 |
| 88 | 3,266 | 3,645 | 4,310 | 3,778 | 1,208 | 2,646 |
| 89 | 3,358 | 3,745 | 4,430 | 3,883 | 1,240 | 2,719 |
| 90 | 3,450 | 3,849 | 4,552 | 3,989 | 1,274 | 2,794 |
| 91 | 3,544 | 3,954 | 4,675 | 4,099 | 1,310 | 2,869 |
| 92 | 3,640 | 4,060 | 4,802 | 4,210 | 1,344 | 2,948 |
| 93 | 3,736 | 4,167 | 4,932 | 4,321 | 1,381 | 3,023 |
| 94 | 3,836 | 4,279 | 5,059 | 4,436 | 1,416 | 3,105 |
| 95 | 3,936 | 4,390 | 5,191 | 4,552 | 1,453 | 3,185 |
| 96 | 4,037 | 4,505 | 5,326 | 4,669 | 1,492 | 3,267 |
| 97 | 4,141 | 4,619 | 5,462 | 4,790 | 1,528 | 3,352 |
| 98 | 4,245 | 4,735 | 5,601 | 4,910 | 1,568 | 3,436 |
| 99+ | 4,350 | 4,855 | 5,741 | 5,032 | 1,607 | 3,524 |

| ATTAINED AGE | STANDARD | | | | | |
|---|---|---|---|---|---|---|
| | Plan A | Plan B | Plan F | Plan G | Plan HG | Plan N |
| Under 65 | 1,944 | - | - | - | - | - |
| 65 | 1,944 | 2,168 | 2,566 | 2,251 | 720 | 1,488 |
| 66 | 1,944 | 2,168 | 2,566 | 2,251 | 720 | 1,488 |
| 67 | 1,944 | 2,168 | 2,566 | 2,251 | 720 | 1,488 |
| 68 | 1,965 | 2,194 | 2,595 | 2,274 | 726 | 1,543 |
| 69 | 2,011 | 2,243 | 2,651 | 2,326 | 742 | 1,607 |
| 70 | 2,064 | 2,303 | 2,724 | 2,386 | 762 | 1,669 |
| 71 | 2,126 | 2,374 | 2,806 | 2,460 | 785 | 1,724 |
| 72 | 2,193 | 2,447 | 2,893 | 2,536 | 811 | 1,784 |
| 73 | 2,266 | 2,528 | 2,987 | 2,620 | 836 | 1,844 |
| 74 | 2,346 | 2,615 | 3,094 | 2,709 | 866 | 1,907 |
| 75 | 2,426 | 2,707 | 3,202 | 2,805 | 897 | 1,967 |
| 76 | 2,510 | 2,801 | 3,314 | 2,904 | 929 | 2,030 |
| 77 | 2,600 | 2,902 | 3,430 | 3,006 | 961 | 2,101 |
| 78 | 2,686 | 2,998 | 3,545 | 3,107 | 993 | 2,167 |
| 79 | 2,772 | 3,092 | 3,657 | 3,205 | 1,022 | 2,239 |
| 80 | 2,859 | 3,188 | 3,772 | 3,307 | 1,055 | 2,316 |
| 81 | 2,949 | 3,289 | 3,890 | 3,410 | 1,088 | 2,386 |
| 82 | 3,036 | 3,387 | 4,008 | 3,509 | 1,123 | 2,458 |
| 83 | 3,130 | 3,491 | 4,130 | 3,622 | 1,154 | 2,535 |
| 84 | 3,221 | 3,594 | 4,250 | 3,726 | 1,191 | 2,608 |
| 85 | 3,338 | 3,724 | 4,403 | 3,864 | 1,233 | 2,701 |
| 86 | 3,435 | 3,830 | 4,530 | 3,971 | 1,268 | 2,781 |
| 87 | 3,531 | 3,939 | 4,660 | 4,084 | 1,304 | 2,859 |
| 88 | 3,630 | 4,049 | 4,788 | 4,197 | 1,342 | 2,939 |
| 89 | 3,733 | 4,162 | 4,922 | 4,314 | 1,378 | 3,019 |
| 90 | 3,834 | 4,277 | 5,058 | 4,435 | 1,416 | 3,105 |
| 91 | 3,939 | 4,392 | 5,195 | 4,554 | 1,454 | 3,187 |
| 92 | 4,043 | 4,511 | 5,335 | 4,678 | 1,493 | 3,274 |
| 93 | 4,152 | 4,632 | 5,478 | 4,801 | 1,533 | 3,359 |
| 94 | 4,260 | 4,755 | 5,623 | 4,927 | 1,574 | 3,450 |
| 95 | 4,373 | 4,876 | 5,770 | 5,058 | 1,615 | 3,538 |
| 96 | 4,484 | 5,005 | 5,919 | 5,186 | 1,656 | 3,630 |
| 97 | 4,599 | 5,132 | 6,068 | 5,320 | 1,699 | 3,724 |
| 98 | 4,715 | 5,260 | 6,223 | 5,455 | 1,744 | 3,816 |
| 99+ | 4,835 | 5,392 | 6,379 | 5,589 | 1,786 | 3,913 |

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-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 1/1/2024

| ATTAINED AGE | PREFERRED | | | | | |
|---|---|---|---|---|---|---|
| | Plan A | Plan B | Plan F | Plan G | Plan HG | Plan N |
| Under 65 | 1,258 | - | - | - | - | - |
| 65 | 1,258 | 1,403 | 1,659 | 1,454 | 465 | 964 |
| 66 | 1,258 | 1,403 | 1,659 | 1,454 | 465 | 964 |
| 67 | 1,258 | 1,403 | 1,659 | 1,454 | 465 | 964 |
| 68 | 1,271 | 1,418 | 1,678 | 1,470 | 469 | 997 |
| 69 | 1,301 | 1,451 | 1,717 | 1,504 | 480 | 1,038 |
| 70 | 1,335 | 1,490 | 1,762 | 1,545 | 494 | 1,078 |
| 71 | 1,376 | 1,535 | 1,814 | 1,590 | 508 | 1,116 |
| 72 | 1,418 | 1,582 | 1,871 | 1,639 | 524 | 1,153 |
| 73 | 1,465 | 1,634 | 1,932 | 1,694 | 541 | 1,192 |
| 74 | 1,516 | 1,691 | 2,000 | 1,753 | 561 | 1,234 |
| 75 | 1,569 | 1,750 | 2,071 | 1,814 | 580 | 1,273 |
| 76 | 1,624 | 1,812 | 2,143 | 1,878 | 601 | 1,313 |
| 77 | 1,681 | 1,876 | 2,219 | 1,945 | 621 | 1,358 |
| 78 | 1,739 | 1,939 | 2,293 | 2,010 | 643 | 1,403 |
| 79 | 1,793 | 2,000 | 2,366 | 2,072 | 662 | 1,448 |
| 80 | 1,849 | 2,062 | 2,440 | 2,137 | 683 | 1,497 |
| 81 | 1,906 | 2,127 | 2,517 | 2,205 | 705 | 1,545 |
| 82 | 1,964 | 2,191 | 2,591 | 2,270 | 726 | 1,589 |
| 83 | 2,024 | 2,257 | 2,671 | 2,340 | 748 | 1,638 |
| 84 | 2,083 | 2,324 | 2,749 | 2,410 | 770 | 1,686 |
| 85 | 2,159 | 2,409 | 2,850 | 2,497 | 797 | 1,747 |
| 86 | 2,220 | 2,477 | 2,931 | 2,568 | 821 | 1,798 |
| 87 | 2,284 | 2,548 | 3,014 | 2,642 | 843 | 1,848 |
| 88 | 2,348 | 2,619 | 3,098 | 2,715 | 867 | 1,900 |
| 89 | 2,413 | 2,692 | 3,184 | 2,791 | 891 | 1,953 |
| 90 | 2,480 | 2,766 | 3,272 | 2,868 | 916 | 2,007 |
| 91 | 2,546 | 2,842 | 3,360 | 2,946 | 941 | 2,062 |
| 92 | 2,615 | 2,917 | 3,450 | 3,026 | 966 | 2,117 |
| 93 | 2,685 | 2,995 | 3,544 | 3,105 | 992 | 2,173 |
| 94 | 2,757 | 3,075 | 3,636 | 3,187 | 1,017 | 2,230 |
| 95 | 2,827 | 3,155 | 3,732 | 3,271 | 1,045 | 2,288 |
| 96 | 2,900 | 3,237 | 3,827 | 3,355 | 1,072 | 2,348 |
| 97 | 2,975 | 3,319 | 3,926 | 3,442 | 1,098 | 2,409 |
| 98 | 3,050 | 3,403 | 4,025 | 3,528 | 1,127 | 2,469 |
| 99+ | 3,127 | 3,488 | 4,125 | 3,616 | 1,155 | 2,531 |

| ATTAINED AGE | STANDARD | | | | | |
|---|---|---|---|---|---|---|
| | Plan A | Plan B | Plan F | Plan G | Plan HG | Plan N |
| Under 65 | 1,397 | - | - | - | - | - |
| 65 | 1,397 | 1,559 | 1,844 | 1,616 | 517 | 1,071 |
| 66 | 1,397 | 1,559 | 1,844 | 1,616 | 517 | 1,071 |
| 67 | 1,397 | 1,559 | 1,844 | 1,616 | 517 | 1,071 |
| 68 | 1,413 | 1,576 | 1,866 | 1,634 | 521 | 1,109 |
| 69 | 1,444 | 1,613 | 1,907 | 1,671 | 533 | 1,153 |
| 70 | 1,482 | 1,655 | 1,958 | 1,716 | 548 | 1,198 |
| 71 | 1,528 | 1,704 | 2,017 | 1,767 | 565 | 1,240 |
| 72 | 1,576 | 1,757 | 2,078 | 1,822 | 582 | 1,282 |
| 73 | 1,627 | 1,816 | 2,146 | 1,882 | 602 | 1,326 |
| 74 | 1,685 | 1,879 | 2,223 | 1,948 | 623 | 1,370 |
| 75 | 1,743 | 1,944 | 2,301 | 2,015 | 645 | 1,413 |
| 76 | 1,804 | 2,013 | 2,380 | 2,086 | 668 | 1,459 |
| 77 | 1,869 | 2,085 | 2,465 | 2,160 | 690 | 1,510 |
| 78 | 1,930 | 2,155 | 2,547 | 2,233 | 714 | 1,558 |
| 79 | 1,993 | 2,222 | 2,628 | 2,303 | 735 | 1,609 |
| 80 | 2,055 | 2,291 | 2,710 | 2,376 | 758 | 1,664 |
| 81 | 2,118 | 2,364 | 2,796 | 2,450 | 782 | 1,715 |
| 82 | 2,181 | 2,435 | 2,878 | 2,522 | 806 | 1,767 |
| 83 | 2,249 | 2,509 | 2,968 | 2,602 | 831 | 1,821 |
| 84 | 2,314 | 2,583 | 3,054 | 2,678 | 856 | 1,875 |
| 85 | 2,399 | 2,677 | 3,166 | 2,775 | 886 | 1,941 |
| 86 | 2,469 | 2,752 | 3,256 | 2,854 | 911 | 1,998 |
| 87 | 2,536 | 2,830 | 3,350 | 2,934 | 938 | 2,054 |
| 88 | 2,608 | 2,910 | 3,442 | 3,016 | 964 | 2,112 |
| 89 | 2,681 | 2,991 | 3,539 | 3,100 | 990 | 2,170 |
| 90 | 2,756 | 3,074 | 3,635 | 3,186 | 1,017 | 2,230 |
| 91 | 2,829 | 3,157 | 3,734 | 3,272 | 1,046 | 2,291 |
| 92 | 2,905 | 3,243 | 3,834 | 3,362 | 1,073 | 2,354 |
| 93 | 2,983 | 3,328 | 3,936 | 3,450 | 1,103 | 2,414 |
| 94 | 3,062 | 3,416 | 4,040 | 3,541 | 1,131 | 2,479 |
| 95 | 3,142 | 3,505 | 4,148 | 3,635 | 1,160 | 2,543 |
| 96 | 3,222 | 3,596 | 4,253 | 3,728 | 1,191 | 2,608 |
| 97 | 3,305 | 3,688 | 4,361 | 3,823 | 1,221 | 2,677 |
| 98 | 3,389 | 3,781 | 4,472 | 3,920 | 1,253 | 2,743 |
| 99+ | 3,474 | 3,876 | 4,584 | 4,017 | 1,284 | 2,812 |

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-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 1/1/2024

| ATTAINED AGE | PREFERRED | | | | | |
|---|---|---|---|---|---|---|
| | Plan A | Plan B | Plan F | Plan G | Plan HG | Plan N |
| Under 65 | 1,446 | - | - | - | - | - |
| 65 | 1,446 | 1,615 | 1,909 | 1,673 | 536 | 1,109 |
| 66 | 1,446 | 1,615 | 1,909 | 1,673 | 536 | 1,109 |
| 67 | 1,446 | 1,615 | 1,909 | 1,673 | 536 | 1,109 |
| 68 | 1,463 | 1,630 | 1,931 | 1,692 | 540 | 1,147 |
| 69 | 1,495 | 1,668 | 1,974 | 1,730 | 552 | 1,193 |
| 70 | 1,536 | 1,713 | 2,027 | 1,776 | 567 | 1,240 |
| 71 | 1,583 | 1,764 | 2,087 | 1,830 | 585 | 1,284 |
| 72 | 1,632 | 1,819 | 2,151 | 1,886 | 603 | 1,328 |
| 73 | 1,685 | 1,879 | 2,222 | 1,949 | 622 | 1,371 |
| 74 | 1,744 | 1,944 | 2,301 | 2,015 | 645 | 1,419 |
| 75 | 1,804 | 2,012 | 2,380 | 2,086 | 666 | 1,464 |
| 76 | 1,867 | 2,084 | 2,463 | 2,159 | 690 | 1,511 |
| 77 | 1,933 | 2,157 | 2,552 | 2,236 | 714 | 1,562 |
| 78 | 1,998 | 2,230 | 2,637 | 2,312 | 738 | 1,613 |
| 79 | 2,062 | 2,299 | 2,720 | 2,384 | 761 | 1,665 |
| 80 | 2,127 | 2,372 | 2,805 | 2,459 | 785 | 1,721 |
| 81 | 2,193 | 2,445 | 2,894 | 2,535 | 810 | 1,775 |
| 82 | 2,258 | 2,518 | 2,980 | 2,612 | 835 | 1,828 |
| 83 | 2,327 | 2,597 | 3,072 | 2,692 | 860 | 1,884 |
| 84 | 2,395 | 2,673 | 3,162 | 2,771 | 886 | 1,939 |
| 85 | 2,483 | 2,771 | 3,277 | 2,872 | 917 | 2,009 |
| 86 | 2,555 | 2,849 | 3,369 | 2,954 | 944 | 2,067 |
| 87 | 2,626 | 2,931 | 3,466 | 3,038 | 970 | 2,124 |
| 88 | 2,699 | 3,012 | 3,562 | 3,122 | 998 | 2,187 |
| 89 | 2,775 | 3,095 | 3,661 | 3,209 | 1,025 | 2,247 |
| 90 | 2,851 | 3,181 | 3,762 | 3,297 | 1,053 | 2,309 |
| 91 | 2,929 | 3,268 | 3,864 | 3,388 | 1,083 | 2,371 |
| 92 | 3,008 | 3,355 | 3,969 | 3,479 | 1,111 | 2,436 |
| 93 | 3,088 | 3,444 | 4,076 | 3,571 | 1,141 | 2,498 |
| 94 | 3,170 | 3,536 | 4,181 | 3,666 | 1,170 | 2,566 |
| 95 | 3,253 | 3,628 | 4,290 | 3,762 | 1,201 | 2,632 |
| 96 | 3,336 | 3,723 | 4,402 | 3,859 | 1,233 | 2,700 |
| 97 | 3,422 | 3,817 | 4,514 | 3,959 | 1,263 | 2,770 |
| 98 | 3,508 | 3,913 | 4,629 | 4,058 | 1,296 | 2,840 |
| 99+ | 3,595 | 4,012 | 4,745 | 4,159 | 1,328 | 2,912 |

| ATTAINED AGE | STANDARD | | | | | |
|---|---|---|---|---|---|---|
| | Plan A | Plan B | Plan F | Plan G | Plan HG | Plan N |
| Under 65 | 1,607 | - | - | - | - | - |
| 65 | 1,607 | 1,792 | 2,121 | 1,860 | 595 | 1,230 |
| 66 | 1,607 | 1,792 | 2,121 | 1,860 | 595 | 1,230 |
| 67 | 1,607 | 1,792 | 2,121 | 1,860 | 595 | 1,230 |
| 68 | 1,624 | 1,813 | 2,145 | 1,879 | 600 | 1,275 |
| 69 | 1,662 | 1,854 | 2,191 | 1,922 | 613 | 1,328 |
| 70 | 1,706 | 1,903 | 2,251 | 1,972 | 630 | 1,379 |
| 71 | 1,757 | 1,962 | 2,319 | 2,033 | 649 | 1,425 |
| 72 | 1,812 | 2,022 | 2,391 | 2,096 | 670 | 1,474 |
| 73 | 1,873 | 2,089 | 2,469 | 2,165 | 691 | 1,524 |
| 74 | 1,939 | 2,161 | 2,557 | 2,239 | 716 | 1,576 |
| 75 | 2,005 | 2,237 | 2,646 | 2,318 | 741 | 1,626 |
| 76 | 2,074 | 2,315 | 2,739 | 2,400 | 768 | 1,678 |
| 77 | 2,149 | 2,398 | 2,835 | 2,484 | 794 | 1,736 |
| 78 | 2,220 | 2,478 | 2,930 | 2,568 | 821 | 1,791 |
| 79 | 2,291 | 2,555 | 3,022 | 2,649 | 845 | 1,850 |
| 80 | 2,363 | 2,635 | 3,117 | 2,733 | 872 | 1,914 |
| 81 | 2,437 | 2,718 | 3,215 | 2,818 | 899 | 1,972 |
| 82 | 2,509 | 2,799 | 3,312 | 2,900 | 928 | 2,031 |
| 83 | 2,587 | 2,885 | 3,413 | 2,993 | 954 | 2,095 |
| 84 | 2,662 | 2,970 | 3,512 | 3,079 | 984 | 2,155 |
| 85 | 2,759 | 3,078 | 3,639 | 3,193 | 1,019 | 2,232 |
| 86 | 2,839 | 3,165 | 3,744 | 3,282 | 1,048 | 2,298 |
| 87 | 2,918 | 3,255 | 3,851 | 3,375 | 1,078 | 2,363 |
| 88 | 3,000 | 3,346 | 3,957 | 3,469 | 1,109 | 2,429 |
| 89 | 3,085 | 3,440 | 4,068 | 3,565 | 1,139 | 2,495 |
| 90 | 3,169 | 3,535 | 4,180 | 3,665 | 1,170 | 2,566 |
| 91 | 3,255 | 3,630 | 4,293 | 3,764 | 1,202 | 2,634 |
| 92 | 3,341 | 3,728 | 4,409 | 3,866 | 1,234 | 2,706 |
| 93 | 3,431 | 3,828 | 4,527 | 3,968 | 1,267 | 2,776 |
| 94 | 3,521 | 3,930 | 4,647 | 4,072 | 1,301 | 2,851 |
| 95 | 3,614 | 4,030 | 4,769 | 4,180 | 1,335 | 2,924 |
| 96 | 3,706 | 4,136 | 4,892 | 4,286 | 1,369 | 3,000 |
| 97 | 3,801 | 4,241 | 5,015 | 4,397 | 1,404 | 3,078 |
| 98 | 3,897 | 4,347 | 5,143 | 4,508 | 1,441 | 3,154 |
| 99+ | 3,996 | 4,456 | 5,272 | 4,619 | 1,476 | 3,234 |

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-annual ..... 0.5200
Quarterly ..... 0.2650
Monthly ..... 0.0833

## PREMIUM INFORMATION

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

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

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

## HOUSEHOLD DISCOUNT

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

## DISCLOSURES

Use this outline to compare benefits and premium among policies.

## READ YOUR POLICY VERY CAREFULLY

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

## RIGHT TO RETURN POLICY

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

## POLICY REPLACEMENT

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

## NOTICE

The policy may not cover all of your medical costs.

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

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

## COMPLETE ANSWERS ARE VERY IMPORTANT

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

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

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

**PLAN A**

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

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

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **HOSPITALIZATION*** Semiprivate room and board, general nursing and miscellaneous services and supplies | | | |
| First 60 days | All but $1,632 | $0 | $1,632 (Part A Deductible) |
| 61st thru 90th day | All but $408 a day | $408 a day | $0 |
| 91st day and after While using 60 lifetime reserve days | All but $816 a day | $816 a day | $0 |
| Once lifetime reserve days are used: | | | |
| Additional 365 days | $0 | 100% of Medicare Eligible Expenses | $0** |
| Beyond the Additional 365 days | $0 | $0 | All costs |
| **SKILLED NURSING FACILITY CARE*** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital | | | |
| First 20 days | All approved amounts | $0 | $0 |
| 21st thru 100th day | All but $204 a day | $0 | Up to $204 a day |
| 101st day and after | $0 | $0 | All costs |
| **BLOOD** | | | |
| First 3 pints | $0 | 3 pints | $0 |
| Additional amounts | 100% | $0 | $0 |
| **HOSPICE CARE** | | | |
| You must meet Medicare's requirements, including a doctor's certification of terminal illness. | All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care | Medicare copayment/ coinsurance | $0 |

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

**PLAN A**

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

*Once you have been billed $240 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **MEDICAL EXPENSES –** IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment | | | |
| First $240 of Medicare-Approved amounts* | $0 | $0 | $240 (Part B Deductible) |
| Remainder of Medicare-Approved amounts | Generally 80% | Generally 20% | $0 |
| **PART B EXCESS CHARGES** (Above Medicare-Approved amounts) | $0 | $0 | All costs |
| **BLOOD** | | | |
| First 3 pints | $0 | All costs | $0 |
| Next $240 of Medicare-Approved amounts* | $0 | $0 | $240 (Part B Deductible) |
| Remainder of Medicare-Approved amounts | 80% | 20% | $0 |
| **CLINICAL LABORATORY SERVICES –** TESTS FOR DIAGNOSTIC SERVICES | 100% | $0 | $0 |

**PARTS A & B**

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **HOME HEALTH CARE –** MEDICARE APPROVED SERVICES | | | |
| Medically necessary skilled care services and medical supplies | 100% | $0 | $0 |
| Durable medical equipment | | | |
| First $240 of Medicare-Approved amounts* | $0 | $0 | $240 (Part B Deductible) |
| Remainder of Medicare-Approved amounts | 80% | 20% | $0 |

**PLAN B**

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

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

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **HOSPITALIZATION*** Semiprivate room and board, general nursing and miscellaneous services and supplies | | | |
| First 60 days | All but $1,632 | $1,632 (Part A Deductible) | $0 |
| 61st thru 90th day | All but $408 a day | $408 a day | $0 |
| 91st day and after While using 60 lifetime reserve days | All but $816 a day | $816 a day | $0 |
| Once lifetime reserve days are used: | | | |
| Additional 365 days | $0 | 100% of Medicare Eligible Expenses | $0** |
| Beyond the Additional 365 days | $0 | $0 | All costs |
| **SKILLED NURSING FACILITY CARE*** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital | | | |
| First 20 days | All approved amounts | $0 | $0 |
| 21st thru 100th day | All but $204 a day | $0 | Up to $204 a day |
| 101st day and after | $0 | $0 | All costs |
| **BLOOD** | | | |
| First 3 pints | $0 | 3 pints | $0 |
| Additional amounts | 100% | $0 | $0 |
| **HOSPICE CARE** | | | |
| You must meet Medicare's requirements, including a doctor's certification of terminal illness. | All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care | Medicare copayment/ coinsurance | $0 |

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

## PLAN B

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

*Once you have been billed $240 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **MEDICAL EXPENSES –** IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment | | | |
| First $240 of Medicare-Approved amounts* | $0 | $0 | $240 (Part B Deductible) |
| Remainder of Medicare-Approved amounts | Generally 80% | Generally 20% | $0 |
| **PART B EXCESS CHARGES** (Above Medicare-Approved amounts) | $0 | $0 | All costs |
| **BLOOD** | | | |
| First 3 pints | $0 | All costs | $0 |
| Next $240 of Medicare-Approved amounts* | $0 | $0 | $240 (Part B Deductible) |
| Remainder of Medicare-Approved amounts | 80% | 20% | $0 |
| **CLINICAL LABORATORY SERVICES –** TESTS FOR DIAGNOSTIC SERVICES | 100% | $0 | $0 |

## PARTS A & B

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **HOME HEALTH CARE –** MEDICARE APPROVED SERVICES | | | |
| Medically necessary skilled care services and medical supplies | 100% | $0 | $0 |
| Durable medical equipment | | | |
| First $240 of Medicare-Approved amounts* | $0 | $0 | $240 (Part B Deductible) |
| Remainder of Medicare-Approved amounts | 80% | 20% | $0 |

**PLAN F**

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

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

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **HOSPITALIZATION*** Semiprivate room and board, general nursing and miscellaneous services and supplies | | | |
| First 60 days | All but $1,632 | $1,632 (Part A Deductible) | $0 |
| 61st thru 90th day | All but $408 a day | $408 a day | $0 |
| 91st day and after While using 60 lifetime reserve days | All but $816 a day | $816 a day | $0 |
| Once lifetime reserve days are used: | | | |
| Additional 365 days | $0 | 100% of Medicare Eligible Expenses | $0** |
| Beyond the Additional 365 days | $0 | $0 | All costs |
| **SKILLED NURSING FACILITY CARE*** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital | | | |
| First 20 days | All approved amounts | $0 | $0 |
| 21st thru 100th day | All but $204 a day | Up to $204 a day | $0 |
| 101st day and after | $0 | $0 | All costs |
| **BLOOD** | | | |
| First 3 pints | $0 | 3 pints | $0 |
| Additional amounts | 100% | $0 | $0 |
| **HOSPICE CARE** | | | |
| You must meet Medicare's requirements, including a doctor's certification of terminal illness. | All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care | Medicare copayment/ coinsurance | $0 |

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

## PLAN F

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

*Once you have been billed $240 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **MEDICAL EXPENSES –** IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment | | | |
| First $240 of Medicare-Approved amounts* | $0 | $240 (Part B Deductible) | $0 |
| Remainder of Medicare-Approved amounts | Generally 80% | Generally 20% | $0 |
| **PART B EXCESS CHARGES** (Above Medicare-Approved amounts) | $0 | 100% | $0 |
| **BLOOD** | | | |
| First 3 pints | $0 | All costs | $0 |
| Next $240 of Medicare-Approved amounts* | $0 | $240 (Part B Deductible) | $0 |
| Remainder of Medicare-Approved amounts | 80% | 20% | $0 |
| **CLINICAL LABORATORY SERVICES –** TESTS FOR DIAGNOSTIC SERVICES | 100% | $0 | $0 |

## PARTS A & B

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **HOME HEALTH CARE –** MEDICARE APPROVED SERVICES | | | |
| Medically necessary skilled care services and medical supplies | 100% | $0 | $0 |
| Durable medical equipment | | | |
| First $240 of Medicare-Approved amounts* | $0 | $240 (Part B Deductible) | $0 |
| Remainder of Medicare-Approved amounts | 80% | 20% | $0 |

**PLAN F**

**OTHER BENEFITS – NOT COVERED BY MEDICARE**

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

## PLAN G

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

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

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **HOSPITALIZATION*** Semiprivate room and board, general nursing and miscellaneous services and supplies | | | |
| First 60 days | All but $1,632 | $1,632 (Part A Deductible) | $0 |
| 61st thru 90th day | All but $408 a day | $408 a day | $0 |
| 91st day and after While using 60 lifetime reserve days | All but $816 a day | $816 a day | $0 |
| Once lifetime reserve days are used: | | | |
| Additional 365 days | $0 | 100% of Medicare Eligible Expenses | $0** |
| Beyond the Additional 365 days | $0 | $0 | All costs |
| **SKILLED NURSING FACILITY CARE*** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital | | | |
| First 20 days | All approved amounts | $0 | $0 |
| 21st thru 100th day | All but $204 a day | Up to $204 a day | $0 |
| 101st day and after | $0 | $0 | All costs |
| **BLOOD** | | | |
| First 3 pints | $0 | 3 pints | $0 |
| Additional amounts | 100% | $0 | $0 |
| **HOSPICE CARE** | | | |
| You must meet Medicare's requirements, including a doctor's certification of terminal illness. | All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care | Medicare copayment/ coinsurance | $0 |

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

## PLAN G

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

*Once you have been billed $240 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **MEDICAL EXPENSES –** IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment | | | |
| First $240 of Medicare-Approved amounts* | $0 | $0 | $240 (Part B Deductible) |
| Remainder of Medicare-Approved amounts | Generally 80% | Generally 20% | $0 |
| **PART B EXCESS CHARGES** (Above Medicare-Approved amounts) | $0 | 100% | $0 |
| **BLOOD** | | | |
| First 3 pints | $0 | All costs | $0 |
| Next $240 of Medicare-Approved amounts* | $0 | $0 | $240 (Part B Deductible) |
| Remainder of Medicare-Approved amounts | 80% | 20% | $0 |
| **CLINICAL LABORATORY SERVICES –** TESTS FOR DIAGNOSTIC SERVICES | 100% | $0 | $0 |

### PARTS A & B

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **HOME HEALTH CARE –** MEDICARE APPROVED SERVICES | | | |
| Medically necessary skilled care services and medical supplies | 100% | $0 | $0 |
| Durable medical equipment | | | |
| First $240 of Medicare-Approved amounts* | $0 | $0 | $240 (Part B Deductible) |
| Remainder of Medicare-Approved amounts | 80% | 20% | $0 |

**PLAN G**

**OTHER BENEFITS – NOT COVERED BY MEDICARE**

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

## HIGH DEDUCTIBLE PLAN G

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

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

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

| SERVICES | MEDICARE PAYS | AFTER YOU PAY $2,800 DEDUCTIBLE*** PLAN PAYS | IN ADDITION TO $2,800 DEDUCTIBLE*** YOU PAY |
|---|---|---|---|
| **HOSPITALIZATION*** Semiprivate room and board, general nursing and miscellaneous services and supplies | | | |
| First 60 days | All but $1,632 | $1,632 (Part A Deductible) | $0 |
| 61st thru 90th day | All but $408 a day | $408 a day | $0 |
| 91st day and after While using 60 lifetime reserve days | All but $816 a day | $816 a day | $0 |
| Once lifetime reserve days are used: | | | |
| Additional 365 days | $0 | 100% of Medicare Eligible Expenses | $0** |
| Beyond the Additional 365 days | $0 | $0 | All costs |
| **SKILLED NURSING FACILITY CARE*** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital | | | |
| First 20 days | All approved amounts | $0 | $0 |
| 21st thru 100th day | All but $204 a day | Up to $204 a day | $0 |
| 101st day and after | $0 | $0 | All costs |
| **BLOOD** | | | |
| First 3 pints | $0 | 3 pints | $0 |
| Additional amounts | 100% | $0 | $0 |
| **HOSPICE CARE** | | | |
| You must meet Medicare's requirements, including a doctor's certification of terminal illness. | All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care | Medicare copayment/ coinsurance | $0 |

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

## HIGH DEDUCTIBLE PLAN G

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

*Once you have been billed $240 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

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

| SERVICES | MEDICARE PAYS | AFTER YOU PAY $2,800 DEDUCTIBLE*** PLAN PAYS | IN ADDITION TO $2,800 DEDUCTIBLE*** YOU PAY |
|---|---|---|---|
| **MEDICAL EXPENSES –** IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment | | | |
| First $240 of Medicare-Approved amounts* | $0 | $0 | $240 (Unless Part B Deductible has been met) |
| Remainder of Medicare-Approved amounts | Generally 80% | Generally 20% | $0 |
| **PART B EXCESS CHARGES** (Above Medicare-Approved amounts) | $0 | 100% | $0 |
| **BLOOD** | | | |
| First 3 pints | $0 | All costs | $0 |
| Next $240 of Medicare-Approved amounts* | $0 | $0 | $240 (Unless Part B Deductible has been met) |
| Remainder of Medicare-Approved amounts | 80% | 20% | $0 |
| **CLINICAL LABORATORY SERVICES –** TESTS FOR DIAGNOSTIC SERVICES | 100% | $0 | $0 |

## HIGH DEDUCTIBLE PLAN G

## PARTS A & B

| SERVICES | MEDICARE PAYS | AFTER YOU PAY $2,800 DEDUCTIBLE*** PLAN PAYS | IN ADDITION TO $2,800 DEDUCTIBLE*** YOU PAY |
|---|---|---|---|
| **HOME HEALTH CARE –** MEDICARE APPROVED SERVICES | | | |
| Medically necessary skilled care services and medical supplies | 100% | $0 | $0 |
| Durable medical equipment | | | |
| First $240 of Medicare-Approved amounts* | $0 | $0 | $240 (Unless Part B Deductible has been met) |
| Remainder of Medicare-Approved amounts | 80% | 20% | $0 |

## OTHER BENEFITS – NOT COVERED BY MEDICARE

| SERVICES | MEDICARE PAYS | AFTER YOU PAY $2,800 DEDUCTIBLE*** PLAN PAYS | IN ADDITION TO $2,800 DEDUCTIBLE*** YOU PAY |
|---|---|---|---|
| **FOREIGN TRAVEL – NOT COVERED BY MEDICARE** Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA | | | |
| First $250 each calendar year | $0 | $0 | $250 |
| Remainder of charges | $0 | 80% to a lifetime maximum benefit of $50,000 | 20% and amounts over the $50,000 lifetime maximum |

## PLAN N

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

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

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **HOSPITALIZATION*** Semiprivate room and board, general nursing and miscellaneous services and supplies | | | |
| First 60 days | All but $1,632 | $1,632 (Part A Deductible) | $0 |
| 61st thru 90th day | All but $408 a day | $408 a day | $0 |
| 91st day and after While using 60 lifetime reserve days | All but $816 a day | $816 a day | $0 |
| Once lifetime reserve days are used: | | | |
| Additional 365 days | $0 | 100% of Medicare Eligible Expenses | $0** |
| Beyond the Additional 365 days | $0 | $0 | All costs |
| **SKILLED NURSING FACILITY CARE*** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Approved facility within 30 days after leaving the hospital | | | |
| First 20 days | All approved amounts | $0 | $0 |
| 21st thru 100th day | All but $204 a day | Up to $204 a day | $0 |
| 101st day and after | $0 | $0 | All costs |
| **BLOOD** | | | |
| First 3 pints | $0 | 3 pints | $0 |
| Additional amounts | 100% | $0 | $0 |
| **HOSPICE CARE** | | | |
| You must meet Medicare's requirements, including a doctor's certification of terminal illness. | All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care | Medicare copayment/ coinsurance | $0 |

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

**PLAN N**

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

*Once you have been billed $240 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **MEDICAL EXPENSES** – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment | | | |
| First $240 of Medicare-Approved amounts* | $0 | $0 | $240 (Part B Deductible) |
| Remainder of Medicare-Approved amounts | Generally 80% | Balance, other than up to $20 per office visit and up to $50 per emergency room visit. The co-payment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense. | Up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense. |
| **PART B EXCESS CHARGES** (Above Medicare-Approved amounts) | $0 | $0 | All costs |
| **BLOOD** | | | |
| First 3 pints | $0 | All costs | $0 |
| Next $240 of Medicare-Approved amounts* | $0 | $0 | $240 (Part B Deductible) |
| Remainder of Medicare-Approved amounts | 80% | 20% | $0 |
| **CLINICAL LABORATORY SERVICES** – TESTS FOR DIAGNOSTIC SERVICES | 100% | $0 | $0 |

**PLAN N**

**PARTS A & B**

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| **HOME HEALTH CARE –**<br>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<br>(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 –**<br>**NOT COVERED BY MEDICARE**<br>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 |