800 Crescent Centre Dr.
Suite 200
Franklin, TN 37067
800 264.4000
aetnaseniorproducts.com

Outline of Coverage

Medicare Supplement Insurance

BENEFIT PLANS A, B, F, High Deductible F, G, N

Underwritten by

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

TEXAS

CLIMS01625TX

Rates Effective: 09/2016 A

CONTINENTAL LIFE INSURANCE COMPANY OF BRENTWOOD, TENNESSEE
OUTLINE OF MEDICARE SUPPLEMENT COVERAGE COVER PAGE: Page 1 of 2
BENEFIT PLANS AVAILABLE: A, B, F, HIGH DEDUCTIBLE F, G, N

These charts show the benefits included in each of the standard Medicare supplement plans. Every company must make available Plan "A." Some plans may not be available in your state.

Basic Benefits:
Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
Medical Expenses: Part B coinsurance (generally 20% of Medicare-Approved expenses) or, co-payments for hospital outpatient services. Plans K, L, and N require insureds to pay a portion of coinsurance or copayments
Blood: First three pints of blood each year.
Hospice: Part A coinsurance

A	B	C	D	F/F*	G	K	L	M	N
Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance*	Basic, including 100% Part B coinsurance	Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance, except up to $20 copayment for office visit, and up to $50 copayment for ER
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Part B Deductible		Part B Deductible					
				Part B Excess (100%)	Part B Excess (100%)				
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency			Foreign Travel Emergency	Foreign Travel Emergency
						Out-of-pocket limit $4960; paid at 100% after limit reached	Out-of-pocket limit $2480; paid at 100% after limit reached		

*Plan F also has an option called a high deductible plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2180 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed $2180. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

Continental Life Insurance Company of Brentwood, Tennessee

Annual Attained Age Premiums

For Use in ZIP Codes: 733, 750-753, 760, 761, 774, 776, 777, 782, 784, 793, 794

Female Rates

Rates Effective 09/01/2016

Attained	Preferred					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	8,375	n/a	n/a	n/a	n/a	n/a
65	1,603	1,650	1,975	669	1,352	1,176
66	1,603	1,650	1,975	669	1,352	1,176
67	1,603	1,650	1,975	669	1,352	1,176
68	1,678	1,731	2,075	703	1,418	1,235
69	1,756	1,807	2,154	729	1,482	1,291
70	1,827	1,881	2,232	758	1,541	1,342
71	1,895	1,952	2,312	783	1,600	1,393
72	1,961	2,017	2,382	806	1,654	1,443
73	2,023	2,084	2,450	830	1,705	1,487
74	2,080	2,142	2,508	851	1,756	1,531
75	2,133	2,198	2,567	869	1,801	1,570
76	2,182	2,247	2,617	888	1,841	1,605
77	2,228	2,295	2,660	902	1,881	1,641
78	2,274	2,340	2,703	917	1,917	1,671
79	2,310	2,381	2,742	929	1,950	1,700
80	2,348	2,416	2,774	942	1,983	1,727
81	2,381	2,453	2,811	953	2,010	1,753
82	2,414	2,486	2,847	965	2,038	1,777
83	2,444	2,519	2,881	978	2,063	1,800
84	2,476	2,548	2,914	988	2,090	1,824
85	2,507	2,579	2,947	999	2,115	1,843
86	2,535	2,608	2,979	1,009	2,138	1,863
87	2,560	2,636	3,008	1,020	2,160	1,883
88	2,584	2,661	3,037	1,029	2,183	1,902
89	2,609	2,688	3,059	1,037	2,203	1,922
90	2,632	2,711	3,087	1,047	2,222	1,938
91	2,654	2,735	3,111	1,055	2,241	1,953
92	2,676	2,757	3,130	1,061	2,257	1,968
93	2,694	2,775	3,151	1,067	2,272	1,980
94	2,712	2,792	3,167	1,074	2,289	1,993
95	2,726	2,807	3,182	1,080	2,302	2,004
96	2,744	2,824	3,200	1,086	2,315	2,017
97	2,760	2,841	3,215	1,093	2,330	2,029
98	2,776	2,859	3,233	1,096	2,341	2,040
99	2,792	2,873	3,246	1,099	2,356	2,054

Attained	Standard					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	9,306	n/a	n/a	n/a	n/a	n/a
65	1,779	1,831	2,194	743	1,502	1,308
66	1,779	1,831	2,194	743	1,502	1,308
67	1,779	1,831	2,194	743	1,502	1,308
68	1,866	1,922	2,302	782	1,577	1,374
69	1,950	2,007	2,395	813	1,648	1,435
70	2,027	2,090	2,482	840	1,709	1,493
71	2,107	2,168	2,567	869	1,776	1,548
72	2,179	2,244	2,646	898	1,838	1,603
73	2,247	2,314	2,720	922	1,898	1,653
74	2,310	2,381	2,789	946	1,950	1,701
75	2,370	2,441	2,853	966	2,002	1,741
76	2,427	2,497	2,906	986	2,046	1,783
77	2,476	2,548	2,957	1,003	2,091	1,824
78	2,524	2,599	3,005	1,019	2,131	1,856
79	2,568	2,646	3,045	1,032	2,168	1,887
80	2,609	2,688	3,084	1,045	2,203	1,922
81	2,648	2,726	3,123	1,059	2,234	1,947
82	2,683	2,763	3,164	1,074	2,264	1,975
83	2,719	2,800	3,202	1,086	2,294	1,999
84	2,749	2,832	3,238	1,096	2,323	2,023
85	2,783	2,866	3,276	1,110	2,349	2,047
86	2,816	2,899	3,310	1,121	2,377	2,070
87	2,844	2,929	3,342	1,133	2,400	2,092
88	2,872	2,958	3,371	1,143	2,425	2,111
89	2,899	2,985	3,401	1,153	2,446	2,132
90	2,928	3,012	3,428	1,162	2,470	2,151
91	2,950	3,036	3,452	1,171	2,491	2,169
92	2,973	3,061	3,481	1,180	2,508	2,186
93	2,993	3,082	3,502	1,187	2,527	2,202
94	3,013	3,104	3,519	1,194	2,543	2,217
95	3,030	3,119	3,536	1,198	2,558	2,232
96	3,048	3,138	3,555	1,205	2,573	2,241
97	3,066	3,159	3,572	1,212	2,586	2,253
98	3,083	3,176	3,591	1,219	2,602	2,267
99	3,102	3,196	3,611	1,224	2,619	2,282

Modal Factors: Semi-Annual: 0.5200 Quarterly: 0.2650 Monthly: 0.0833

The above rates do not include the $20 application fee.

To calculate a Household discount:

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

Modal premium x .95 = discounted premium

If applying during Open Enrollment or Guaranteed Issue Period, use Preferred rates.

Continental Life Insurance Company of Brentwood, Tennessee

Annual Attained Age Premiums

For Use in ZIP Codes: 733, 750-753, 760, 761, 774, 776, 777, 782, 784, 793, 794

Male Rates

Rates Effective 09/01/2016

Attained	Preferred					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	9,634	n/a	n/a	n/a	n/a	n/a
65	1,841	1,896	2,272	771	1,555	1,352
66	1,841	1,896	2,272	771	1,555	1,352
67	1,841	1,896	2,272	771	1,555	1,352
68	1,933	1,990	2,382	806	1,628	1,421
69	2,021	2,079	2,478	841	1,704	1,485
70	2,099	2,162	2,568	871	1,771	1,544
71	2,179	2,244	2,657	900	1,838	1,603
72	2,253	2,322	2,742	929	1,903	1,658
73	2,324	2,392	2,813	953	1,964	1,710
74	2,392	2,463	2,890	980	2,019	1,760
75	2,453	2,525	2,953	1,001	2,071	1,806
76	2,509	2,583	3,008	1,020	2,118	1,846
77	2,563	2,640	3,059	1,037	2,162	1,885
78	2,613	2,690	3,108	1,055	2,206	1,924
79	2,658	2,737	3,153	1,067	2,243	1,957
80	2,700	2,782	3,195	1,082	2,278	1,986
81	2,739	2,820	3,233	1,096	2,313	2,015
82	2,777	2,860	3,276	1,110	2,343	2,041
83	2,814	2,898	3,313	1,122	2,375	2,069
84	2,846	2,931	3,351	1,136	2,404	2,093
85	2,880	2,966	3,388	1,150	2,432	2,119
86	2,912	2,999	3,425	1,162	2,459	2,142
87	2,945	3,031	3,460	1,172	2,484	2,164
88	2,974	3,062	3,490	1,185	2,510	2,187
89	3,004	3,094	3,519	1,194	2,533	2,208
90	3,029	3,117	3,547	1,203	2,556	2,226
91	3,052	3,143	3,574	1,212	2,578	2,245
92	3,077	3,167	3,600	1,221	2,597	2,261
93	3,100	3,194	3,621	1,227	2,616	2,278
94	3,118	3,212	3,643	1,234	2,632	2,293
95	3,134	3,230	3,660	1,242	2,647	2,306
96	3,152	3,248	3,678	1,248	2,662	2,320
97	3,172	3,267	3,698	1,254	2,678	2,335
98	3,192	3,286	3,716	1,262	2,694	2,347
99	3,212	3,306	3,736	1,266	2,709	2,363

Attained	Standard					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	10,708	n/a	n/a	n/a	n/a	n/a
65	2,044	2,105	2,525	856	1,726	1,504
66	2,044	2,105	2,525	856	1,726	1,504
67	2,044	2,105	2,525	856	1,726	1,504
68	2,147	2,211	2,651	898	1,811	1,579
69	2,243	2,308	2,752	933	1,893	1,650
70	2,332	2,402	2,853	966	1,969	1,716
71	2,418	2,492	2,953	1,001	2,044	1,780
72	2,507	2,579	3,045	1,032	2,114	1,843
73	2,583	2,660	3,127	1,060	2,180	1,900
74	2,658	2,737	3,207	1,088	2,243	1,957
75	2,726	2,807	3,281	1,112	2,299	2,003
76	2,788	2,869	3,343	1,133	2,353	2,052
77	2,849	2,935	3,401	1,153	2,404	2,093
78	2,903	2,989	3,452	1,170	2,450	2,134
79	2,954	3,043	3,503	1,187	2,493	2,171
80	3,002	3,091	3,545	1,203	2,532	2,208
81	3,045	3,135	3,593	1,219	2,568	2,238
82	3,084	3,177	3,637	1,233	2,604	2,269
83	3,125	3,218	3,682	1,249	2,638	2,299
84	3,165	3,257	3,725	1,263	2,669	2,329
85	3,200	3,297	3,766	1,278	2,703	2,354
86	3,237	3,334	3,804	1,289	2,734	2,379
87	3,268	3,368	3,840	1,302	2,761	2,406
88	3,304	3,401	3,878	1,314	2,788	2,431
89	3,335	3,433	3,912	1,326	2,815	2,453
90	3,365	3,464	3,945	1,337	2,842	2,476
91	3,393	3,494	3,973	1,347	2,865	2,496
92	3,418	3,520	3,999	1,355	2,884	2,516
93	3,441	3,543	4,023	1,364	2,905	2,532
94	3,463	3,566	4,046	1,371	2,924	2,548
95	3,485	3,589	4,065	1,379	2,942	2,562
96	3,504	3,610	4,088	1,385	2,959	2,577
97	3,526	3,633	4,108	1,392	2,975	2,593
98	3,549	3,654	4,129	1,400	2,992	2,609
99	3,568	3,675	4,149	1,409	3,012	2,623

Modal Factors: Semi-Annual: 0.5200 Quarterly: 0.2650 Monthly: 0.0833

The above rates do not include the $20 application fee.

To calculate a Household discount:

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

Modal premium x .95 = discounted premium

If applying during Open Enrollment or Guaranteed Issue Period, use Preferred rates.

Continental Life Insurance Company of Brentwood, Tennessee

Annual Attained Age Premiums

For Use in ZIP Codes: 770-773, 775

Female Rates

Rates Effective 09/01/2016

Attained Age	Preferred					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	8,812	n/a	n/a	n/a	n/a	n/a
65	1,687	1,736	2,078	704	1,423	1,238
66	1,687	1,736	2,078	704	1,423	1,238
67	1,687	1,736	2,078	704	1,423	1,238
68	1,765	1,821	2,183	739	1,492	1,300
69	1,848	1,901	2,266	767	1,560	1,359
70	1,923	1,980	2,349	797	1,621	1,412
71	1,994	2,053	2,432	824	1,683	1,465
72	2,063	2,122	2,506	848	1,740	1,519
73	2,128	2,193	2,577	874	1,794	1,565
74	2,189	2,254	2,639	895	1,848	1,611
75	2,245	2,312	2,701	915	1,895	1,652
76	2,295	2,364	2,754	934	1,937	1,689
77	2,344	2,415	2,799	949	1,980	1,727
78	2,392	2,462	2,844	964	2,017	1,758
79	2,431	2,505	2,885	978	2,052	1,788
80	2,471	2,542	2,919	991	2,086	1,817
81	2,505	2,581	2,957	1,003	2,115	1,844
82	2,540	2,616	2,996	1,015	2,144	1,869
83	2,571	2,650	3,031	1,029	2,171	1,894
84	2,605	2,681	3,066	1,039	2,199	1,919
85	2,638	2,714	3,101	1,051	2,225	1,940
86	2,667	2,744	3,134	1,061	2,249	1,960
87	2,693	2,773	3,165	1,073	2,272	1,981
88	2,719	2,800	3,196	1,083	2,297	2,001
89	2,745	2,828	3,219	1,091	2,318	2,022
90	2,770	2,852	3,248	1,101	2,338	2,039
91	2,793	2,877	3,273	1,110	2,358	2,055
92	2,816	2,900	3,294	1,117	2,375	2,070
93	2,835	2,920	3,315	1,123	2,391	2,084
94	2,853	2,938	3,332	1,130	2,408	2,097
95	2,868	2,954	3,348	1,136	2,422	2,109
96	2,887	2,972	3,367	1,142	2,436	2,122
97	2,904	2,989	3,383	1,150	2,451	2,134
98	2,921	3,008	3,401	1,153	2,464	2,147
99	2,938	3,023	3,416	1,157	2,479	2,161

Attained Age	Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	9,791	n/a	n/a	n/a	n/a	n/a
65	1,872	1,926	2,309	782	1,580	1,376
66	1,872	1,926	2,309	782	1,580	1,376
67	1,872	1,926	2,309	782	1,580	1,376
68	1,964	2,022	2,422	823	1,659	1,446
69	2,052	2,111	2,520	855	1,734	1,510
70	2,133	2,199	2,611	883	1,798	1,571
71	2,217	2,281	2,701	915	1,868	1,629
72	2,293	2,361	2,784	945	1,934	1,687
73	2,364	2,435	2,862	970	1,997	1,739
74	2,431	2,505	2,934	996	2,052	1,790
75	2,494	2,569	3,002	1,016	2,107	1,832
76	2,553	2,627	3,058	1,037	2,153	1,876
77	2,605	2,681	3,111	1,055	2,200	1,919
78	2,656	2,735	3,162	1,072	2,242	1,953
79	2,702	2,784	3,204	1,085	2,281	1,986
80	2,745	2,828	3,245	1,100	2,318	2,022
81	2,787	2,868	3,286	1,114	2,351	2,049
82	2,823	2,908	3,329	1,130	2,382	2,078
83	2,860	2,946	3,369	1,142	2,414	2,103
84	2,892	2,980	3,407	1,153	2,444	2,128
85	2,928	3,015	3,447	1,168	2,472	2,154
86	2,963	3,050	3,482	1,180	2,501	2,178
87	2,992	3,082	3,516	1,192	2,525	2,201
88	3,021	3,112	3,547	1,203	2,552	2,222
89	3,050	3,141	3,578	1,214	2,574	2,243
90	3,081	3,169	3,607	1,222	2,599	2,263
91	3,104	3,194	3,632	1,232	2,621	2,282
92	3,128	3,221	3,663	1,241	2,639	2,300
93	3,150	3,243	3,684	1,249	2,658	2,317
94	3,170	3,266	3,703	1,256	2,675	2,333
95	3,188	3,282	3,721	1,261	2,691	2,349
96	3,207	3,302	3,740	1,268	2,707	2,358
97	3,226	3,324	3,758	1,275	2,721	2,370
98	3,244	3,342	3,779	1,283	2,738	2,385
99	3,263	3,363	3,799	1,287	2,755	2,401

Modal Factors: Semi-Annual: 0.5200 Quarterly: 0.2650 Monthly: 0.0833

The above rates do not include the $20 application fee.

To calculate a Household discount:

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

Modal premium x .95 = discounted premium

If applying during Open Enrollment or Guaranteed Issue Period, use Preferred rates.

Continental Life Insurance Company of Brentwood, Tennessee

Annual Attained Age Premiums

For Use in ZIP Codes: 770-773, 775

Male Rates

Rates Effective 09/01/2016

Attained Age	Preferred						Attained Age	Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N		Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	10,136	n/a	n/a	n/a	n/a	n/a	Under 65	11,266	n/a	n/a	n/a	n/a	n/a
65	1,937	1,995	2,391	811	1,636	1,423	65	2,150	2,214	2,657	900	1,816	1,583
66	1,937	1,995	2,391	811	1,636	1,423	66	2,150	2,214	2,657	900	1,816	1,583
67	1,937	1,995	2,391	811	1,636	1,423	67	2,150	2,214	2,657	900	1,816	1,583
68	2,034	2,093	2,506	848	1,713	1,496	68	2,259	2,327	2,789	945	1,906	1,661
69	2,126	2,188	2,608	885	1,793	1,562	69	2,360	2,428	2,896	981	1,992	1,736
70	2,208	2,275	2,702	916	1,863	1,625	70	2,454	2,528	3,002	1,016	2,072	1,805
71	2,293	2,361	2,795	947	1,934	1,687	71	2,545	2,622	3,107	1,053	2,150	1,873
72	2,370	2,443	2,885	978	2,003	1,745	72	2,638	2,714	3,204	1,085	2,224	1,940
73	2,445	2,517	2,960	1,003	2,067	1,799	73	2,718	2,799	3,290	1,116	2,294	1,999
74	2,517	2,592	3,041	1,031	2,125	1,851	74	2,796	2,880	3,375	1,145	2,360	2,059
75	2,581	2,657	3,107	1,053	2,179	1,900	75	2,868	2,954	3,452	1,170	2,419	2,108
76	2,640	2,718	3,165	1,073	2,229	1,942	76	2,933	3,019	3,517	1,192	2,476	2,159
77	2,697	2,778	3,219	1,091	2,275	1,983	77	2,997	3,088	3,578	1,214	2,529	2,202
78	2,749	2,830	3,271	1,110	2,321	2,024	78	3,054	3,145	3,632	1,231	2,577	2,246
79	2,796	2,880	3,318	1,123	2,360	2,059	79	3,108	3,202	3,686	1,249	2,623	2,284
80	2,841	2,927	3,361	1,139	2,397	2,090	80	3,158	3,252	3,730	1,266	2,664	2,323
81	2,882	2,967	3,401	1,153	2,433	2,120	81	3,204	3,298	3,780	1,283	2,702	2,355
82	2,922	3,009	3,447	1,168	2,465	2,148	82	3,245	3,343	3,827	1,297	2,739	2,387
83	2,961	3,049	3,486	1,181	2,499	2,177	83	3,288	3,386	3,874	1,314	2,776	2,419
84	2,995	3,084	3,526	1,195	2,529	2,202	84	3,330	3,427	3,919	1,329	2,808	2,450
85	3,030	3,121	3,565	1,210	2,559	2,230	85	3,367	3,469	3,963	1,344	2,844	2,477
86	3,064	3,156	3,603	1,222	2,587	2,254	86	3,406	3,508	4,003	1,356	2,876	2,503
87	3,099	3,190	3,641	1,233	2,614	2,277	87	3,439	3,544	4,040	1,370	2,905	2,531
88	3,129	3,222	3,672	1,246	2,641	2,301	88	3,476	3,578	4,080	1,383	2,933	2,558
89	3,161	3,255	3,703	1,256	2,666	2,323	89	3,509	3,612	4,116	1,395	2,962	2,581
90	3,187	3,279	3,732	1,266	2,690	2,343	90	3,540	3,645	4,150	1,407	2,990	2,605
91	3,211	3,307	3,761	1,275	2,713	2,362	91	3,570	3,676	4,181	1,417	3,014	2,626
92	3,238	3,332	3,787	1,285	2,732	2,379	92	3,596	3,704	4,207	1,425	3,035	2,647
93	3,262	3,360	3,810	1,291	2,753	2,397	93	3,620	3,728	4,233	1,435	3,056	2,664
94	3,280	3,380	3,833	1,298	2,770	2,413	94	3,643	3,752	4,257	1,442	3,077	2,681
95	3,297	3,399	3,851	1,307	2,785	2,426	95	3,666	3,776	4,277	1,451	3,095	2,696
96	3,317	3,417	3,870	1,313	2,801	2,441	96	3,687	3,798	4,302	1,457	3,113	2,712
97	3,337	3,438	3,891	1,319	2,818	2,456	97	3,710	3,822	4,322	1,464	3,130	2,729
98	3,359	3,457	3,910	1,327	2,835	2,470	98	3,734	3,844	4,344	1,473	3,148	2,745
99	3,380	3,479	3,931	1,332	2,851	2,487	99	3,755	3,867	4,366	1,482	3,169	2,760

Modal Factors: Semi-Annual: 0.5200 Quarterly: 0.2650 Monthly: 0.0833

The above rates do not include the $20 application fee.

To calculate a Household discount:

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

Modal premium x .95 = discounted premium

If applying during Open Enrollment or Guaranteed Issue Period, use Preferred rates.

Continental Life Insurance Company of Brentwood, Tennessee

Annual Attained Age Premiums

For Use in ZIP Codes: Rest of State

Female Rates

Rates Effective 09/01/2016

Attained	Preferred					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	7,283	n/a	n/a	n/a	n/a	n/a
65	1,394	1,435	1,717	582	1,176	1,023
66	1,394	1,435	1,717	582	1,176	1,023
67	1,394	1,435	1,717	582	1,176	1,023
68	1,459	1,505	1,804	611	1,233	1,074
69	1,527	1,571	1,873	634	1,289	1,123
70	1,589	1,636	1,941	659	1,340	1,167
71	1,648	1,697	2,010	681	1,391	1,211
72	1,705	1,754	2,071	701	1,438	1,255
73	1,759	1,812	2,130	722	1,483	1,293
74	1,809	1,863	2,181	740	1,527	1,331
75	1,855	1,911	2,232	756	1,566	1,365
76	1,897	1,954	2,276	772	1,601	1,396
77	1,937	1,996	2,313	784	1,636	1,427
78	1,977	2,035	2,350	797	1,667	1,453
79	2,009	2,070	2,384	808	1,696	1,478
80	2,042	2,101	2,412	819	1,724	1,502
81	2,070	2,133	2,444	829	1,748	1,524
82	2,099	2,162	2,476	839	1,772	1,545
83	2,125	2,190	2,505	850	1,794	1,565
84	2,153	2,216	2,534	859	1,817	1,586
85	2,180	2,243	2,563	869	1,839	1,603
86	2,204	2,268	2,590	877	1,859	1,620
87	2,226	2,292	2,616	887	1,878	1,637
88	2,247	2,314	2,641	895	1,898	1,654
89	2,269	2,337	2,660	902	1,916	1,671
90	2,289	2,357	2,684	910	1,932	1,685
91	2,308	2,378	2,705	917	1,949	1,698
92	2,327	2,397	2,722	923	1,963	1,711
93	2,343	2,413	2,740	928	1,976	1,722
94	2,358	2,428	2,754	934	1,990	1,733
95	2,370	2,441	2,767	939	2,002	1,743
96	2,386	2,456	2,783	944	2,013	1,754
97	2,400	2,470	2,796	950	2,026	1,764
98	2,414	2,486	2,811	953	2,036	1,774
99	2,428	2,498	2,823	956	2,049	1,786

Attained	Standard					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	8,092	n/a	n/a	n/a	n/a	n/a
65	1,547	1,592	1,908	646	1,306	1,137
66	1,547	1,592	1,908	646	1,306	1,137
67	1,547	1,592	1,908	646	1,306	1,137
68	1,623	1,671	2,002	680	1,371	1,195
69	1,696	1,745	2,083	707	1,433	1,248
70	1,763	1,817	2,158	730	1,486	1,298
71	1,832	1,885	2,232	756	1,544	1,346
72	1,895	1,951	2,301	781	1,598	1,394
73	1,954	2,012	2,365	802	1,650	1,437
74	2,009	2,070	2,425	823	1,696	1,479
75	2,061	2,123	2,481	840	1,741	1,514
76	2,110	2,171	2,527	857	1,779	1,550
77	2,153	2,216	2,571	872	1,818	1,586
78	2,195	2,260	2,613	886	1,853	1,614
79	2,233	2,301	2,648	897	1,885	1,641
80	2,269	2,337	2,682	909	1,916	1,671
81	2,303	2,370	2,716	921	1,943	1,693
82	2,333	2,403	2,751	934	1,969	1,717
83	2,364	2,435	2,784	944	1,995	1,738
84	2,390	2,463	2,816	953	2,020	1,759
85	2,420	2,492	2,849	965	2,043	1,780
86	2,449	2,521	2,878	975	2,067	1,800
87	2,473	2,547	2,906	985	2,087	1,819
88	2,497	2,572	2,931	994	2,109	1,836
89	2,521	2,596	2,957	1,003	2,127	1,854
90	2,546	2,619	2,981	1,010	2,148	1,870
91	2,565	2,640	3,002	1,018	2,166	1,886
92	2,585	2,662	3,027	1,026	2,181	1,901
93	2,603	2,680	3,045	1,032	2,197	1,915
94	2,620	2,699	3,060	1,038	2,211	1,928
95	2,635	2,712	3,075	1,042	2,224	1,941
96	2,650	2,729	3,091	1,048	2,237	1,949
97	2,666	2,747	3,106	1,054	2,249	1,959
98	2,681	2,762	3,123	1,060	2,263	1,971
99	2,697	2,779	3,140	1,064	2,277	1,984

Modal Factors: Semi-Annual: 0.5200 Quarterly: 0.2650 Monthly: 0.0833

The above rates do not include the $20 application fee.

To calculate a Household discount:

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

Modal premium x .95 = discounted premium

If applying during Open Enrollment or Guaranteed Issue Period, use Preferred rates.

Continental Life Insurance Company of Brentwood, Tennessee

Annual Attained Age Premiums

For Use in ZIP Codes: Rest of State

Male Rates

Rates Effective 09/01/2016

Attained Age	Preferred					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	8,377	n/a	n/a	n/a	n/a	n/a
65	1,601	1,649	1,976	670	1,352	1,176
66	1,601	1,649	1,976	670	1,352	1,176
67	1,601	1,649	1,976	670	1,352	1,176
68	1,681	1,730	2,071	701	1,416	1,236
69	1,757	1,808	2,155	731	1,482	1,291
70	1,825	1,880	2,233	757	1,540	1,343
71	1,895	1,951	2,310	783	1,598	1,394
72	1,959	2,019	2,384	808	1,655	1,442
73	2,021	2,080	2,446	829	1,708	1,487
74	2,080	2,142	2,513	852	1,756	1,530
75	2,133	2,196	2,568	870	1,801	1,570
76	2,182	2,246	2,616	887	1,842	1,605
77	2,229	2,296	2,660	902	1,880	1,639
78	2,272	2,339	2,703	917	1,918	1,673
79	2,311	2,380	2,742	928	1,950	1,702
80	2,348	2,419	2,778	941	1,981	1,727
81	2,382	2,452	2,811	953	2,011	1,752
82	2,415	2,487	2,849	965	2,037	1,775
83	2,447	2,520	2,881	976	2,065	1,799
84	2,475	2,549	2,914	988	2,090	1,820
85	2,504	2,579	2,946	1,000	2,115	1,843
86	2,532	2,608	2,978	1,010	2,138	1,863
87	2,561	2,636	3,009	1,019	2,160	1,882
88	2,586	2,663	3,035	1,030	2,183	1,902
89	2,612	2,690	3,060	1,038	2,203	1,920
90	2,634	2,710	3,084	1,046	2,223	1,936
91	2,654	2,733	3,108	1,054	2,242	1,952
92	2,676	2,754	3,130	1,062	2,258	1,966
93	2,696	2,777	3,149	1,067	2,275	1,981
94	2,711	2,793	3,168	1,073	2,289	1,994
95	2,725	2,809	3,183	1,080	2,302	2,005
96	2,741	2,824	3,198	1,085	2,315	2,017
97	2,758	2,841	3,216	1,090	2,329	2,030
98	2,776	2,857	3,231	1,097	2,343	2,041
99	2,793	2,875	3,249	1,101	2,356	2,055

Attained Age	Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	9,311	n/a	n/a	n/a	n/a	n/a
65	1,777	1,830	2,196	744	1,501	1,308
66	1,777	1,830	2,196	744	1,501	1,308
67	1,777	1,830	2,196	744	1,501	1,308
68	1,867	1,923	2,305	781	1,575	1,373
69	1,950	2,007	2,393	811	1,646	1,435
70	2,028	2,089	2,481	840	1,712	1,492
71	2,103	2,167	2,568	870	1,777	1,548
72	2,180	2,243	2,648	897	1,838	1,603
73	2,246	2,313	2,719	922	1,896	1,652
74	2,311	2,380	2,789	946	1,950	1,702
75	2,370	2,441	2,853	967	1,999	1,742
76	2,424	2,495	2,907	985	2,046	1,784
77	2,477	2,552	2,957	1,003	2,090	1,820
78	2,524	2,599	3,002	1,017	2,130	1,856
79	2,569	2,646	3,046	1,032	2,168	1,888
80	2,610	2,688	3,083	1,046	2,202	1,920
81	2,648	2,726	3,124	1,060	2,233	1,946
82	2,682	2,763	3,163	1,072	2,264	1,973
83	2,717	2,798	3,202	1,086	2,294	1,999
84	2,752	2,832	3,239	1,098	2,321	2,025
85	2,783	2,867	3,275	1,111	2,350	2,047
86	2,815	2,899	3,308	1,121	2,377	2,069
87	2,842	2,929	3,339	1,132	2,401	2,092
88	2,873	2,957	3,372	1,143	2,424	2,114
89	2,900	2,985	3,402	1,153	2,448	2,133
90	2,926	3,012	3,430	1,163	2,471	2,153
91	2,950	3,038	3,455	1,171	2,491	2,170
92	2,972	3,061	3,477	1,178	2,508	2,188
93	2,992	3,081	3,498	1,186	2,526	2,202
94	3,011	3,101	3,518	1,192	2,543	2,216
95	3,030	3,121	3,535	1,199	2,558	2,228
96	3,047	3,139	3,555	1,204	2,573	2,241
97	3,066	3,159	3,572	1,210	2,587	2,255
98	3,086	3,177	3,590	1,217	2,602	2,269
99	3,103	3,196	3,608	1,225	2,619	2,281

Modal Factors: Semi-Annual: 0.5200 Quarterly: 0.2650 Monthly: 0.0833

The above rates do not include the $20 application fee.

To calculate a Household discount:

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

Modal premium x .95 = discounted premium

If applying during Open Enrollment or Guaranteed Issue Period, use Preferred rates.

PREMIUM INFORMATION

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

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

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

HOUSEHOLD DISCOUNT

In order to be eligible for the Household discount under a Continental Life Insurance Company of Brentwood, Tennessee Medicare supplement plan, you must apply for a Medicare supplement plan at the same time as another Medicare eligible adult or the other Medicare eligible adult must currently be covered by a Continental Life Insurance Company of Brentwood, Tennessee Medicare supplement policy. The Medicare eligible adult must be either (a) your spouse; or (b) be a permanent resident in your home. The household discount will only be applicable if a policy for each applicant is issued. The discounted rate will be 5 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.

LIMITATIONS AND EXCLUSIONS

This policy does not cover any expenses of the type excluded by Medicare or not covered under the terms of this policy.

Benefits covered by this policy will not duplicate Medicare benefits.

We will not be liable for any loss which was caused by your committing or attempting to commit any felony or from engaging in an illegal occupation.

REFUND OF PREMIUM

The company shall refund any premium paid for the period beyond the end of the policy month in which the death or cancellation occurred. Unearned premium shall be paid in a lump sum to your estate no later than thirty (30) days after receipt of proof of death or cancellation is received by the company.

COMPLETE ANSWERS ARE VERY IMPORTANT

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

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

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

PLAN A

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

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

**$0 Indicates your liability for covered charges. You are responsible for all other non-covered charges.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1288	$0	$1288 (Part A Deductible)
61st thru 90th day	All but $322 a day	$322 a day	$0**
91st day and after:			
While using 60 lifetime reserve days	All but $644 a day	$644 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 $161.00 a day	$0	Up to $161.00 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 $166 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.

**$0 Indicates your liability for covered charges. You are responsible for all other non-covered charges.

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 test, durable medical equipment			
First $166 of Medicare-Approved amounts*	$0	$0	$166 (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 $166 of Medicare-Approved amounts*	$0	$0	$166 (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 $166 of Medicare Approved amounts*	$0	$0	$166 (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.

**$0 Indicates your liability for covered charges. You are responsible for all other non-covered charges.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1288	$1288 (Part A Deductible)	$0**
61st thru 90th day	All but $322 a day	$322 a day	$0**
91st day and after:			
While using 60 lifetime reserve days	All but $644 a day	$644 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 $161.00 a day	$0	Up to $161.00 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 $166 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.

**$0 Indicates your liability for covered charges. You are responsible for all other non-covered charges.

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 test, durable medical equipment			
First $166 of Medicare-Approved amounts*	$0	$0	$166 (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 $166 of Medicare-Approved amounts*	$0	$0	$166 (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 $166 of Medicare Approved amounts*	$0	$0	$166 (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.

**$0 Indicates your liability for covered charges. You are responsible for all other non-covered charges.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1288	$1288 (Part A Deductible)	$0**
61st thru 90th day	All but $322 a day	$322 a day	$0**
91st day and after			
While using 60 lifetime reserve days	All but $644 a day	$644 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 $161.00 a day	Up to $161.00 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 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 $166 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.

**$0 Indicates your liability for covered charges. You are responsible for all other non-covered charges.

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 test, durable medical equipment			
First $166 of Medicare-Approved amounts*	$0	$166 (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 $166 of Medicare-Approved amounts*	$0	$166 (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 $166 of Medicare Approved amounts*	$0	$166 (Part B Deductible)	$0**
Remainder of Medicare Approved amounts	80%	20%	$0**

PLAN F

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

HIGH DEDUCTIBLE PLAN F

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

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

**$0 Indicates your liability for covered charges. You are responsible for all other non-covered charges.

*****This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2180 deductible. Benefits from high deductible Plan F will not begin until out-of-pocket expenses are $2180. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.**

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2180 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2180 DEDUCTIBLE*** YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1288	$1288 (Part A Deductible)	$0**
61st thru 90th day	All but $322 a day	$322 a day	$0**
91st day and after			
While using 60 lifetime reserve days	All but $644 a day	$644 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 $161.00 a day	Up to $161.00 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 Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

HIGH DEDUCTIBLE PLAN F

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

*Once you have been billed $166 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.

**$0 Indicates your liability for covered charges. You are responsible for all other non-covered charges.

****This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2180 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed $2180. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.**

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2180 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2180 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 test, durable medical equipment			
First $166 of Medicare-Approved amounts*	$0	$166 (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 $166 of Medicare-Approved amounts*	$0	$166 (Part B Deductible)	$0**
Remainder of Medicare-Approved amounts	80%	20%	$0**
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0**

HIGH DEDUCTIBLE PLAN F

PARTS A & B

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2180 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2180 DEDUCTIBLE*** YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0**
Durable medical equipment			
First $166 of Medicare Approved amounts*	$0	$166 (Part B Deductible)	$0**
Remainder of Medicare Approved amounts	80%	20%	$0**

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2180 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2180 DEDUCTIBLE*** YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN G

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

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

**$0 Indicates your liability for covered charges. You are responsible for all other non-covered charges.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1288	$1288 (Part A Deductible)	$0**
61st thru 90th day	All but $322 a day	$322 a day	$0**
91st day and after			
While using 60 lifetime reserve days	All but $644 a day	$644 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 $161.00 a day	Up to $161.00 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 services	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 $166 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.

**$0 Indicates your liability for covered charges. You are responsible for all other non-covered charges.

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 test, durable medical equipment			
First $166 of Medicare-Approved amounts*	$0	$0	$166 (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 $166 of Medicare-Approved amounts*	$0	$0	$166 (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 $166 of Medicare Approved amounts*	$0	$0	$166 (Part B Deductible)
Remainder of Medicare Approved amounts	80%	20%	$0**

PLAN G

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

PLAN N

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

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

**$0 Indicates your liability for covered charges. You are responsible for all other non-covered charges.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1288	$1288 (Part A Deductible)	$0**
61st thru 90th day	All but $322 a day	$322 a day	$0**
91st day and after			
While using 60 lifetime reserve days	All but $644 a day	$644 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 $161.00 a day	Up to $161.00 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 co-payment/ 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 $166 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.

**$0 Indicates your liability for covered charges. You are responsible for all other non-covered charges.

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 test, durable medical equipment			
First $166 of Medicare-Approved amounts*	$0	$0	$166 (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 $166 of Medicare-Approved amounts*	$0	$0	$166 (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 $166 of Medicare Approved amounts*	$0	$0	$166 (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