



Outline of coverage

Medicare Supplement Insurance

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

Michigan

Underwritten by

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

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

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

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

Benefits	Plans Available to All Applicants								Medicare first eligible before 2020 only	
	A	B	D	G ¹	K	L	M	N	C	F ¹
Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Medicare Part B coinsurance or copayment	✓	✓	✓	✓	50%	75%	✓	✓ copays apply ³	✓	✓
Blood (first three pints)	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Part A hospice care coinsurance or copayment	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Skilled nursing facility coinsurance			✓	✓	50%	75%	✓	✓	✓	✓
Medicare Part A deductible		✓	✓	✓	50%	75%	50%	✓	✓	✓
Medicare Part B deductible									✓	✓
Medicare Part B excess charges				✓						✓
Foreign travel emergency (up to plan limits)			✓	✓			✓	✓	✓	✓
Out-of-pocket limit in 2026 ²					\$8,000²	\$4,000²				

¹ Plans F and G also have a high deductible option, which require first paying a plan deductible of **\$2,950** before the plan begins to pay. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High deductible plan G does not cover the Medicare Part B deductible. However, high deductible plans F and G count your payment of the Medicare Part B deductible toward meeting the plan deductible.

² Plans K and L pay 100% of covered services for the rest of the calendar year once you meet the out-of-pocket yearly limit.

³ Plan N pays 100% of the Part B coinsurance, except for a copayment of up to \$20 for some office visits and up to a \$50 copayment for emergency room visits that do not result in an inpatient admission.

Continental Life Insurance Company of Brentwood, Tennessee

Annual premiums

For Use in ZIP Codes: 480-485

Female rates

Rates effective 5/1/2026

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
65	2,303	2,471	2,867	2,359	778	1,803
66	2,303	2,471	2,867	2,359	778	1,803
67	2,303	2,471	2,867	2,359	778	1,803
68	2,329	2,500	2,899	2,386	787	1,868
69	2,383	2,556	2,966	2,441	805	1,943
70	2,444	2,623	3,043	2,506	826	2,018
71	2,519	2,701	3,134	2,582	850	2,089
72	2,599	2,788	3,233	2,658	877	2,161
73	2,682	2,876	3,338	2,747	904	2,235
74	2,773	2,978	3,454	2,843	938	2,308
75	2,873	3,083	3,575	2,944	970	2,385
76	2,972	3,192	3,699	3,045	1,004	2,461
77	3,077	3,304	3,830	3,155	1,039	2,544
78	3,183	3,415	3,960	3,261	1,075	2,627
79	3,282	3,521	4,083	3,364	1,109	2,712
80	3,386	3,630	4,215	3,468	1,144	2,802
81	3,492	3,745	4,346	3,578	1,179	2,890
82	3,595	3,856	4,477	3,686	1,214	2,976
83	3,706	3,976	4,613	3,798	1,252	3,068
84	3,815	4,094	4,747	3,906	1,288	3,157
85	3,953	4,242	4,921	4,050	1,336	3,272
86	4,066	4,365	5,063	4,166	1,374	3,365
87	4,181	4,486	5,205	4,285	1,412	3,464
88	4,297	4,612	5,353	4,404	1,452	3,556
89	4,420	4,740	5,502	4,525	1,492	3,655
90	4,540	4,871	5,652	4,652	1,534	3,759
91	4,664	5,004	5,805	4,779	1,575	3,859
92	4,789	5,139	5,961	4,907	1,618	3,964
93	4,918	5,275	6,120	5,036	1,659	4,070
94	5,047	5,414	6,281	5,169	1,704	4,176
95	5,179	5,556	6,446	5,306	1,748	4,287
96	5,314	5,700	6,615	5,441	1,795	4,397
97	5,449	5,844	6,781	5,582	1,841	4,509
98	5,585	5,994	6,952	5,721	1,886	4,625
99+	5,727	6,141	7,126	5,866	1,934	4,740

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
65	2,558	2,749	3,185	2,624	865	2,004
66	2,558	2,749	3,185	2,624	865	2,004
67	2,558	2,749	3,185	2,624	865	2,004
68	2,588	2,774	3,222	2,651	874	2,076
69	2,646	2,838	3,294	2,708	895	2,161
70	2,717	2,916	3,379	2,784	917	2,241
71	2,797	3,001	3,482	2,866	947	2,320
72	2,885	3,096	3,593	2,957	974	2,402
73	2,979	3,195	3,708	3,052	1,007	2,483
74	3,084	3,309	3,838	3,160	1,042	2,567
75	3,193	3,423	3,972	3,268	1,077	2,650
76	3,304	3,545	4,110	3,386	1,118	2,733
77	3,418	3,670	4,257	3,506	1,155	2,827
78	3,536	3,794	4,402	3,625	1,193	2,918
79	3,645	3,913	4,541	3,738	1,232	3,013
80	3,760	4,035	4,681	3,854	1,270	3,116
81	3,881	4,163	4,829	3,975	1,312	3,210
82	3,996	4,286	4,974	4,091	1,349	3,307
83	4,120	4,421	5,128	4,219	1,391	3,409
84	4,240	4,547	5,275	4,342	1,430	3,509
85	4,391	4,712	5,468	4,499	1,484	3,636
86	4,516	4,847	5,625	4,629	1,526	3,739
87	4,646	4,986	5,783	4,760	1,568	3,848
88	4,778	5,125	5,945	4,893	1,613	3,954
89	4,911	5,266	6,112	5,030	1,658	4,061
90	5,045	5,412	6,279	5,168	1,704	4,176
91	5,183	5,561	6,450	5,311	1,751	4,290
92	5,322	5,711	6,623	5,452	1,797	4,405
93	5,463	5,861	6,800	5,599	1,845	4,521
94	5,605	6,016	6,981	5,744	1,895	4,642
95	5,752	6,174	7,161	5,897	1,943	4,765
96	5,902	6,335	7,348	6,046	1,993	4,884
97	6,055	6,494	7,534	6,204	2,045	5,009
98	6,206	6,660	7,725	6,357	2,095	5,139
99+	6,362	6,823	7,919	6,520	2,148	5,266

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: 480-485

Male rates

Rates effective 5/1/2026

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
65	2,651	2,843	3,295	2,717	895	2,075
66	2,651	2,843	3,295	2,717	895	2,075
67	2,651	2,843	3,295	2,717	895	2,075
68	2,680	2,872	3,334	2,741	904	2,147
69	2,738	2,939	3,412	2,806	926	2,236
70	2,813	3,018	3,500	2,882	949	2,320
71	2,899	3,109	3,605	2,968	980	2,403
72	2,985	3,205	3,720	3,061	1,008	2,484
73	3,084	3,310	3,838	3,160	1,041	2,571
74	3,193	3,423	3,974	3,268	1,078	2,656
75	3,304	3,545	4,114	3,386	1,115	2,741
76	3,418	3,670	4,255	3,505	1,155	2,828
77	3,536	3,799	4,407	3,626	1,197	2,924
78	3,662	3,927	4,554	3,753	1,236	3,020
79	3,776	4,050	4,699	3,870	1,276	3,120
80	3,893	4,177	4,846	3,988	1,315	3,223
81	4,017	4,308	4,997	4,116	1,355	3,323
82	4,135	4,437	5,150	4,236	1,396	3,423
83	4,265	4,575	5,305	4,366	1,440	3,529
84	4,387	4,706	5,462	4,496	1,481	3,632
85	4,545	4,878	5,660	4,658	1,536	3,766
86	4,676	5,018	5,819	4,792	1,580	3,871
87	4,808	5,159	5,984	4,929	1,623	3,980
88	4,942	5,303	6,154	5,067	1,670	4,093
89	5,078	5,450	6,327	5,206	1,717	4,204
90	5,218	5,602	6,498	5,348	1,763	4,324
91	5,362	5,754	6,673	5,494	1,810	4,440
92	5,507	5,908	6,855	5,644	1,859	4,562
93	5,653	6,065	7,037	5,794	1,909	4,679
94	5,804	6,228	7,222	5,945	1,962	4,804
95	5,951	6,390	7,414	6,100	2,011	4,930
96	6,110	6,555	7,603	6,256	2,063	5,056
97	6,265	6,722	7,799	6,420	2,115	5,185
98	6,421	6,892	7,995	6,581	2,169	5,318
99+	6,583	7,064	8,196	6,745	2,223	5,450

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
65	2,945	3,162	3,661	3,018	996	2,306
66	2,945	3,162	3,661	3,018	996	2,306
67	2,945	3,162	3,661	3,018	996	2,306
68	2,978	3,193	3,704	3,050	1,004	2,388
69	3,044	3,266	3,791	3,117	1,031	2,484
70	3,126	3,350	3,889	3,203	1,055	2,577
71	3,216	3,453	4,006	3,298	1,089	2,669
72	3,317	3,562	4,132	3,399	1,121	2,762
73	3,425	3,677	4,265	3,510	1,157	2,855
74	3,548	3,804	4,415	3,634	1,199	2,952
75	3,670	3,937	4,569	3,758	1,238	3,045
76	3,799	4,077	4,725	3,892	1,285	3,145
77	3,931	4,220	4,896	4,031	1,330	3,249
78	4,067	4,365	5,063	4,169	1,373	3,357
79	4,194	4,498	5,222	4,298	1,419	3,465
80	4,327	4,641	5,384	4,431	1,460	3,582
81	4,463	4,786	5,553	4,573	1,507	3,694
82	4,596	4,931	5,718	4,707	1,551	3,803
83	4,736	5,085	5,894	4,853	1,599	3,920
84	4,876	5,230	6,066	4,992	1,646	4,035
85	5,051	5,417	6,289	5,175	1,707	4,183
86	5,194	5,578	6,467	5,323	1,756	4,301
87	5,344	5,734	6,648	5,473	1,804	4,424
88	5,494	5,893	6,838	5,627	1,854	4,547
89	5,646	6,059	7,031	5,785	1,906	4,671
90	5,799	6,226	7,221	5,944	1,962	4,804
91	5,957	6,393	7,418	6,107	2,012	4,935
92	6,117	6,567	7,618	6,271	2,068	5,067
93	6,281	6,741	7,821	6,437	2,123	5,201
94	6,444	6,917	8,025	6,605	2,179	5,336
95	6,617	7,099	8,239	6,781	2,234	5,478
96	6,791	7,285	8,451	6,954	2,292	5,617
97	6,963	7,468	8,664	7,135	2,352	5,760
98	7,136	7,659	8,884	7,311	2,410	5,910
99+	7,314	7,847	9,106	7,496	2,473	6,056

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: 486-489 and 492

Female rates

Rates effective 5/1/2026

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
65	1,964	2,106	2,444	2,011	664	1,537
66	1,964	2,106	2,444	2,011	664	1,537
67	1,964	2,106	2,444	2,011	664	1,537
68	1,985	2,131	2,471	2,034	671	1,592
69	2,031	2,179	2,528	2,081	686	1,657
70	2,083	2,236	2,594	2,136	704	1,720
71	2,148	2,303	2,672	2,201	725	1,780
72	2,215	2,376	2,756	2,266	748	1,842
73	2,286	2,451	2,845	2,342	771	1,905
74	2,364	2,539	2,944	2,423	800	1,968
75	2,449	2,628	3,047	2,510	827	2,033
76	2,533	2,721	3,153	2,596	856	2,098
77	2,623	2,816	3,265	2,689	886	2,168
78	2,713	2,911	3,376	2,780	916	2,239
79	2,798	3,001	3,481	2,867	945	2,312
80	2,886	3,094	3,593	2,957	976	2,389
81	2,976	3,193	3,704	3,050	1,005	2,464
82	3,065	3,287	3,817	3,142	1,035	2,537
83	3,160	3,389	3,932	3,238	1,067	2,616
84	3,252	3,490	4,047	3,330	1,098	2,692
85	3,370	3,616	4,195	3,453	1,139	2,789
86	3,466	3,721	4,316	3,552	1,171	2,868
87	3,564	3,824	4,437	3,652	1,203	2,953
88	3,663	3,931	4,564	3,754	1,238	3,032
89	3,768	4,040	4,690	3,857	1,272	3,116
90	3,870	4,153	4,818	3,966	1,307	3,204
91	3,976	4,266	4,948	4,074	1,343	3,290
92	4,082	4,380	5,081	4,183	1,379	3,379
93	4,192	4,497	5,217	4,293	1,414	3,469
94	4,302	4,616	5,354	4,406	1,453	3,560
95	4,415	4,736	5,495	4,523	1,490	3,655
96	4,530	4,859	5,639	4,638	1,530	3,748
97	4,645	4,982	5,780	4,758	1,569	3,844
98	4,761	5,110	5,926	4,877	1,608	3,943
99+	4,882	5,235	6,075	5,000	1,648	4,040

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
65	2,181	2,343	2,715	2,237	737	1,709
66	2,181	2,343	2,715	2,237	737	1,709
67	2,181	2,343	2,715	2,237	737	1,709
68	2,206	2,365	2,747	2,260	745	1,770
69	2,256	2,419	2,808	2,309	763	1,842
70	2,316	2,486	2,881	2,373	782	1,910
71	2,385	2,558	2,968	2,443	807	1,978
72	2,460	2,640	3,063	2,521	830	2,048
73	2,540	2,724	3,161	2,602	858	2,116
74	2,629	2,820	3,272	2,694	888	2,188
75	2,722	2,918	3,386	2,786	918	2,259
76	2,816	3,022	3,504	2,886	953	2,330
77	2,914	3,128	3,629	2,989	985	2,410
78	3,014	3,234	3,752	3,090	1,017	2,488
79	3,108	3,335	3,871	3,187	1,050	2,569
80	3,205	3,439	3,990	3,285	1,083	2,656
81	3,308	3,548	4,116	3,388	1,118	2,736
82	3,406	3,654	4,240	3,487	1,150	2,819
83	3,512	3,769	4,371	3,596	1,186	2,906
84	3,614	3,876	4,497	3,701	1,219	2,991
85	3,743	4,016	4,661	3,836	1,265	3,099
86	3,850	4,132	4,795	3,946	1,301	3,188
87	3,960	4,250	4,930	4,058	1,336	3,280
88	4,073	4,369	5,068	4,171	1,375	3,371
89	4,186	4,489	5,210	4,288	1,413	3,462
90	4,300	4,613	5,353	4,405	1,453	3,560
91	4,418	4,740	5,498	4,527	1,492	3,657
92	4,536	4,868	5,646	4,648	1,532	3,755
93	4,657	4,996	5,797	4,773	1,572	3,854
94	4,778	5,128	5,951	4,896	1,615	3,957
95	4,904	5,263	6,105	5,027	1,657	4,062
96	5,032	5,401	6,264	5,154	1,699	4,163
97	5,162	5,536	6,422	5,288	1,743	4,270
98	5,290	5,677	6,585	5,419	1,786	4,380
99+	5,424	5,817	6,751	5,558	1,831	4,489

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

To calculate a household discount:

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

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

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

Modal factors

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

Continental Life Insurance Company of Brentwood, Tennessee

Annual premiums

For Use in ZIP Codes: 486-489 and 492

Male rates

Rates effective 5/1/2026

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
65	2,260	2,423	2,809	2,316	763	1,769
66	2,260	2,423	2,809	2,316	763	1,769
67	2,260	2,423	2,809	2,316	763	1,769
68	2,285	2,448	2,842	2,337	771	1,830
69	2,334	2,505	2,909	2,392	789	1,906
70	2,398	2,573	2,984	2,456	809	1,978
71	2,471	2,650	3,073	2,530	835	2,049
72	2,545	2,732	3,171	2,609	859	2,117
73	2,629	2,822	3,272	2,694	887	2,191
74	2,722	2,918	3,387	2,786	919	2,264
75	2,816	3,022	3,507	2,886	951	2,337
76	2,914	3,128	3,628	2,988	985	2,411
77	3,014	3,239	3,756	3,091	1,020	2,493
78	3,122	3,348	3,882	3,199	1,054	2,574
79	3,219	3,453	4,006	3,299	1,088	2,659
80	3,319	3,561	4,131	3,400	1,121	2,748
81	3,425	3,672	4,260	3,509	1,155	2,833
82	3,525	3,782	4,390	3,611	1,190	2,918
83	3,636	3,900	4,522	3,722	1,227	3,009
84	3,740	4,011	4,656	3,832	1,263	3,096
85	3,874	4,158	4,825	3,971	1,309	3,210
86	3,986	4,278	4,961	4,085	1,347	3,300
87	4,099	4,398	5,101	4,202	1,383	3,392
88	4,213	4,521	5,246	4,319	1,424	3,489
89	4,328	4,646	5,393	4,438	1,463	3,584
90	4,448	4,776	5,539	4,559	1,503	3,686
91	4,571	4,905	5,689	4,683	1,543	3,785
92	4,695	5,037	5,844	4,811	1,585	3,889
93	4,819	5,170	5,999	4,939	1,628	3,988
94	4,947	5,309	6,157	5,068	1,672	4,096
95	5,073	5,448	6,320	5,200	1,714	4,203
96	5,208	5,588	6,481	5,333	1,759	4,310
97	5,340	5,730	6,649	5,472	1,803	4,420
98	5,474	5,875	6,815	5,610	1,849	4,533
99+	5,612	6,022	6,987	5,750	1,895	4,646

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
65	2,511	2,696	3,121	2,573	849	1,966
66	2,511	2,696	3,121	2,573	849	1,966
67	2,511	2,696	3,121	2,573	849	1,966
68	2,539	2,722	3,157	2,600	856	2,035
69	2,595	2,784	3,231	2,657	879	2,117
70	2,664	2,856	3,316	2,730	900	2,196
71	2,741	2,943	3,415	2,811	929	2,276
72	2,828	3,037	3,522	2,897	956	2,355
73	2,919	3,135	3,636	2,992	986	2,434
74	3,024	3,243	3,764	3,098	1,022	2,517
75	3,128	3,356	3,895	3,203	1,056	2,596
76	3,239	3,476	4,028	3,318	1,095	2,681
77	3,351	3,597	4,174	3,436	1,134	2,770
78	3,467	3,721	4,316	3,554	1,170	2,862
79	3,576	3,834	4,451	3,664	1,210	2,954
80	3,689	3,956	4,590	3,777	1,245	3,053
81	3,804	4,080	4,734	3,898	1,284	3,149
82	3,918	4,204	4,874	4,012	1,322	3,242
83	4,037	4,335	5,024	4,137	1,363	3,342
84	4,157	4,458	5,171	4,256	1,403	3,439
85	4,306	4,618	5,361	4,412	1,455	3,566
86	4,427	4,755	5,513	4,538	1,497	3,666
87	4,555	4,888	5,667	4,665	1,538	3,771
88	4,683	5,023	5,829	4,796	1,581	3,876
89	4,813	5,165	5,994	4,932	1,624	3,982
90	4,943	5,307	6,156	5,067	1,672	4,096
91	5,078	5,450	6,323	5,206	1,715	4,207
92	5,215	5,598	6,494	5,346	1,763	4,319
93	5,354	5,746	6,667	5,487	1,810	4,434
94	5,493	5,897	6,841	5,631	1,857	4,549
95	5,641	6,052	7,023	5,780	1,904	4,670
96	5,789	6,210	7,204	5,928	1,954	4,788
97	5,935	6,366	7,386	6,082	2,005	4,910
98	6,083	6,529	7,573	6,233	2,054	5,038
99+	6,235	6,689	7,763	6,390	2,108	5,163

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

To calculate a household discount:

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

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

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

Modal factors

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

Continental Life Insurance Company of Brentwood, Tennessee

Annual premiums

For Use in: Rest of State

Female rates

Rates effective 5/1/2026

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
65	1,888	2,025	2,350	1,934	638	1,478
66	1,888	2,025	2,350	1,934	638	1,478
67	1,888	2,025	2,350	1,934	638	1,478
68	1,909	2,049	2,376	1,956	645	1,531
69	1,953	2,095	2,431	2,001	660	1,593
70	2,003	2,150	2,494	2,054	677	1,654
71	2,065	2,214	2,569	2,116	697	1,712
72	2,130	2,285	2,650	2,179	719	1,771
73	2,198	2,357	2,736	2,252	741	1,832
74	2,273	2,441	2,831	2,330	769	1,892
75	2,355	2,527	2,930	2,413	795	1,955
76	2,436	2,616	3,032	2,496	823	2,017
77	2,522	2,708	3,139	2,586	852	2,085
78	2,609	2,799	3,246	2,673	881	2,153
79	2,690	2,886	3,347	2,757	909	2,223
80	2,775	2,975	3,455	2,843	938	2,297
81	2,862	3,070	3,562	2,933	966	2,369
82	2,947	3,161	3,670	3,021	995	2,439
83	3,038	3,259	3,781	3,113	1,026	2,515
84	3,127	3,356	3,891	3,202	1,056	2,588
85	3,240	3,477	4,034	3,320	1,095	2,682
86	3,333	3,578	4,150	3,415	1,126	2,758
87	3,427	3,677	4,266	3,512	1,157	2,839
88	3,522	3,780	4,388	3,610	1,190	2,915
89	3,623	3,885	4,510	3,709	1,223	2,996
90	3,721	3,993	4,633	3,813	1,257	3,081
91	3,823	4,102	4,758	3,917	1,291	3,163
92	3,925	4,212	4,886	4,022	1,326	3,249
93	4,031	4,324	5,016	4,128	1,360	3,336
94	4,137	4,438	5,148	4,237	1,397	3,423
95	4,245	4,554	5,284	4,349	1,433	3,514
96	4,356	4,672	5,422	4,460	1,471	3,604
97	4,466	4,790	5,558	4,575	1,509	3,696
98	4,578	4,913	5,698	4,689	1,546	3,791
99+	4,694	5,034	5,841	4,808	1,585	3,885

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
65	2,097	2,253	2,611	2,151	709	1,643
66	2,097	2,253	2,611	2,151	709	1,643
67	2,097	2,253	2,611	2,151	709	1,643
68	2,121	2,274	2,641	2,173	716	1,702
69	2,169	2,326	2,700	2,220	734	1,771
70	2,227	2,390	2,770	2,282	752	1,837
71	2,293	2,460	2,854	2,349	776	1,902
72	2,365	2,538	2,945	2,424	798	1,969
73	2,442	2,619	3,039	2,502	825	2,035
74	2,528	2,712	3,146	2,590	854	2,104
75	2,617	2,806	3,256	2,679	883	2,172
76	2,708	2,906	3,369	2,775	916	2,240
77	2,802	3,008	3,489	2,874	947	2,317
78	2,898	3,110	3,608	2,971	978	2,392
79	2,988	3,207	3,722	3,064	1,010	2,470
80	3,082	3,307	3,837	3,159	1,041	2,554
81	3,181	3,412	3,958	3,258	1,075	2,631
82	3,275	3,513	4,077	3,353	1,106	2,711
83	3,377	3,624	4,203	3,458	1,140	2,794
84	3,475	3,727	4,324	3,559	1,172	2,876
85	3,599	3,862	4,482	3,688	1,216	2,980
86	3,702	3,973	4,611	3,794	1,251	3,065
87	3,808	4,087	4,740	3,902	1,285	3,154
88	3,916	4,201	4,873	4,011	1,322	3,241
89	4,025	4,316	5,010	4,123	1,359	3,329
90	4,135	4,436	5,147	4,236	1,397	3,423
91	4,248	4,558	5,287	4,353	1,435	3,516
92	4,362	4,681	5,429	4,469	1,473	3,611
93	4,478	4,804	5,574	4,589	1,512	3,706
94	4,594	4,931	5,722	4,708	1,553	3,805
95	4,715	5,061	5,870	4,834	1,593	3,906
96	4,838	5,193	6,023	4,956	1,634	4,003
97	4,963	5,323	6,175	5,085	1,676	4,106
98	5,087	5,459	6,332	5,211	1,717	4,212
99+	5,215	5,593	6,491	5,344	1,761	4,316

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

To calculate a household discount:

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

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

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

Modal factors

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

Continental Life Insurance Company of Brentwood, Tennessee

Annual premiums

For Use in: Rest of State

Male rates

Rates effective 5/1/2026

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
65	2,173	2,330	2,701	2,227	734	1,701
66	2,173	2,330	2,701	2,227	734	1,701
67	2,173	2,330	2,701	2,227	734	1,701
68	2,197	2,354	2,733	2,247	741	1,760
69	2,244	2,409	2,797	2,300	759	1,833
70	2,306	2,474	2,869	2,362	778	1,902
71	2,376	2,548	2,955	2,433	803	1,970
72	2,447	2,627	3,049	2,509	826	2,036
73	2,528	2,713	3,146	2,590	853	2,107
74	2,617	2,806	3,257	2,679	884	2,177
75	2,708	2,906	3,372	2,775	914	2,247
76	2,802	3,008	3,488	2,873	947	2,318
77	2,898	3,114	3,612	2,972	981	2,397
78	3,002	3,219	3,733	3,076	1,013	2,475
79	3,095	3,320	3,852	3,172	1,046	2,557
80	3,191	3,424	3,972	3,269	1,078	2,642
81	3,293	3,531	4,096	3,374	1,111	2,724
82	3,389	3,637	4,221	3,472	1,144	2,806
83	3,496	3,750	4,348	3,579	1,180	2,893
84	3,596	3,857	4,477	3,685	1,214	2,977
85	3,725	3,998	4,639	3,818	1,259	3,087
86	3,833	4,113	4,770	3,928	1,295	3,173
87	3,941	4,229	4,905	4,040	1,330	3,262
88	4,051	4,347	5,044	4,153	1,369	3,355
89	4,162	4,467	5,186	4,267	1,407	3,446
90	4,277	4,592	5,326	4,384	1,445	3,544
91	4,395	4,716	5,470	4,503	1,484	3,639
92	4,514	4,843	5,619	4,626	1,524	3,739
93	4,634	4,971	5,768	4,749	1,565	3,835
94	4,757	5,105	5,920	4,873	1,608	3,938
95	4,878	5,238	6,077	5,000	1,648	4,041
96	5,008	5,373	6,232	5,128	1,691	4,144
97	5,135	5,510	6,393	5,262	1,734	4,250
98	5,263	5,649	6,553	5,394	1,778	4,359
99+	5,396	5,790	6,718	5,529	1,822	4,467

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
65	2,414	2,592	3,001	2,474	816	1,890
66	2,414	2,592	3,001	2,474	816	1,890
67	2,414	2,592	3,001	2,474	816	1,890
68	2,441	2,617	3,036	2,500	823	1,957
69	2,495	2,677	3,107	2,555	845	2,036
70	2,562	2,746	3,188	2,625	865	2,112
71	2,636	2,830	3,284	2,703	893	2,188
72	2,719	2,920	3,387	2,786	919	2,264
73	2,807	3,014	3,496	2,877	948	2,340
74	2,908	3,118	3,619	2,979	983	2,420
75	3,008	3,227	3,745	3,080	1,015	2,496
76	3,114	3,342	3,873	3,190	1,053	2,578
77	3,222	3,459	4,013	3,304	1,090	2,663
78	3,334	3,578	4,150	3,417	1,125	2,752
79	3,438	3,687	4,280	3,523	1,163	2,840
80	3,547	3,804	4,413	3,632	1,197	2,936
81	3,658	3,923	4,552	3,748	1,235	3,028
82	3,767	4,042	4,687	3,858	1,271	3,117
83	3,882	4,168	4,831	3,978	1,311	3,213
84	3,997	4,287	4,972	4,092	1,349	3,307
85	4,140	4,440	5,155	4,242	1,399	3,429
86	4,257	4,572	5,301	4,363	1,439	3,525
87	4,380	4,700	5,449	4,486	1,479	3,626
88	4,503	4,830	5,605	4,612	1,520	3,727
89	4,628	4,966	5,763	4,742	1,562	3,829
90	4,753	5,103	5,919	4,872	1,608	3,938
91	4,883	5,240	6,080	5,006	1,649	4,045
92	5,014	5,383	6,244	5,140	1,695	4,153
93	5,148	5,525	6,411	5,276	1,740	4,263
94	5,282	5,670	6,578	5,414	1,786	4,374
95	5,424	5,819	6,753	5,558	1,831	4,490
96	5,566	5,971	6,927	5,700	1,879	4,604
97	5,707	6,121	7,102	5,848	1,928	4,721
98	5,849	6,278	7,282	5,993	1,975	4,844
99+	5,995	6,432	7,464	6,144	2,027	4,964

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 be covered by an Aetna Company Medicare supplement policy. The Medicare eligible adult must be either (a) your spouse or your civil union partner; and (b) someone with whom you have continuously resided for the past 12 months. The household discount will only be applicable if a policy for each applicant is issued. The discounted rate will be 7 percent lower than the individual rates and will apply as long as both policies remain in force.

DISCLOSURES

Use this outline to compare benefits and premium among policies.

READ YOUR POLICY VERY CAREFULLY

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

RIGHT TO RETURN POLICY

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

POLICY REPLACEMENT

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

NOTICE

The policy may not cover all of your medical costs.

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

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

COMPLETE ANSWERS ARE VERY IMPORTANT

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

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

THE FOLLOWING CHARTS DESCRIBE PLANS A, 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 \$1,736	\$0	\$1,736 (Part A Deductible)
61st thru 90th day	All but \$434 a day	\$434 a day	\$0
91st day and after While using 60 lifetime reserve days	All but \$868 a day	\$868 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 \$217 a day	\$0	Up to \$217 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 \$283 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 \$283 of Medicare-Approved amounts*	\$0	\$0	\$283 (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 \$283 of Medicare-Approved amounts*	\$0	\$0	\$283 (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 \$283 of Medicare-Approved amounts*	\$0	\$0	\$283 (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 \$1,736	\$1,736 (Part A Deductible)	\$0
61st thru 90th day	All but \$434 a day	\$434 a day	\$0
91st day and after While using 60 lifetime reserve days	All but \$868 a day	\$868 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 \$217 a day	\$0	Up to \$217 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 \$283 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 \$283 of Medicare-Approved amounts*	\$0	\$0	\$283 (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 \$283 of Medicare-Approved amounts*	\$0	\$0	\$283 (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 \$283 of Medicare-Approved amounts*	\$0	\$0	\$283 (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 \$1,736	\$1,736 (Part A Deductible)	\$0
61st thru 90th day	All but \$434 a day	\$434 a day	\$0
91st day and after While using 60 lifetime reserve days	All but \$868 a day	\$868 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 \$217 a day	Up to \$217 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 \$283 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 \$283 of Medicare-Approved amounts*	\$0	\$283 (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 \$283 of Medicare-Approved amounts*	\$0	\$283 (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 \$283 of Medicare-Approved amounts*	\$0	\$283 (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 \$1,736	\$1,736 (Part A Deductible)	\$0
61st thru 90th day	All but \$434 a day	\$434 a day	\$0
91st day and after While using 60 lifetime reserve days	All but \$868 a day	\$868 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 \$217 a day	Up to \$217 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 \$283 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 \$283 of Medicare-Approved amounts*	\$0	\$0	\$283 (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 \$283 of Medicare-Approved amounts*	\$0	\$0	\$283 (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 \$283 of Medicare-Approved amounts*	\$0	\$0	\$283 (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 \$2,950 deductible. Benefits from High Deductible Plan G will not begin until out-of-pocket expenses are \$2,950. 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 \$2,950 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO \$2,950 DEDUCTIBLE*** YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$1,736	\$1,736 (Part A Deductible)	\$0
61st thru 90th day	All but \$434 a day	\$434 a day	\$0
91st day and after While using 60 lifetime reserve days	All but \$868 a day	\$868 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 \$217 a day	Up to \$217 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 \$283 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 \$2,950 deductible. Benefits from High Deductible Plan G will not begin until out-of-pocket expenses are \$2,950. 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 \$2,950 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO \$2,950 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 \$283 of Medicare-Approved amounts*	\$0	\$0	\$283 (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 \$283 of Medicare-Approved amounts*	\$0	\$0	\$283 (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 \$2,950 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO \$2,950 DEDUCTIBLE*** YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment			
First \$283 of Medicare-Approved amounts*	\$0	\$0	\$283 (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 \$2,950 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO \$2,950 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 \$1,736	\$1,736 (Part A Deductible)	\$0
61st thru 90th day	All but \$434 a day	\$434 a day	\$0
91st day and after While using 60 lifetime reserve days	All but \$868 a day	\$868 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 \$217 a day	Up to \$217 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 \$283 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 \$283 of Medicare-Approved amounts*	\$0	\$0	\$283 (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 \$283 of Medicare-Approved amounts*	\$0	\$0	\$283 (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 \$283 of Medicare-Approved amounts*	\$0	\$0	\$283 (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