Outline of coverage

Medicare Supplement Insurance

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

Nebraska

Underwritten by

Continental Life Insurance Company of Brentwood, Tennessee

An Aetna Company

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CLIMS05026NE

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Rates effective: 08/2020 B

CONTINENTAL LIFE INSURANCE COMPANY OF BRENTWOOD, TENNESSEE
OUTLINE OF MEDICARE SUPPLEMENT COVERAGE COVER PAGE:
BENEFIT PLANS AVAILABLE: A, B, F, HF, 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 2021[2]					$6,220[2]	$3,110[2]				

[1] Plans F and G also have a high deductible option, which require first paying a plan deductible of $2,370 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: 690-693

Female Rates

Rates Effective 8/1/2020

Attained	Preferred					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,320	1,444	1,600	546	1,391	1,032
66	1,320	1,444	1,600	546	1,391	1,032
67	1,320	1,444	1,600	546	1,391	1,032
68	1,331	1,456	1,613	550	1,402	1,066
69	1,357	1,486	1,646	562	1,429	1,106
70	1,392	1,524	1,690	577	1,467	1,149
71	1,434	1,571	1,741	594	1,511	1,189
72	1,481	1,623	1,796	615	1,561	1,232
73	1,530	1,674	1,855	633	1,612	1,272
74	1,582	1,731	1,917	655	1,666	1,315
75	1,637	1,792	1,985	678	1,724	1,356
76	1,697	1,857	2,057	703	1,787	1,402
77	1,755	1,919	2,127	727	1,848	1,446
78	1,814	1,985	2,200	752	1,911	1,494
79	1,874	2,049	2,270	776	1,972	1,545
80	1,931	2,114	2,342	800	2,035	1,597
81	1,994	2,181	2,415	825	2,099	1,647
82	2,056	2,249	2,492	851	2,165	1,698
83	2,118	2,320	2,568	877	2,231	1,751
84	2,183	2,389	2,647	905	2,300	1,805
85	2,250	2,463	2,727	932	2,369	1,860
86	2,324	2,544	2,818	962	2,447	1,921
87	2,389	2,616	2,897	990	2,518	1,975
88	2,457	2,689	2,979	1,018	2,588	2,031
89	2,526	2,763	3,062	1,046	2,661	2,087
90	2,595	2,839	3,146	1,075	2,733	2,144
91	2,665	2,917	3,231	1,104	2,808	2,203
92	2,737	2,996	3,318	1,134	2,882	2,262
93	2,810	3,076	3,407	1,164	2,959	2,323
94	2,883	3,157	3,497	1,195	3,038	2,384
95	2,959	3,239	3,588	1,226	3,117	2,446
96	3,036	3,323	3,681	1,258	3,197	2,509
97	3,114	3,407	3,775	1,291	3,279	2,573
98	3,192	3,495	3,871	1,323	3,363	2,638
99+	3,272	3,582	3,967	1,356	3,447	2,704

Attained	Standard					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,466	1,606	1,778	607	1,546	1,147
66	1,466	1,606	1,778	607	1,546	1,147
67	1,466	1,606	1,778	607	1,546	1,147
68	1,479	1,619	1,792	613	1,558	1,185
69	1,507	1,650	1,829	625	1,588	1,230
70	1,547	1,694	1,877	642	1,630	1,276
71	1,595	1,744	1,935	659	1,679	1,321
72	1,646	1,803	1,996	682	1,734	1,369
73	1,700	1,861	2,061	704	1,792	1,414
74	1,757	1,924	2,131	728	1,851	1,461
75	1,819	1,990	2,206	753	1,915	1,506
76	1,886	2,063	2,286	782	1,985	1,558
77	1,950	2,134	2,363	807	2,054	1,607
78	2,015	2,206	2,444	835	2,123	1,660
79	2,081	2,278	2,523	862	2,191	1,716
80	2,146	2,349	2,603	888	2,261	1,775
81	2,215	2,423	2,684	917	2,333	1,830
82	2,284	2,498	2,768	945	2,405	1,887
83	2,352	2,577	2,854	974	2,480	1,945
84	2,426	2,655	2,941	1,005	2,556	2,006
85	2,499	2,736	3,031	1,036	2,632	2,067
86	2,583	2,827	3,130	1,069	2,720	2,134
87	2,655	2,906	3,220	1,100	2,797	2,194
88	2,729	2,988	3,309	1,131	2,875	2,256
89	2,807	3,072	3,402	1,163	2,956	2,320
90	2,882	3,154	3,496	1,194	3,037	2,383
91	2,962	3,242	3,589	1,226	3,120	2,448
92	3,040	3,329	3,686	1,259	3,204	2,514
93	3,123	3,418	3,784	1,294	3,289	2,581
94	3,205	3,509	3,885	1,328	3,376	2,649
95	3,287	3,600	3,987	1,363	3,464	2,717
96	3,374	3,693	4,091	1,397	3,552	2,788
97	3,460	3,787	4,194	1,433	3,644	2,859
98	3,547	3,883	4,300	1,470	3,735	2,931
99+	3,635	3,981	4,408	1,506	3,829	3,005

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

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 Period, use Preferred rates.

Continental Life Insurance Company of Brentwood, Tennessee

Annual Premiums

For Use in ZIP Codes: 690-693

Male Rates

Rates Effective 8/1/2020

Attained	Preferred					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,517	1,661	1,840	628	1,600	1,187
66	1,517	1,661	1,840	628	1,600	1,187
67	1,517	1,661	1,840	628	1,600	1,187
68	1,531	1,675	1,855	633	1,612	1,226
69	1,561	1,707	1,892	646	1,643	1,272
70	1,601	1,754	1,942	663	1,687	1,321
71	1,649	1,806	2,000	683	1,739	1,368
72	1,704	1,865	2,066	706	1,795	1,417
73	1,759	1,925	2,133	729	1,854	1,463
74	1,819	1,990	2,206	754	1,915	1,512
75	1,884	2,061	2,282	780	1,983	1,560
76	1,951	2,135	2,366	809	2,056	1,612
77	2,018	2,207	2,446	835	2,124	1,663
78	2,086	2,284	2,529	863	2,196	1,719
79	2,154	2,358	2,612	894	2,268	1,777
80	2,220	2,432	2,693	920	2,340	1,837
81	2,292	2,508	2,777	948	2,414	1,894
82	2,362	2,587	2,865	980	2,490	1,953
83	2,436	2,667	2,954	1,009	2,566	2,013
84	2,510	2,748	3,044	1,041	2,644	2,075
85	2,588	2,833	3,138	1,071	2,724	2,139
86	2,674	2,927	3,239	1,106	2,814	2,208
87	2,748	3,008	3,332	1,138	2,895	2,272
88	2,824	3,091	3,426	1,171	2,976	2,335
89	2,905	3,180	3,521	1,202	3,060	2,400
90	2,984	3,266	3,617	1,236	3,142	2,466
91	3,065	3,355	3,716	1,270	3,229	2,533
92	3,147	3,447	3,816	1,304	3,315	2,601
93	3,232	3,536	3,916	1,339	3,404	2,672
94	3,316	3,631	4,021	1,373	3,495	2,741
95	3,403	3,726	4,127	1,410	3,586	2,813
96	3,492	3,820	4,234	1,448	3,678	2,885
97	3,581	3,920	4,340	1,483	3,771	2,959
98	3,670	4,018	4,450	1,522	3,867	3,033
99+	3,763	4,119	4,563	1,559	3,963	3,110

Attained	Standard					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,687	1,846	2,045	699	1,778	1,319
66	1,687	1,846	2,045	699	1,778	1,319
67	1,687	1,846	2,045	699	1,778	1,319
68	1,701	1,862	2,061	704	1,792	1,363
69	1,733	1,898	2,103	718	1,827	1,414
70	1,780	1,949	2,158	738	1,875	1,468
71	1,833	2,007	2,225	759	1,930	1,519
72	1,892	2,073	2,294	785	1,995	1,574
73	1,954	2,140	2,371	810	2,060	1,626
74	2,020	2,214	2,451	837	2,129	1,680
75	2,092	2,289	2,536	867	2,203	1,732
76	2,168	2,374	2,628	898	2,284	1,791
77	2,243	2,454	2,717	929	2,361	1,848
78	2,318	2,538	2,809	961	2,442	1,909
79	2,393	2,618	2,902	992	2,520	1,973
80	2,469	2,701	2,993	1,022	2,600	2,040
81	2,546	2,786	3,087	1,054	2,681	2,105
82	2,626	2,873	3,183	1,087	2,766	2,170
83	2,706	2,965	3,283	1,122	2,851	2,237
84	2,788	3,053	3,383	1,156	2,940	2,306
85	2,874	3,146	3,485	1,190	3,027	2,376
86	2,970	3,250	3,600	1,228	3,127	2,455
87	3,053	3,342	3,701	1,265	3,217	2,523
88	3,139	3,436	3,805	1,301	3,306	2,595
89	3,226	3,533	3,912	1,337	3,399	2,667
90	3,315	3,628	4,020	1,372	3,492	2,740
91	3,406	3,727	4,128	1,410	3,588	2,815
92	3,497	3,828	4,238	1,449	3,683	2,891
93	3,590	3,931	4,352	1,487	3,781	2,968
94	3,684	4,035	4,468	1,527	3,881	3,047
95	3,780	4,140	4,585	1,566	3,984	3,125
96	3,880	4,246	4,704	1,608	4,086	3,207
97	3,979	4,355	4,822	1,648	4,190	3,287
98	4,079	4,465	4,945	1,692	4,296	3,370
99+	4,180	4,577	5,069	1,732	4,404	3,456

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

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 Period, use Preferred rates.

Continental Life Insurance Company of Brentwood, Tennessee

Annual Premiums

For Use in: Rest of State

Female Rates

Rates Effective 8/1/2020

Attained	Preferred					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,211	1,325	1,468	501	1,276	947
66	1,211	1,325	1,468	501	1,276	947
67	1,211	1,325	1,468	501	1,276	947
68	1,221	1,336	1,480	505	1,286	978
69	1,245	1,363	1,510	516	1,311	1,015
70	1,277	1,398	1,550	529	1,346	1,054
71	1,316	1,441	1,597	545	1,386	1,091
72	1,359	1,489	1,648	564	1,432	1,130
73	1,404	1,536	1,702	581	1,479	1,167
74	1,451	1,588	1,759	601	1,528	1,206
75	1,502	1,644	1,821	622	1,582	1,244
76	1,557	1,704	1,887	645	1,639	1,286
77	1,610	1,761	1,951	667	1,695	1,327
78	1,664	1,821	2,018	690	1,753	1,371
79	1,719	1,880	2,083	712	1,809	1,417
80	1,772	1,939	2,149	734	1,867	1,465
81	1,829	2,001	2,216	757	1,926	1,511
82	1,886	2,063	2,286	781	1,986	1,558
83	1,943	2,128	2,356	805	2,047	1,606
84	2,003	2,192	2,428	830	2,110	1,656
85	2,064	2,260	2,502	855	2,173	1,706
86	2,132	2,334	2,585	883	2,245	1,762
87	2,192	2,400	2,658	908	2,310	1,812
88	2,254	2,467	2,733	934	2,374	1,863
89	2,317	2,535	2,809	960	2,441	1,915
90	2,381	2,605	2,886	986	2,507	1,967
91	2,445	2,676	2,964	1,013	2,576	2,021
92	2,511	2,749	3,044	1,040	2,644	2,075
93	2,578	2,822	3,126	1,068	2,715	2,131
94	2,645	2,896	3,208	1,096	2,787	2,187
95	2,715	2,972	3,292	1,125	2,860	2,244
96	2,785	3,049	3,377	1,154	2,933	2,302
97	2,857	3,126	3,463	1,184	3,008	2,361
98	2,928	3,206	3,551	1,214	3,085	2,420
99+	3,002	3,286	3,639	1,244	3,162	2,481

Attained	Standard					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,345	1,473	1,631	557	1,418	1,052
66	1,345	1,473	1,631	557	1,418	1,052
67	1,345	1,473	1,631	557	1,418	1,052
68	1,357	1,485	1,644	562	1,429	1,087
69	1,383	1,514	1,678	573	1,457	1,128
70	1,419	1,554	1,722	589	1,495	1,171
71	1,463	1,600	1,775	605	1,540	1,212
72	1,510	1,654	1,831	626	1,591	1,256
73	1,560	1,707	1,891	646	1,644	1,297
74	1,612	1,765	1,955	668	1,698	1,340
75	1,669	1,826	2,024	691	1,757	1,382
76	1,730	1,893	2,097	717	1,821	1,429
77	1,789	1,958	2,168	740	1,884	1,474
78	1,849	2,024	2,242	766	1,948	1,523
79	1,909	2,090	2,315	791	2,010	1,574
80	1,969	2,155	2,388	815	2,074	1,628
81	2,032	2,223	2,462	841	2,140	1,679
82	2,095	2,292	2,539	867	2,206	1,731
83	2,158	2,364	2,618	894	2,275	1,784
84	2,226	2,436	2,698	922	2,345	1,840
85	2,293	2,510	2,781	950	2,415	1,896
86	2,370	2,594	2,872	981	2,495	1,958
87	2,436	2,666	2,954	1,009	2,566	2,013
88	2,504	2,741	3,036	1,038	2,638	2,070
89	2,575	2,818	3,121	1,067	2,712	2,128
90	2,644	2,894	3,207	1,095	2,786	2,186
91	2,717	2,974	3,293	1,125	2,862	2,246
92	2,789	3,054	3,382	1,155	2,939	2,306
93	2,865	3,136	3,472	1,187	3,017	2,368
94	2,940	3,219	3,564	1,218	3,097	2,430
95	3,016	3,303	3,658	1,250	3,178	2,493
96	3,095	3,388	3,753	1,282	3,259	2,558
97	3,174	3,474	3,848	1,315	3,343	2,623
98	3,254	3,562	3,945	1,349	3,427	2,689
99+	3,335	3,652	4,044	1,382	3,513	2,757

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

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 Period, use Preferred rates.

Continental Life Insurance Company of Brentwood, Tennessee

Annual Premiums

For Use in: Rest of State

Male Rates

Rates Effective 8/1/2020

Attained	Preferred					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,392	1,524	1,688	576	1,468	1,089
66	1,392	1,524	1,688	576	1,468	1,089
67	1,392	1,524	1,688	576	1,468	1,089
68	1,405	1,537	1,702	581	1,479	1,125
69	1,432	1,566	1,736	593	1,507	1,167
70	1,469	1,609	1,782	608	1,548	1,212
71	1,513	1,657	1,835	627	1,595	1,255
72	1,563	1,711	1,895	648	1,647	1,300
73	1,614	1,766	1,957	669	1,701	1,342
74	1,669	1,826	2,024	692	1,757	1,387
75	1,728	1,891	2,094	716	1,819	1,431
76	1,790	1,959	2,171	742	1,886	1,479
77	1,851	2,025	2,244	766	1,949	1,526
78	1,914	2,095	2,320	792	2,015	1,577
79	1,976	2,163	2,396	820	2,081	1,630
80	2,037	2,231	2,471	844	2,147	1,685
81	2,103	2,301	2,548	870	2,215	1,738
82	2,167	2,373	2,628	899	2,284	1,792
83	2,235	2,447	2,710	926	2,354	1,847
84	2,303	2,521	2,793	955	2,426	1,904
85	2,374	2,599	2,879	983	2,499	1,962
86	2,453	2,685	2,972	1,015	2,582	2,026
87	2,521	2,760	3,057	1,044	2,656	2,084
88	2,591	2,836	3,143	1,074	2,730	2,142
89	2,665	2,917	3,230	1,103	2,807	2,202
90	2,738	2,996	3,318	1,134	2,883	2,262
91	2,812	3,078	3,409	1,165	2,962	2,324
92	2,887	3,162	3,501	1,196	3,041	2,386
93	2,965	3,244	3,593	1,228	3,123	2,451
94	3,042	3,331	3,689	1,260	3,206	2,515
95	3,122	3,418	3,786	1,294	3,290	2,581
96	3,204	3,505	3,884	1,328	3,374	2,647
97	3,285	3,596	3,982	1,361	3,460	2,715
98	3,367	3,686	4,083	1,396	3,548	2,783
99+	3,452	3,779	4,186	1,430	3,636	2,853

Attained	Standard					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,548	1,694	1,876	641	1,631	1,210
66	1,548	1,694	1,876	641	1,631	1,210
67	1,548	1,694	1,876	641	1,631	1,210
68	1,561	1,708	1,891	646	1,644	1,250
69	1,590	1,741	1,929	659	1,676	1,297
70	1,633	1,788	1,980	677	1,720	1,347
71	1,682	1,841	2,041	696	1,771	1,394
72	1,736	1,902	2,105	720	1,830	1,444
73	1,793	1,963	2,175	743	1,890	1,492
74	1,853	2,031	2,249	768	1,953	1,541
75	1,919	2,100	2,327	795	2,021	1,589
76	1,989	2,178	2,411	824	2,095	1,643
77	2,058	2,251	2,493	852	2,166	1,695
78	2,127	2,328	2,577	882	2,240	1,751
79	2,195	2,402	2,662	910	2,312	1,810
80	2,265	2,478	2,746	938	2,385	1,872
81	2,336	2,556	2,832	967	2,460	1,931
82	2,409	2,636	2,920	997	2,538	1,991
83	2,483	2,720	3,012	1,029	2,616	2,052
84	2,558	2,801	3,104	1,061	2,697	2,116
85	2,637	2,886	3,197	1,092	2,777	2,180
86	2,725	2,982	3,303	1,127	2,869	2,252
87	2,801	3,066	3,395	1,161	2,951	2,315
88	2,880	3,152	3,491	1,194	3,033	2,381
89	2,960	3,241	3,589	1,227	3,118	2,447
90	3,041	3,328	3,688	1,259	3,204	2,514
91	3,125	3,419	3,787	1,294	3,292	2,583
92	3,208	3,512	3,888	1,329	3,379	2,652
93	3,294	3,606	3,993	1,364	3,469	2,723
94	3,380	3,702	4,099	1,401	3,561	2,795
95	3,468	3,798	4,206	1,437	3,655	2,867
96	3,560	3,895	4,316	1,475	3,749	2,942
97	3,650	3,995	4,424	1,512	3,844	3,016
98	3,742	4,096	4,537	1,552	3,941	3,092
99+	3,835	4,199	4,650	1,589	4,040	3,171

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

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 Period, use Preferred rates.

PREM IUM 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 an 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 Continental Life Insurance Company of Brentwood, Tennessee Medicare supplement policy. The Medicare eligible adult must be either (a) your spouse; (b) someone with whom you are in a civil union partnership; and (c) 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.

COM PLETE ANSWERS ARE VERY IM PORTANT

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 COM PANY 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 $1,484	$0	$1,484 (Part A Deductible)
61st thru 90th day	All but $371 a day	$371 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $742 a day	$742 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 $185.50 a day	$0	Up to $185.50 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 $203 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 test, durable medical equipment			
First $203 of Medicare-Approved amounts*	$0	$0	$203 (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 $203 of Medicare-Approved amounts*	$0	$0	$203 (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 $203 of Medicare Approved amounts*	$0	$0	$203 (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 $1,484	$1,484 (Part A Deductible)	$0
61st thru 90th day	All but $371 a day	$371 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $742 a day	$742 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 $185.50 a day	$0	Up to $185.50 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 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 $203 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 test, durable medical equipment			
First $203 of Medicare-Approved amounts*	$0	$0	$203 (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 $203 of Medicare-Approved amounts*	$0	$0	$203 (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 $203 of Medicare Approved amounts*	$0	$0	$203 (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 $1,484	$1,484 (Part A Deductible)	$0
61st thru 90th day	All but $371 a day	$371 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $742 a day	$742 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 $185.50 a day	Up to $185.50 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 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 $203 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 test, durable medical equipment			
First $203 of Medicare-Approved amounts*	$0	$203 (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 $203 of Medicare-Approved amounts*	$0	$203 (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 $203 of Medicare Approved amounts*	$0	$203 (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.

*****This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2,370 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses are $2,370. 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 th e plan's separate foreign travel emergency deductible.**

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,370 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2,370 DEDUCTIBLE*** YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,484	$1,484 (Part A Deductible)	$0
61st thru 90th day	All but $371 a day	$371 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $742 a day	$742 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 $185.50 a day	Up to $185.50 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 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 $203 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 F after one has paid a calendar year $2,370 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses are $2,370. 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.**

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,370 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2,370 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 $203 of Medicare-Approved amounts*	$0	$203 (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 $203 of Medicare-Approved amounts*	$0	$203 (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 $2,370 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2,370 DEDUCTIBLE*** YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
•Medically necessary skilled care services and medical supplies	100%	$0	$0
•Durable medical equipment			
•First $203 of Medicare Approved amounts*	$0	$203 (Part B Deductible)	$0
•Remainder of Medicare Approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,370 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2,370 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.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,484	$1,484 (Part A Deductible)	$0
61st thru 90th day	All but $371 a day	$371 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $742 a day	$742 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 $185.50 a day	Up to $185.50 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 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 $203 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 test, durable medical equipment			
First $203 of Medicare-Approved amounts*	$0	$0	$203 (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 $203 of Medicare-Approved amounts*	$0	$0	$203 (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 $203 of Medicare Approved amounts*	$0	$0	$203 (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.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,484	$1,484 (Part A Deductible)	$0
61st thru 90th day	All but $371 a day	$371 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $742 a day	$742 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 $185.50 a day	Up to $185.50 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 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 $203 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 test, durable medical equipment			
First $203 of Medicare-Approved amounts*	$0	$0	$203 (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 $203 of Medicare-Approved amounts*	$0	$0	$203 (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 $203 of Medicare Approved amounts*	$0	$0	$203 (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