Outline of coverage

Medicare Supplement Insurance

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

Nevada

Underwritten by

Continental Life Insurance Company of Brentwood, Tennessee

An Aetna Company

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CLIMS04881NV

Rates effective: 03/2025 A

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

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

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

Benefits	Plans Available to All Applicants								Medicare first eligible before 2020 only	
	A	B	D	G[1]	K	L	M	N	C	F[1]
Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Medicare Part B coinsurance or copayment	✓	✓	✓	✓	50%	75%	✓	✓ copays apply[3]	✓	✓
Blood (first three pints)	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Part A hospice care coinsurance or copayment	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Skilled nursing facility coinsurance			✓	✓	50%	75%	✓	✓	✓	✓
Medicare Part A deductible		✓	✓	✓	50%	75%	50%	✓	✓	✓
Medicare Part B deductible									✓	✓
Medicare Part B excess charges				✓						✓
Foreign travel emergency (up to plan limits)			✓	✓			✓	✓	✓	✓
Out-of-pocket limit in 2025[2]					**$7,220[2]**	**$3,610[2]**				

[1] Plans F and G also have a high deductible option, which require first paying a plan deductible of **$2,870** 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: 889-891

Female rates

Rates effective 3/1/2025

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
65	2,191	2,322	2,797	2,233	775	1,684
66	2,191	2,322	2,797	2,233	775	1,684
67	2,191	2,322	2,797	2,233	775	1,684
68	2,214	2,346	2,825	2,257	784	1,743
69	2,263	2,399	2,890	2,308	801	1,815
70	2,325	2,465	2,968	2,371	822	1,886
71	2,395	2,538	3,056	2,443	848	1,950
72	2,468	2,618	3,151	2,516	874	2,017
73	2,549	2,702	3,254	2,600	903	2,084
74	2,638	2,798	3,369	2,690	933	2,157
75	2,730	2,894	3,486	2,784	967	2,225
76	2,825	2,996	3,608	2,884	1,000	2,296
77	2,924	3,102	3,735	2,983	1,036	2,372
78	3,026	3,207	3,861	3,087	1,070	2,452
79	3,121	3,307	3,984	3,182	1,104	2,532
80	3,216	3,411	4,107	3,281	1,139	2,617
81	3,320	3,519	4,237	3,387	1,175	2,700
82	3,417	3,623	4,362	3,486	1,210	2,779
83	3,525	3,735	4,498	3,592	1,246	2,863
84	3,627	3,845	4,631	3,700	1,284	2,948
85	3,756	3,985	4,800	3,832	1,329	3,054
86	3,864	4,096	4,933	3,942	1,367	3,143
87	3,973	4,213	5,074	4,055	1,407	3,231
88	4,085	4,331	5,216	4,169	1,446	3,322
89	4,198	4,453	5,361	4,284	1,486	3,415
90	4,316	4,574	5,508	4,401	1,527	3,507
91	4,431	4,699	5,659	4,522	1,568	3,604
92	4,553	4,825	5,813	4,642	1,611	3,701
93	4,673	4,956	5,967	4,767	1,653	3,798
94	4,800	5,086	6,124	4,895	1,698	3,899
95	4,919	5,217	6,285	5,021	1,742	4,002
96	5,049	5,354	6,447	5,151	1,787	4,103
97	5,179	5,491	6,611	5,282	1,833	4,210
98	5,307	5,630	6,778	5,416	1,879	4,316
99+	5,441	5,772	6,947	5,552	1,926	4,425

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
65	2,432	2,579	3,106	2,483	862	1,872
66	2,432	2,579	3,106	2,483	862	1,872
67	2,432	2,579	3,106	2,483	862	1,872
68	2,460	2,606	3,141	2,509	873	1,938
69	2,514	2,665	3,212	2,567	890	2,017
70	2,583	2,740	3,297	2,635	914	2,094
71	2,657	2,821	3,396	2,714	942	2,169
72	2,742	2,908	3,504	2,798	971	2,242
73	2,831	3,002	3,616	2,888	1,003	2,316
74	2,933	3,109	3,741	2,988	1,037	2,397
75	3,033	3,216	3,875	3,093	1,074	2,473
76	3,141	3,330	4,009	3,203	1,112	2,553
77	3,251	3,446	4,153	3,316	1,149	2,636
78	3,361	3,563	4,290	3,428	1,190	2,724
79	3,467	3,675	4,425	3,536	1,227	2,813
80	3,573	3,792	4,563	3,646	1,266	2,905
81	3,687	3,910	4,709	3,763	1,305	2,999
82	3,796	4,026	4,847	3,874	1,344	3,087
83	3,914	4,153	5,000	3,992	1,386	3,182
84	4,028	4,272	5,144	4,110	1,427	3,277
85	4,174	4,427	5,328	4,257	1,477	3,394
86	4,294	4,553	5,481	4,382	1,521	3,492
87	4,417	4,683	5,638	4,505	1,564	3,590
88	4,540	4,814	5,797	4,632	1,607	3,691
89	4,667	4,949	5,955	4,761	1,651	3,793
90	4,797	5,085	6,121	4,888	1,697	3,897
91	4,924	5,222	6,288	5,023	1,742	4,004
92	5,059	5,361	6,461	5,158	1,790	4,114
93	5,192	5,507	6,629	5,295	1,838	4,221
94	5,328	5,651	6,805	5,437	1,887	4,333
95	5,468	5,799	6,983	5,580	1,935	4,446
96	5,610	5,949	7,163	5,723	1,987	4,561
97	5,752	6,103	7,346	5,870	2,036	4,677
98	5,898	6,255	7,531	6,018	2,088	4,794
99+	6,046	6,413	7,720	6,167	2,138	4,916

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

To calculate the 7% 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: 889-891

Male rates

Rates effective 3/1/2025

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
65	2,516	2,669	3,216	2,570	892	1,936
66	2,516	2,669	3,216	2,570	892	1,936
67	2,516	2,669	3,216	2,570	892	1,936
68	2,544	2,700	3,249	2,596	901	2,004
69	2,603	2,759	3,323	2,655	921	2,087
70	2,672	2,834	3,413	2,727	945	2,169
71	2,752	2,918	3,514	2,807	974	2,244
72	2,838	3,011	3,623	2,897	1,004	2,321
73	2,933	3,109	3,744	2,992	1,038	2,398
74	3,033	3,216	3,873	3,093	1,074	2,480
75	3,141	3,330	4,009	3,203	1,112	2,559
76	3,249	3,446	4,149	3,317	1,149	2,640
77	3,363	3,568	4,295	3,433	1,191	2,728
78	3,479	3,688	4,441	3,549	1,231	2,820
79	3,589	3,803	4,581	3,660	1,270	2,910
80	3,700	3,925	4,724	3,774	1,309	3,009
81	3,817	4,048	4,874	3,893	1,352	3,105
82	3,929	4,168	5,016	4,009	1,391	3,196
83	4,050	4,296	5,173	4,133	1,433	3,294
84	4,172	4,422	5,324	4,255	1,476	3,390
85	4,321	4,581	5,519	4,407	1,528	3,513
86	4,445	4,712	5,675	4,535	1,572	3,612
87	4,571	4,846	5,836	4,661	1,618	3,715
88	4,697	4,982	6,000	4,794	1,664	3,818
89	4,829	5,120	6,167	4,926	1,710	3,927
90	4,963	5,262	6,335	5,061	1,756	4,035
91	5,098	5,404	6,508	5,199	1,804	4,143
92	5,234	5,549	6,683	5,340	1,852	4,256
93	5,373	5,698	6,861	5,481	1,903	4,369
94	5,519	5,849	7,044	5,629	1,952	4,485
95	5,659	6,002	7,226	5,774	2,003	4,601
96	5,806	6,156	7,412	5,924	2,055	4,722
97	5,953	6,314	7,602	6,076	2,107	4,841
98	6,104	6,472	7,795	6,228	2,162	4,963
99+	6,260	6,637	7,989	6,384	2,214	5,088

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
65	2,797	2,967	3,573	2,857	991	2,151
66	2,797	2,967	3,573	2,857	991	2,151
67	2,797	2,967	3,573	2,857	991	2,151
68	2,826	2,998	3,609	2,884	1,003	2,228
69	2,892	3,064	3,693	2,951	1,024	2,321
70	2,970	3,150	3,792	3,030	1,051	2,408
71	3,056	3,244	3,906	3,122	1,083	2,494
72	3,154	3,344	4,028	3,218	1,116	2,577
73	3,258	3,454	4,158	3,322	1,155	2,664
74	3,371	3,575	4,303	3,437	1,192	2,755
75	3,487	3,699	4,456	3,560	1,236	2,843
76	3,609	3,829	4,609	3,685	1,278	2,934
77	3,739	3,965	4,774	3,812	1,322	3,032
78	3,864	4,096	4,933	3,942	1,367	3,132
79	3,987	4,226	5,089	4,065	1,412	3,235
80	4,110	4,361	5,248	4,194	1,456	3,343
81	4,240	4,496	5,413	4,326	1,502	3,448
82	4,365	4,631	5,574	4,456	1,544	3,549
83	4,504	4,774	5,747	4,592	1,594	3,660
84	4,632	4,912	5,916	4,725	1,642	3,767
85	4,802	5,091	6,130	4,898	1,699	3,905
86	4,939	5,237	6,305	5,039	1,747	4,017
87	5,079	5,385	6,484	5,182	1,799	4,128
88	5,223	5,534	6,668	5,327	1,849	4,244
89	5,365	5,692	6,852	5,475	1,899	4,362
90	5,516	5,847	7,038	5,624	1,950	4,484
91	5,662	6,006	7,231	5,776	2,003	4,606
92	5,819	6,167	7,426	5,934	2,058	4,729
93	5,970	6,332	7,626	6,090	2,114	4,855
94	6,130	6,499	7,827	6,253	2,170	4,984
95	6,288	6,669	8,031	6,416	2,227	5,114
96	6,449	6,842	8,237	6,582	2,285	5,244
97	6,615	7,017	8,448	6,750	2,340	5,379
98	6,783	7,192	8,662	6,921	2,402	5,514
99+	6,954	7,374	8,875	7,091	2,460	5,651

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

To calculate the 7% household discount:

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

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

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

Modal factors

Semi-annual 0.5200

Quarterly 0.2650

Monthly 0.0833

Continental Life Insurance Company of Brentwood, Tennessee

Annual premiums

For Use in: Rest of State

Female rates

Rates effective 3/1/2025

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
65	2,029	2,150	2,590	2,068	718	1,559
66	2,029	2,150	2,590	2,068	718	1,559
67	2,029	2,150	2,590	2,068	718	1,559
68	2,050	2,172	2,616	2,090	726	1,614
69	2,095	2,221	2,676	2,137	742	1,681
70	2,153	2,282	2,748	2,195	761	1,746
71	2,218	2,350	2,830	2,262	785	1,806
72	2,285	2,424	2,918	2,330	809	1,868
73	2,360	2,502	3,013	2,407	836	1,930
74	2,443	2,591	3,119	2,491	864	1,997
75	2,528	2,680	3,228	2,578	895	2,060
76	2,616	2,774	3,341	2,670	926	2,126
77	2,707	2,872	3,458	2,762	959	2,196
78	2,802	2,969	3,575	2,858	991	2,270
79	2,890	3,062	3,689	2,946	1,022	2,344
80	2,978	3,158	3,803	3,038	1,055	2,423
81	3,074	3,258	3,923	3,136	1,088	2,500
82	3,164	3,355	4,039	3,228	1,120	2,573
83	3,264	3,458	4,165	3,326	1,154	2,651
84	3,358	3,560	4,288	3,426	1,189	2,730
85	3,478	3,690	4,444	3,548	1,231	2,828
86	3,578	3,793	4,568	3,650	1,266	2,910
87	3,679	3,901	4,698	3,755	1,303	2,992
88	3,782	4,010	4,830	3,860	1,339	3,076
89	3,887	4,123	4,964	3,967	1,376	3,162
90	3,996	4,235	5,100	4,075	1,414	3,247
91	4,103	4,351	5,240	4,187	1,452	3,337
92	4,216	4,468	5,382	4,298	1,492	3,427
93	4,327	4,589	5,525	4,414	1,531	3,517
94	4,444	4,709	5,670	4,532	1,572	3,610
95	4,555	4,831	5,819	4,649	1,613	3,706
96	4,675	4,957	5,969	4,769	1,655	3,799
97	4,795	5,084	6,121	4,891	1,697	3,898
98	4,914	5,213	6,276	5,015	1,740	3,996
99+	5,038	5,344	6,432	5,141	1,783	4,097

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
65	2,252	2,388	2,876	2,299	798	1,733
66	2,252	2,388	2,876	2,299	798	1,733
67	2,252	2,388	2,876	2,299	798	1,733
68	2,278	2,413	2,908	2,323	808	1,794
69	2,328	2,468	2,974	2,377	824	1,868
70	2,392	2,537	3,053	2,440	846	1,939
71	2,460	2,612	3,144	2,513	872	2,008
72	2,539	2,693	3,244	2,591	899	2,076
73	2,621	2,780	3,348	2,674	929	2,144
74	2,716	2,879	3,464	2,767	960	2,219
75	2,808	2,978	3,588	2,864	994	2,290
76	2,908	3,083	3,712	2,966	1,030	2,364
77	3,010	3,191	3,845	3,070	1,064	2,441
78	3,112	3,299	3,972	3,174	1,102	2,522
79	3,210	3,403	4,097	3,274	1,136	2,605
80	3,308	3,511	4,225	3,376	1,172	2,690
81	3,414	3,620	4,360	3,484	1,208	2,777
82	3,515	3,728	4,488	3,587	1,244	2,858
83	3,624	3,845	4,630	3,696	1,283	2,946
84	3,730	3,956	4,763	3,806	1,321	3,034
85	3,865	4,099	4,933	3,942	1,368	3,143
86	3,976	4,216	5,075	4,057	1,408	3,233
87	4,090	4,336	5,220	4,171	1,448	3,324
88	4,204	4,457	5,368	4,289	1,488	3,418
89	4,321	4,582	5,514	4,408	1,529	3,512
90	4,442	4,708	5,668	4,526	1,571	3,608
91	4,559	4,835	5,822	4,651	1,613	3,707
92	4,684	4,964	5,982	4,776	1,657	3,809
93	4,807	5,099	6,138	4,903	1,702	3,908
94	4,933	5,232	6,301	5,034	1,747	4,012
95	5,063	5,369	6,466	5,167	1,792	4,117
96	5,194	5,508	6,632	5,299	1,840	4,223
97	5,326	5,651	6,802	5,435	1,885	4,331
98	5,461	5,792	6,973	5,572	1,933	4,439
99+	5,598	5,938	7,148	5,710	1,980	4,552

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

To calculate the 7% household discount:

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

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

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

Modal factors

Semi-annual 0.5200

Quarterly 0.2650

Monthly 0.0833

Continental Life Insurance Company of Brentwood, Tennessee

Annual premiums

For Use in: Rest of State

Male rates

Rates effective 3/1/2025

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
65	2,330	2,471	2,978	2,380	826	1,793
66	2,330	2,471	2,978	2,380	826	1,793
67	2,330	2,471	2,978	2,380	826	1,793
68	2,356	2,500	3,008	2,404	834	1,856
69	2,410	2,555	3,077	2,458	853	1,932
70	2,474	2,624	3,160	2,525	875	2,008
71	2,548	2,702	3,254	2,599	902	2,078
72	2,628	2,788	3,355	2,682	930	2,149
73	2,716	2,879	3,467	2,770	961	2,220
74	2,808	2,978	3,586	2,864	994	2,296
75	2,908	3,083	3,712	2,966	1,030	2,369
76	3,008	3,191	3,842	3,071	1,064	2,444
77	3,114	3,304	3,977	3,179	1,103	2,526
78	3,221	3,415	4,112	3,286	1,140	2,611
79	3,323	3,521	4,242	3,389	1,176	2,694
80	3,426	3,634	4,374	3,494	1,212	2,786
81	3,534	3,748	4,513	3,605	1,252	2,875
82	3,638	3,859	4,644	3,712	1,288	2,959
83	3,750	3,978	4,790	3,827	1,327	3,050
84	3,863	4,094	4,930	3,940	1,367	3,139
85	4,001	4,242	5,110	4,081	1,415	3,253
86	4,116	4,363	5,255	4,199	1,456	3,344
87	4,232	4,487	5,404	4,316	1,498	3,440
88	4,349	4,613	5,556	4,439	1,541	3,535
89	4,471	4,741	5,710	4,561	1,583	3,636
90	4,595	4,872	5,866	4,686	1,626	3,736
91	4,720	5,004	6,026	4,814	1,670	3,836
92	4,846	5,138	6,188	4,944	1,715	3,941
93	4,975	5,276	6,353	5,075	1,762	4,045
94	5,110	5,416	6,522	5,212	1,807	4,153
95	5,240	5,557	6,691	5,346	1,855	4,260
96	5,376	5,700	6,863	5,485	1,903	4,372
97	5,512	5,846	7,039	5,626	1,951	4,482
98	5,652	5,993	7,218	5,767	2,002	4,595
99+	5,796	6,145	7,397	5,911	2,050	4,711

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
65	2,590	2,747	3,308	2,645	918	1,992
66	2,590	2,747	3,308	2,645	918	1,992
67	2,590	2,747	3,308	2,645	918	1,992
68	2,617	2,776	3,342	2,670	929	2,063
69	2,678	2,837	3,419	2,732	948	2,149
70	2,750	2,917	3,511	2,806	973	2,230
71	2,830	3,004	3,617	2,891	1,003	2,309
72	2,920	3,096	3,730	2,980	1,033	2,386
73	3,017	3,198	3,850	3,076	1,069	2,467
74	3,121	3,310	3,984	3,182	1,104	2,551
75	3,229	3,425	4,126	3,296	1,144	2,632
76	3,342	3,545	4,268	3,412	1,183	2,717
77	3,462	3,671	4,420	3,530	1,224	2,807
78	3,578	3,793	4,568	3,650	1,266	2,900
79	3,692	3,913	4,712	3,764	1,307	2,995
80	3,806	4,038	4,859	3,883	1,348	3,095
81	3,926	4,163	5,012	4,006	1,391	3,193
82	4,042	4,288	5,161	4,126	1,430	3,286
83	4,170	4,420	5,321	4,252	1,476	3,389
84	4,289	4,548	5,478	4,375	1,520	3,488
85	4,446	4,714	5,676	4,535	1,573	3,616
86	4,573	4,849	5,838	4,666	1,618	3,719
87	4,703	4,986	6,004	4,798	1,666	3,822
88	4,836	5,124	6,174	4,932	1,712	3,930
89	4,968	5,270	6,344	5,069	1,758	4,039
90	5,107	5,414	6,517	5,207	1,806	4,152
91	5,243	5,561	6,695	5,348	1,855	4,265
92	5,388	5,710	6,876	5,494	1,906	4,379
93	5,528	5,863	7,061	5,639	1,957	4,495
94	5,676	6,018	7,247	5,790	2,009	4,615
95	5,822	6,175	7,436	5,941	2,062	4,735
96	5,971	6,335	7,627	6,094	2,116	4,856
97	6,125	6,497	7,822	6,250	2,167	4,981
98	6,281	6,659	8,020	6,408	2,224	5,106
99+	6,439	6,828	8,218	6,566	2,278	5,232

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

To calculate the 7% household discount:

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

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

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

Modal factors

Semi-annual 0.5200

Quarterly 0.2650

Monthly 0.0833

PREMIUM INFORMATION

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

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

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

HOUSEHOLD DISCOUNT

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

DISCLOSURES

Use this outline to compare benefits and premium among policies.

READ YOUR POLICY VERY CAREFULLY

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

RIGHT TO RETURN POLICY

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

POLICY REPLACEMENT

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

NOTICE

The policy may not cover all of your medical costs.

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

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

COMPLETE ANSWERS ARE VERY IMPORTANT

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

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

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

PLAN A

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,676	$0	$1,676 (Part A Deductible)
61st thru 90th day	All but $419 a day	$419 a day	$0
91st day and after While using 60 lifetime reserve days	All but $838 a day	$838 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 $209.50 a day	$0	Up to $209.50 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 $257 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 $257 of Medicare-Approved amounts*	$0	$0	$257 (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 $257 of Medicare-Approved amounts*	$0	$0	$257 (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 $257 of Medicare-Approved amounts*	$0	$0	$257 (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 $1,676	$1,676 (Part A Deductible)	$0
61st thru 90th day	All but $419 a day	$419 a day	$0
91st day and after While using 60 lifetime reserve days	All but $838 a day	$838 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 $209.50 a day	$0	Up to $209.50 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 B

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

*Once you have been billed $257 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 $257 of Medicare-Approved amounts*	$0	$0	$257 (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 $257 of Medicare-Approved amounts*	$0	$0	$257 (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 $257 of Medicare-Approved amounts*	$0	$0	$257 (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 $1,676	$1,676 (Part A Deductible)	$0
61st thru 90th day	All but $419 a day	$419 a day	$0
91st day and after While using 60 lifetime reserve days	All but $838 a day	$838 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 $209.50 a day	Up to $209.50 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 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 $257 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 $257 of Medicare-Approved amounts*	$0	$257 (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 $257 of Medicare-Approved amounts*	$0	$257 (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 $257 of Medicare-Approved amounts*	$0	$257 (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 $1,676	$1,676 (Part A Deductible)	$0
61st thru 90th day	All but $419 a day	$419 a day	$0
91st day and after While using 60 lifetime reserve days	All but $838 a day	$838 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 $209.50 a day	Up to $209.50 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 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 $257 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 $257 of Medicare-Approved amounts*	$0	$0	$257 (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 $257 of Medicare-Approved amounts*	$0	$0	$257 (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 $257 of Medicare-Approved amounts*	$0	$0	$257 (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 $2,870 deductible. Benefits from high deductible plan G will not begin until out-of-pocket expenses are $2,870. 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 $2,870 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2,870 DEDUCTIBLE*** YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,676	$1,676 (Part A Deductible)	$0
61st thru 90th day	All but $419 a day	$419 a day	$0
91st day and after While using 60 lifetime reserve days	All but $838 a day	$838 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 $209.50 a day	Up to $209.50 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 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 $257 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 $2,870 deductible. Benefits from high deductible plan G will not begin until out-of-pocket expenses are $2,870. 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 $2,870 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2,870 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 $257 of Medicare-Approved amounts*	$0	$0	$257 (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 $257 of Medicare-Approved amounts*	$0	$0	$257 (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 $2,870 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2,870 DEDUCTIBLE*** YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
First $257 of Medicare-Approved amounts*	$0	$0	$257 (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 $2,870 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2,870 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 $1,676	$1,676 (Part A Deductible)	$0
61st thru 90th day	All but $419 a day	$419 a day	$0
91st day and after While using 60 lifetime reserve days	All but $838 a day	$838 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 $209.50 a day	Up to $209.50 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 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 $257 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 $257 of Medicare-Approved amounts*	$0	$0	$257 (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 $257 of Medicare-Approved amounts*	$0	$0	$257 (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 $257 of Medicare-Approved amounts*	$0	$0	$257 (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