Outline of coverage

Medicare Supplement Insurance

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

Virginia

Underwritten by

Continental Life Insurance Company of Brentwood, Tennessee

An Aetna Company

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CLIMS04884VA

Rates effective: 06/2024 B

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. High deductible plan G is the same as high deductible plan F except that where the annual out-of-pocket expenses are met with Medicare Part A expenses only, any subsequent Medicare Part B deductible expense incurred by the beneficiary after the required annual out-of-pocket expenses is met may not be paid for by the high deductible plan G.

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

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

Continental Life Insurance Company of Brentwood, Tennessee

Annual premiums

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

Female rates

Rates effective 6/1/2024

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	1,659	-	-	-	-	-
65	1,659	1,850	2,188	1,918	613	1,272
66	1,659	1,850	2,188	1,918	613	1,272
67	1,659	1,850	2,188	1,918	613	1,272
68	1,676	1,871	2,213	1,938	618	1,315
69	1,716	1,914	2,265	1,983	633	1,369
70	1,761	1,965	2,324	2,038	651	1,422
71	1,815	2,024	2,392	2,097	670	1,471
72	1,871	2,086	2,467	2,162	691	1,521
73	1,932	2,155	2,548	2,234	714	1,572
74	1,999	2,230	2,638	2,312	739	1,627
75	2,069	2,309	2,731	2,392	765	1,679
76	2,142	2,390	2,827	2,477	793	1,732
77	2,217	2,474	2,927	2,565	819	1,791
78	2,294	2,558	3,024	2,651	848	1,850
79	2,364	2,638	3,121	2,732	874	1,909
80	2,438	2,720	3,219	2,818	900	1,975
81	2,514	2,805	3,320	2,908	929	2,038
82	2,591	2,889	3,417	2,994	957	2,096
83	2,669	2,977	3,522	3,087	986	2,160
84	2,747	3,065	3,625	3,179	1,015	2,224
85	2,847	3,177	3,759	3,294	1,051	2,304
86	2,928	3,267	3,866	3,387	1,083	2,372
87	3,013	3,360	3,975	3,485	1,112	2,437
88	3,096	3,455	4,086	3,580	1,143	2,506
89	3,182	3,550	4,200	3,681	1,175	2,576
90	3,271	3,648	4,315	3,782	1,208	2,647
91	3,358	3,749	4,431	3,885	1,241	2,720
92	3,449	3,848	4,551	3,991	1,274	2,793
93	3,542	3,951	4,674	4,095	1,308	2,866
94	3,636	4,056	4,795	4,204	1,342	2,942
95	3,728	4,161	4,922	4,314	1,378	3,018
96	3,825	4,269	5,047	4,425	1,413	3,096
97	3,924	4,378	5,178	4,540	1,448	3,177
98	4,023	4,488	5,308	4,654	1,486	3,256
99+	4,124	4,600	5,440	4,769	1,523	3,338

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	1,843	-	-	-	-	-
65	1,843	2,056	2,432	2,131	682	1,412
66	1,843	2,056	2,432	2,131	682	1,412
67	1,843	2,056	2,432	2,131	682	1,412
68	1,863	2,079	2,461	2,155	687	1,463
69	1,905	2,127	2,516	2,203	703	1,521
70	1,954	2,183	2,582	2,263	722	1,580
71	2,016	2,247	2,661	2,330	745	1,636
72	2,079	2,317	2,741	2,403	767	1,690
73	2,145	2,395	2,830	2,482	794	1,748
74	2,223	2,478	2,932	2,569	822	1,807
75	2,299	2,564	3,035	2,657	851	1,863
76	2,379	2,655	3,139	2,752	881	1,924
77	2,465	2,750	3,251	2,848	910	1,992
78	2,546	2,842	3,359	2,945	941	2,055
79	2,628	2,931	3,467	3,037	969	2,122
80	2,710	3,021	3,574	3,134	999	2,195
81	2,794	3,118	3,688	3,232	1,031	2,261
82	2,876	3,211	3,796	3,326	1,064	2,330
83	2,966	3,309	3,914	3,432	1,096	2,402
84	3,052	3,406	4,028	3,532	1,129	2,473
85	3,164	3,531	4,176	3,660	1,169	2,560
86	3,256	3,630	4,294	3,764	1,202	2,635
87	3,344	3,733	4,419	3,870	1,237	2,709
88	3,440	3,838	4,540	3,977	1,272	2,785
89	3,536	3,945	4,668	4,089	1,306	2,862
90	3,635	4,055	4,794	4,202	1,342	2,942
91	3,732	4,164	4,925	4,315	1,379	3,021
92	3,831	4,277	5,057	4,435	1,416	3,105
93	3,934	4,390	5,191	4,551	1,454	3,184
94	4,039	4,505	5,329	4,671	1,492	3,269
95	4,144	4,622	5,470	4,794	1,529	3,354
96	4,250	4,743	5,610	4,917	1,571	3,440
97	4,358	4,864	5,751	5,042	1,611	3,531
98	4,470	4,986	5,898	5,170	1,653	3,618
99+	4,582	5,112	6,046	5,299	1,694	3,709

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

To calculate a Household discount:

Annual premium **x** modal factor **= modal premium** (round to nearest whole cent)
Modal premium **x** .93 **= discounted premium**

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

Modal factors

Semi-annual 0.5200
Quarterly 0.2650
Monthly 0.0833

Continental Life Insurance Company of Brentwood, Tennessee

Annual premiums

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

Male rates

Rates effective 6/1/2024

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	1,907	-	-	-	-	-
65	1,907	2,130	2,518	2,207	707	1,463
66	1,907	2,130	2,518	2,207	707	1,463
67	1,907	2,130	2,518	2,207	707	1,463
68	1,930	2,150	2,547	2,231	713	1,513
69	1,972	2,200	2,604	2,282	728	1,573
70	2,026	2,259	2,673	2,343	748	1,636
71	2,087	2,327	2,753	2,414	772	1,694
72	2,153	2,399	2,837	2,488	795	1,752
73	2,223	2,478	2,931	2,570	820	1,808
74	2,300	2,564	3,035	2,657	851	1,872
75	2,379	2,654	3,139	2,752	878	1,931
76	2,462	2,749	3,249	2,847	910	1,993
77	2,549	2,845	3,366	2,949	941	2,061
78	2,635	2,942	3,478	3,049	973	2,127
79	2,720	3,032	3,588	3,145	1,003	2,196
80	2,805	3,128	3,699	3,243	1,036	2,270
81	2,892	3,225	3,816	3,343	1,068	2,341
82	2,978	3,321	3,930	3,445	1,101	2,412
83	3,069	3,426	4,051	3,550	1,134	2,485
84	3,159	3,526	4,171	3,654	1,169	2,558
85	3,274	3,654	4,322	3,787	1,210	2,650
86	3,370	3,757	4,443	3,896	1,245	2,726
87	3,463	3,866	4,571	4,006	1,279	2,801
88	3,560	3,972	4,698	4,118	1,316	2,885
89	3,660	4,083	4,828	4,233	1,352	2,963
90	3,761	4,195	4,962	4,349	1,389	3,046
91	3,864	4,310	5,097	4,469	1,428	3,127
92	3,968	4,425	5,234	4,588	1,465	3,213
93	4,073	4,542	5,376	4,709	1,505	3,295
94	4,181	4,663	5,514	4,835	1,543	3,384
95	4,291	4,786	5,658	4,962	1,584	3,471
96	4,400	4,910	5,806	5,089	1,626	3,561
97	4,513	5,035	5,953	5,221	1,666	3,653
98	4,627	5,161	6,106	5,352	1,710	3,746
99+	4,742	5,291	6,258	5,485	1,752	3,841

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	2,120	-	-	-	-	-
65	2,120	2,363	2,798	2,453	785	1,623
66	2,120	2,363	2,798	2,453	785	1,623
67	2,120	2,363	2,798	2,453	785	1,623
68	2,142	2,391	2,829	2,478	791	1,682
69	2,193	2,445	2,889	2,535	808	1,752
70	2,251	2,510	2,969	2,600	831	1,819
71	2,317	2,588	3,059	2,681	855	1,879
72	2,390	2,667	3,153	2,765	883	1,944
73	2,471	2,755	3,256	2,856	911	2,010
74	2,558	2,850	3,372	2,954	944	2,079
75	2,644	2,950	3,490	3,058	978	2,144
76	2,736	3,053	3,613	3,165	1,013	2,213
77	2,834	3,163	3,739	3,277	1,047	2,289
78	2,928	3,268	3,865	3,387	1,083	2,362
79	3,021	3,370	3,986	3,493	1,114	2,441
80	3,117	3,475	4,112	3,605	1,150	2,524
81	3,214	3,585	4,240	3,717	1,186	2,600
82	3,309	3,692	4,368	3,825	1,225	2,679
83	3,412	3,805	4,501	3,947	1,258	2,764
84	3,511	3,917	4,632	4,061	1,298	2,842
85	3,638	4,060	4,800	4,211	1,344	2,944
86	3,745	4,175	4,938	4,328	1,382	3,031
87	3,849	4,293	5,080	4,452	1,422	3,117
88	3,957	4,413	5,219	4,575	1,463	3,204
89	4,069	4,538	5,365	4,702	1,503	3,291
90	4,179	4,662	5,513	4,834	1,543	3,384
91	4,293	4,788	5,662	4,965	1,585	3,474
92	4,407	4,917	5,815	5,099	1,627	3,570
93	4,525	5,049	5,970	5,233	1,671	3,661
94	4,644	5,184	6,129	5,370	1,716	3,761
95	4,766	5,316	6,290	5,513	1,761	3,856
96	4,888	5,455	6,452	5,653	1,805	3,957
97	5,013	5,594	6,614	5,800	1,851	4,060
98	5,140	5,733	6,783	5,946	1,901	4,160
99+	5,271	5,877	6,953	6,092	1,947	4,265

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

To calculate a Household discount:

Annual premium **x** modal factor **= modal premium** (round to nearest whole cent)
Modal premium **x** .93 **= discounted premium**

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

Modal factors

Semi-annual 0.5200
Quarterly 0.2650
Monthly 0.0833

Continental Life Insurance Company of Brentwood, Tennessee

Annual premiums

For Use in: Rest of State

Female rates

Rates effective 6/1/2024

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	1,371	-	-	-	-	-
65	1,371	1,529	1,808	1,585	507	1,051
66	1,371	1,529	1,808	1,585	507	1,051
67	1,371	1,529	1,808	1,585	507	1,051
68	1,385	1,546	1,829	1,602	511	1,087
69	1,418	1,582	1,872	1,639	523	1,131
70	1,455	1,624	1,921	1,684	538	1,175
71	1,500	1,673	1,977	1,733	554	1,216
72	1,546	1,724	2,039	1,787	571	1,257
73	1,597	1,781	2,106	1,846	590	1,299
74	1,652	1,843	2,180	1,911	611	1,345
75	1,710	1,908	2,257	1,977	632	1,388
76	1,770	1,975	2,336	2,047	655	1,431
77	1,832	2,045	2,419	2,120	677	1,480
78	1,896	2,114	2,499	2,191	701	1,529
79	1,954	2,180	2,579	2,258	722	1,578
80	2,015	2,248	2,660	2,329	744	1,632
81	2,078	2,318	2,744	2,403	768	1,684
82	2,141	2,388	2,824	2,474	791	1,732
83	2,206	2,460	2,911	2,551	815	1,785
84	2,270	2,533	2,996	2,627	839	1,838
85	2,353	2,626	3,107	2,722	869	1,904
86	2,420	2,700	3,195	2,799	895	1,960
87	2,490	2,777	3,285	2,880	919	2,014
88	2,559	2,855	3,377	2,959	945	2,071
89	2,630	2,934	3,471	3,042	971	2,129
90	2,703	3,015	3,566	3,126	998	2,188
91	2,775	3,098	3,662	3,211	1,026	2,248
92	2,850	3,180	3,761	3,298	1,053	2,308
93	2,927	3,265	3,863	3,384	1,081	2,369
94	3,005	3,352	3,963	3,474	1,109	2,431
95	3,081	3,439	4,068	3,565	1,139	2,494
96	3,161	3,528	4,171	3,657	1,168	2,559
97	3,243	3,618	4,279	3,752	1,197	2,626
98	3,325	3,709	4,387	3,846	1,228	2,691
99+	3,408	3,802	4,496	3,941	1,259	2,759

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	1,523	-	-	-	-	-
65	1,523	1,699	2,010	1,761	564	1,167
66	1,523	1,699	2,010	1,761	564	1,167
67	1,523	1,699	2,010	1,761	564	1,167
68	1,540	1,718	2,034	1,781	568	1,209
69	1,574	1,758	2,079	1,821	581	1,257
70	1,615	1,804	2,134	1,870	597	1,306
71	1,666	1,857	2,199	1,926	616	1,352
72	1,718	1,915	2,265	1,986	634	1,397
73	1,773	1,979	2,339	2,051	656	1,445
74	1,837	2,048	2,423	2,123	679	1,493
75	1,900	2,119	2,508	2,196	703	1,540
76	1,966	2,194	2,594	2,274	728	1,590
77	2,037	2,273	2,687	2,354	752	1,646
78	2,104	2,349	2,776	2,434	778	1,698
79	2,172	2,422	2,865	2,510	801	1,754
80	2,240	2,497	2,954	2,590	826	1,814
81	2,309	2,577	3,048	2,671	852	1,869
82	2,377	2,654	3,137	2,749	879	1,926
83	2,451	2,735	3,235	2,836	906	1,985
84	2,522	2,815	3,329	2,919	933	2,044
85	2,615	2,918	3,451	3,025	966	2,116
86	2,691	3,000	3,549	3,111	993	2,178
87	2,764	3,085	3,652	3,198	1,022	2,239
88	2,843	3,172	3,752	3,287	1,051	2,302
89	2,922	3,260	3,858	3,379	1,079	2,365
90	3,004	3,351	3,962	3,473	1,109	2,431
91	3,084	3,441	4,070	3,566	1,140	2,497
92	3,166	3,535	4,179	3,665	1,170	2,566
93	3,251	3,628	4,290	3,761	1,202	2,631
94	3,338	3,723	4,404	3,860	1,233	2,702
95	3,425	3,820	4,521	3,962	1,264	2,772
96	3,512	3,920	4,636	4,064	1,298	2,843
97	3,602	4,020	4,753	4,167	1,331	2,918
98	3,694	4,121	4,874	4,273	1,366	2,990
99+	3,787	4,225	4,997	4,379	1,400	3,065

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

To calculate a Household discount:

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

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

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

Modal factors

Semi-annual 0.5200

Quarterly 0.2650

Monthly 0.0833

Continental Life Insurance Company of Brentwood, Tennessee

Annual premiums

For Use in: Rest of State

Male rates

Rates effective 6/1/2024

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	1,576	-	-	-	-	-
65	1,576	1,760	2,081	1,824	584	1,209
66	1,576	1,760	2,081	1,824	584	1,209
67	1,576	1,760	2,081	1,824	584	1,209
68	1,595	1,777	2,105	1,844	589	1,250
69	1,630	1,818	2,152	1,886	602	1,300
70	1,674	1,867	2,209	1,936	618	1,352
71	1,725	1,923	2,275	1,995	638	1,400
72	1,779	1,983	2,345	2,056	657	1,448
73	1,837	2,048	2,422	2,124	678	1,494
74	1,901	2,119	2,508	2,196	703	1,547
75	1,966	2,193	2,594	2,274	726	1,596
76	2,035	2,272	2,685	2,353	752	1,647
77	2,107	2,351	2,782	2,437	778	1,703
78	2,178	2,431	2,874	2,520	804	1,758
79	2,248	2,506	2,965	2,599	829	1,815
80	2,318	2,585	3,057	2,680	856	1,876
81	2,390	2,665	3,154	2,763	883	1,935
82	2,461	2,745	3,248	2,847	910	1,993
83	2,536	2,831	3,348	2,934	937	2,054
84	2,611	2,914	3,447	3,020	966	2,114
85	2,706	3,020	3,572	3,130	1,000	2,190
86	2,785	3,105	3,672	3,220	1,029	2,253
87	2,862	3,195	3,778	3,311	1,057	2,315
88	2,942	3,283	3,883	3,403	1,088	2,384
89	3,025	3,374	3,990	3,498	1,117	2,449
90	3,108	3,467	4,101	3,594	1,148	2,517
91	3,193	3,562	4,212	3,693	1,180	2,584
92	3,279	3,657	4,326	3,792	1,211	2,655
93	3,366	3,754	4,443	3,892	1,244	2,723
94	3,455	3,854	4,557	3,996	1,275	2,797
95	3,546	3,955	4,676	4,101	1,309	2,869
96	3,636	4,058	4,798	4,206	1,344	2,943
97	3,730	4,161	4,920	4,315	1,377	3,019
98	3,824	4,265	5,046	4,423	1,413	3,096
99+	3,919	4,373	5,172	4,533	1,448	3,174

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	1,752	-	-	-	-	-
65	1,752	1,953	2,312	2,027	649	1,341
66	1,752	1,953	2,312	2,027	649	1,341
67	1,752	1,953	2,312	2,027	649	1,341
68	1,770	1,976	2,338	2,048	654	1,390
69	1,812	2,021	2,388	2,095	668	1,448
70	1,860	2,074	2,454	2,149	687	1,503
71	1,915	2,139	2,528	2,216	707	1,553
72	1,975	2,204	2,606	2,285	730	1,607
73	2,042	2,277	2,691	2,360	753	1,661
74	2,114	2,355	2,787	2,441	780	1,718
75	2,185	2,438	2,884	2,527	808	1,772
76	2,261	2,523	2,986	2,616	837	1,829
77	2,342	2,614	3,090	2,708	865	1,892
78	2,420	2,701	3,194	2,799	895	1,952
79	2,497	2,785	3,294	2,887	921	2,017
80	2,576	2,872	3,398	2,979	950	2,086
81	2,656	2,963	3,504	3,072	980	2,149
82	2,735	3,051	3,610	3,161	1,012	2,214
83	2,820	3,145	3,720	3,262	1,040	2,284
84	2,902	3,237	3,828	3,356	1,073	2,349
85	3,007	3,355	3,967	3,480	1,111	2,433
86	3,095	3,450	4,081	3,577	1,142	2,505
87	3,181	3,548	4,198	3,679	1,175	2,576
88	3,270	3,647	4,313	3,781	1,209	2,648
89	3,363	3,750	4,434	3,886	1,242	2,720
90	3,454	3,853	4,556	3,995	1,275	2,797
91	3,548	3,957	4,679	4,103	1,310	2,871
92	3,642	4,064	4,806	4,214	1,345	2,950
93	3,740	4,173	4,934	4,325	1,381	3,026
94	3,838	4,284	5,065	4,438	1,418	3,108
95	3,939	4,393	5,198	4,556	1,455	3,187
96	4,040	4,508	5,332	4,672	1,492	3,270
97	4,143	4,623	5,466	4,793	1,530	3,355
98	4,248	4,738	5,606	4,914	1,571	3,438
99+	4,356	4,857	5,746	5,035	1,609	3,525

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

To calculate a Household discount:

Annual premium **x** modal factor **= modal premium** (round to nearest whole cent)
Modal premium **x** .93 **= discounted premium**

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

Modal factors

Semi-annual 0.5200
Quarterly 0.2650
Monthly 0.0833

PREMIUM INFORMATION

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

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

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

HOUSEHOLD DISCOUNT

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

DISCLOSURES

Use this outline to compare benefits and premium among policies.

READ YOUR POLICY VERY CAREFULLY

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

RIGHT TO RETURN POLICY

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

POLICY REPLACEMENT

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

NOTICE

The policy may not cover all of your medical costs.

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

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

COMPLETE ANSWERS ARE VERY IMPORTANT

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

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

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

PLAN A

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,676	$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