Outline of coverage

Medicare Supplement Insurance

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

Mississippi

Underwritten by

Continental Life Insurance Company of Brentwood, Tennessee

An Aetna Company

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CLIMS04880MS

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. 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 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: 394-395

Female rates

Rates effective 3/1/2025

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	7,814	8,403	10,486	8,476	3,062	6,273
65	1,848	1,988	2,481	2,006	725	1,401
66	1,848	1,988	2,481	2,006	725	1,401
67	1,848	1,988	2,481	2,006	725	1,401
68	1,869	2,009	2,510	2,028	732	1,451
69	1,912	2,057	2,567	2,074	749	1,511
70	1,964	2,112	2,634	2,129	770	1,568
71	2,023	2,175	2,712	2,193	792	1,624
72	2,083	2,242	2,798	2,260	817	1,679
73	2,153	2,313	2,888	2,335	843	1,733
74	2,228	2,394	2,990	2,417	873	1,793
75	2,306	2,480	3,096	2,502	904	1,851
76	2,388	2,567	3,205	2,588	936	1,910
77	2,471	2,654	3,317	2,680	968	1,975
78	2,556	2,748	3,428	2,771	1,001	2,040
79	2,635	2,832	3,536	2,858	1,032	2,105
80	2,718	2,923	3,648	2,948	1,066	2,176
81	2,802	3,015	3,763	3,042	1,098	2,244
82	2,887	3,103	3,875	3,131	1,131	2,311
83	2,975	3,200	3,993	3,227	1,165	2,383
84	3,062	3,294	4,109	3,323	1,200	2,452
85	3,172	3,413	4,259	3,443	1,244	2,540
86	3,265	3,511	4,381	3,540	1,279	2,615
87	3,357	3,608	4,505	3,640	1,314	2,689
88	3,451	3,711	4,634	3,744	1,354	2,763
89	3,549	3,814	4,761	3,847	1,390	2,840
90	3,645	3,920	4,892	3,954	1,428	2,919
91	3,744	4,025	5,024	4,060	1,467	2,999
92	3,844	4,135	5,157	4,170	1,506	3,080
93	3,947	4,244	5,297	4,282	1,547	3,161
94	4,051	4,357	5,436	4,393	1,588	3,244
95	4,156	4,471	5,580	4,509	1,629	3,329
96	4,265	4,586	5,723	4,625	1,672	3,416
97	4,372	4,703	5,867	4,743	1,713	3,503
98	4,486	4,823	6,020	4,862	1,757	3,591
99+	4,598	4,941	6,168	4,986	1,801	3,682

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	8,683	9,338	11,653	9,417	3,402	6,971
65	2,054	2,209	2,757	2,228	806	1,556
66	2,054	2,209	2,757	2,228	806	1,556
67	2,054	2,209	2,757	2,228	806	1,556
68	2,077	2,234	2,788	2,253	814	1,614
69	2,126	2,284	2,850	2,304	834	1,679
70	2,180	2,346	2,926	2,367	854	1,741
71	2,246	2,414	3,014	2,436	881	1,805
72	2,313	2,491	3,110	2,513	906	1,865
73	2,392	2,571	3,209	2,593	936	1,927
74	2,476	2,662	3,323	2,686	971	1,992
75	2,564	2,756	3,439	2,780	1,005	2,057
76	2,653	2,852	3,558	2,876	1,040	2,120
77	2,746	2,950	3,684	2,978	1,076	2,194
78	2,840	3,053	3,809	3,080	1,113	2,267
79	2,927	3,148	3,929	3,175	1,147	2,339
80	3,020	3,248	4,051	3,275	1,183	2,417
81	3,117	3,349	4,179	3,379	1,222	2,492
82	3,208	3,450	4,305	3,479	1,257	2,568
83	3,306	3,556	4,436	3,587	1,295	2,646
84	3,401	3,661	4,567	3,692	1,335	2,726
85	3,527	3,792	4,732	3,825	1,383	2,824
86	3,628	3,902	4,869	3,934	1,422	2,905
87	3,731	4,009	5,006	4,047	1,462	2,987
88	3,836	4,123	5,149	4,157	1,503	3,069
89	3,941	4,238	5,287	4,274	1,544	3,155
90	4,050	4,356	5,435	4,391	1,587	3,244
91	4,157	4,474	5,583	4,510	1,629	3,331
92	4,274	4,593	5,732	4,632	1,675	3,422
93	4,386	4,717	5,887	4,757	1,718	3,511
94	4,504	4,842	6,040	4,882	1,764	3,605
95	4,619	4,967	6,198	5,010	1,810	3,701
96	4,738	5,096	6,357	5,139	1,858	3,795
97	4,859	5,225	6,520	5,269	1,904	3,891
98	4,984	5,357	6,688	5,405	1,953	3,991
99+	5,106	5,491	6,852	5,540	2,001	4,089

The above rates do not include the $6 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: 394-395

Male rates

Rates effective 3/1/2025

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	8,985	9,666	12,059	9,749	3,521	7,215
65	2,127	2,288	2,853	2,305	835	1,613
66	2,127	2,288	2,853	2,305	835	1,613
67	2,127	2,288	2,853	2,305	835	1,613
68	2,150	2,312	2,887	2,329	843	1,668
69	2,199	2,367	2,953	2,383	861	1,738
70	2,258	2,428	3,030	2,448	884	1,802
71	2,326	2,498	3,119	2,520	911	1,868
72	2,396	2,578	3,216	2,600	939	1,931
73	2,476	2,662	3,321	2,686	970	1,993
74	2,564	2,755	3,439	2,780	1,005	2,062
75	2,652	2,852	3,557	2,876	1,038	2,129
76	2,746	2,950	3,684	2,976	1,077	2,196
77	2,842	3,054	3,814	3,082	1,113	2,272
78	2,938	3,161	3,943	3,187	1,150	2,347
79	3,031	3,259	4,067	3,288	1,188	2,422
80	3,127	3,362	4,195	3,391	1,225	2,503
81	3,225	3,468	4,326	3,497	1,262	2,580
82	3,320	3,570	4,457	3,601	1,302	2,659
83	3,422	3,682	4,592	3,712	1,340	2,740
84	3,521	3,788	4,728	3,822	1,381	2,822
85	3,651	3,924	4,897	3,961	1,431	2,923
86	3,756	4,039	5,039	4,071	1,471	3,006
87	3,861	4,150	5,180	4,187	1,513	3,091
88	3,971	4,266	5,328	4,305	1,556	3,179
89	4,082	4,388	5,474	4,423	1,598	3,266
90	4,193	4,509	5,625	4,547	1,643	3,357
91	4,305	4,630	5,778	4,668	1,686	3,447
92	4,422	4,754	5,933	4,795	1,733	3,540
93	4,538	4,882	6,092	4,925	1,779	3,635
94	4,661	5,009	6,251	5,053	1,827	3,731
95	4,783	5,142	6,416	5,186	1,874	3,828
96	4,904	5,275	6,583	5,319	1,923	3,927
97	5,030	5,408	6,748	5,455	1,971	4,027
98	5,156	5,546	6,924	5,592	2,020	4,129
99+	5,286	5,683	7,094	5,734	2,071	4,234

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	9,985	10,738	13,401	10,830	3,912	8,015
65	2,362	2,539	3,170	2,563	925	1,791
66	2,362	2,539	3,170	2,563	925	1,791
67	2,362	2,539	3,170	2,563	925	1,791
68	2,390	2,570	3,207	2,590	936	1,857
69	2,444	2,628	3,277	2,648	957	1,931
70	2,506	2,695	3,363	2,720	983	2,002
71	2,584	2,778	3,467	2,802	1,014	2,074
72	2,661	2,862	3,573	2,888	1,044	2,146
73	2,749	2,958	3,694	2,983	1,077	2,216
74	2,846	3,061	3,822	3,089	1,116	2,291
75	2,948	3,171	3,955	3,198	1,156	2,363
76	3,051	3,279	4,095	3,310	1,196	2,440
77	3,158	3,393	4,236	3,425	1,237	2,524
78	3,267	3,511	4,381	3,541	1,280	2,607
79	3,365	3,622	4,520	3,651	1,319	2,691
80	3,471	3,734	4,661	3,767	1,361	2,779
81	3,584	3,852	4,807	3,886	1,405	2,866
82	3,688	3,965	4,953	4,000	1,444	2,954
83	3,801	4,089	5,103	4,123	1,489	3,043
84	3,911	4,210	5,251	4,245	1,535	3,133
85	4,057	4,362	5,442	4,401	1,590	3,246
86	4,171	4,487	5,598	4,525	1,635	3,340
87	4,292	4,614	5,755	4,652	1,681	3,436
88	4,410	4,743	5,920	4,781	1,728	3,531
89	4,532	4,874	6,079	4,913	1,775	3,628
90	4,660	5,007	6,250	5,052	1,825	3,731
91	4,784	5,146	6,421	5,187	1,874	3,830
92	4,913	5,283	6,590	5,328	1,926	3,935
93	5,042	5,423	6,771	5,473	1,975	4,039
94	5,179	5,569	6,947	5,615	2,029	4,147
95	5,312	5,713	7,127	5,762	2,083	4,257
96	5,451	5,861	7,312	5,911	2,136	4,363
97	5,590	6,008	7,499	6,059	2,191	4,474
98	5,732	6,162	7,691	6,215	2,244	4,590
99+	5,875	6,314	7,881	6,370	2,303	4,704

The above rates do not include the $6 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 3/1/2025

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	6,915	7,436	9,280	7,501	2,710	5,551
65	1,635	1,759	2,196	1,775	642	1,240
66	1,635	1,759	2,196	1,775	642	1,240
67	1,635	1,759	2,196	1,775	642	1,240
68	1,654	1,778	2,221	1,795	648	1,284
69	1,692	1,820	2,272	1,835	663	1,337
70	1,738	1,869	2,331	1,884	681	1,388
71	1,790	1,925	2,400	1,941	701	1,437
72	1,843	1,984	2,476	2,000	723	1,486
73	1,905	2,047	2,556	2,066	746	1,534
74	1,972	2,119	2,646	2,139	773	1,587
75	2,041	2,195	2,740	2,214	800	1,638
76	2,113	2,272	2,836	2,290	828	1,690
77	2,187	2,349	2,935	2,372	857	1,748
78	2,262	2,432	3,034	2,452	886	1,805
79	2,332	2,506	3,129	2,529	913	1,863
80	2,405	2,587	3,228	2,609	943	1,926
81	2,480	2,668	3,330	2,692	972	1,986
82	2,555	2,746	3,429	2,771	1,001	2,045
83	2,633	2,832	3,534	2,856	1,031	2,109
84	2,710	2,915	3,636	2,941	1,062	2,170
85	2,807	3,020	3,769	3,047	1,101	2,248
86	2,889	3,107	3,877	3,133	1,132	2,314
87	2,971	3,193	3,987	3,221	1,163	2,380
88	3,054	3,284	4,101	3,313	1,198	2,445
89	3,141	3,375	4,213	3,404	1,230	2,513
90	3,226	3,469	4,329	3,499	1,264	2,583
91	3,313	3,562	4,446	3,593	1,298	2,654
92	3,402	3,659	4,564	3,690	1,333	2,726
93	3,493	3,756	4,688	3,789	1,369	2,797
94	3,585	3,856	4,811	3,888	1,405	2,871
95	3,678	3,957	4,938	3,990	1,442	2,946
96	3,774	4,058	5,065	4,093	1,480	3,023
97	3,869	4,162	5,192	4,197	1,516	3,100
98	3,970	4,268	5,327	4,303	1,555	3,178
99+	4,069	4,373	5,458	4,412	1,594	3,258

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	7,684	8,264	10,312	8,334	3,011	6,169
65	1,818	1,955	2,440	1,972	713	1,377
66	1,818	1,955	2,440	1,972	713	1,377
67	1,818	1,955	2,440	1,972	713	1,377
68	1,838	1,977	2,467	1,994	720	1,428
69	1,881	2,021	2,522	2,039	738	1,486
70	1,929	2,076	2,589	2,095	756	1,541
71	1,988	2,136	2,667	2,156	780	1,597
72	2,047	2,204	2,752	2,224	802	1,650
73	2,117	2,275	2,840	2,295	828	1,705
74	2,191	2,356	2,941	2,377	859	1,763
75	2,269	2,439	3,043	2,460	889	1,820
76	2,348	2,524	3,149	2,545	920	1,876
77	2,430	2,611	3,260	2,635	952	1,942
78	2,513	2,702	3,371	2,726	985	2,006
79	2,590	2,786	3,477	2,810	1,015	2,070
80	2,673	2,874	3,585	2,898	1,047	2,139
81	2,758	2,964	3,698	2,990	1,081	2,205
82	2,839	3,053	3,810	3,079	1,112	2,273
83	2,926	3,147	3,926	3,174	1,146	2,342
84	3,010	3,240	4,042	3,267	1,181	2,412
85	3,121	3,356	4,188	3,385	1,224	2,499
86	3,211	3,453	4,309	3,481	1,258	2,571
87	3,302	3,548	4,430	3,581	1,294	2,643
88	3,395	3,649	4,557	3,679	1,330	2,716
89	3,488	3,750	4,679	3,782	1,366	2,792
90	3,584	3,855	4,810	3,886	1,404	2,871
91	3,679	3,959	4,941	3,991	1,442	2,948
92	3,782	4,065	5,073	4,099	1,482	3,028
93	3,881	4,174	5,210	4,210	1,520	3,107
94	3,986	4,285	5,345	4,320	1,561	3,190
95	4,088	4,396	5,485	4,434	1,602	3,275
96	4,193	4,510	5,626	4,548	1,644	3,358
97	4,300	4,624	5,770	4,663	1,685	3,443
98	4,411	4,741	5,919	4,783	1,728	3,532
99+	4,519	4,859	6,064	4,903	1,771	3,619

The above rates do not include the $6 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 3/1/2025

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	7,951	8,554	10,672	8,627	3,116	6,385
65	1,882	2,025	2,525	2,040	739	1,427
66	1,882	2,025	2,525	2,040	739	1,427
67	1,882	2,025	2,525	2,040	739	1,427
68	1,903	2,046	2,555	2,061	746	1,476
69	1,946	2,095	2,613	2,109	762	1,538
70	1,998	2,149	2,681	2,166	782	1,595
71	2,058	2,211	2,760	2,230	806	1,653
72	2,120	2,281	2,846	2,301	831	1,709
73	2,191	2,356	2,939	2,377	858	1,764
74	2,269	2,438	3,043	2,460	889	1,825
75	2,347	2,524	3,148	2,545	919	1,884
76	2,430	2,611	3,260	2,634	953	1,943
77	2,515	2,703	3,375	2,727	985	2,011
78	2,600	2,797	3,489	2,820	1,018	2,077
79	2,682	2,884	3,599	2,910	1,051	2,143
80	2,767	2,975	3,712	3,001	1,084	2,215
81	2,854	3,069	3,828	3,095	1,117	2,283
82	2,938	3,159	3,944	3,187	1,152	2,353
83	3,028	3,258	4,064	3,285	1,186	2,425
84	3,116	3,352	4,184	3,382	1,222	2,497
85	3,231	3,473	4,334	3,505	1,266	2,587
86	3,324	3,574	4,459	3,603	1,302	2,660
87	3,417	3,673	4,584	3,705	1,339	2,735
88	3,514	3,775	4,715	3,810	1,377	2,813
89	3,612	3,883	4,844	3,914	1,414	2,890
90	3,711	3,990	4,978	4,024	1,454	2,971
91	3,810	4,097	5,113	4,131	1,492	3,050
92	3,913	4,207	5,250	4,243	1,534	3,133
93	4,016	4,320	5,391	4,358	1,574	3,217
94	4,125	4,433	5,532	4,472	1,617	3,302
95	4,233	4,550	5,678	4,589	1,658	3,388
96	4,340	4,668	5,826	4,707	1,702	3,475
97	4,451	4,786	5,972	4,827	1,744	3,564
98	4,563	4,908	6,127	4,949	1,788	3,654
99+	4,678	5,029	6,278	5,074	1,833	3,747

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	8,836	9,503	11,859	9,584	3,462	7,093
65	2,090	2,247	2,805	2,268	819	1,585
66	2,090	2,247	2,805	2,268	819	1,585
67	2,090	2,247	2,805	2,268	819	1,585
68	2,115	2,274	2,838	2,292	828	1,643
69	2,163	2,326	2,900	2,343	847	1,709
70	2,218	2,385	2,976	2,407	870	1,772
71	2,287	2,458	3,068	2,480	897	1,835
72	2,355	2,533	3,162	2,556	924	1,899
73	2,433	2,618	3,269	2,640	953	1,961
74	2,519	2,709	3,382	2,734	988	2,027
75	2,609	2,806	3,500	2,830	1,023	2,091
76	2,700	2,902	3,624	2,929	1,058	2,159
77	2,795	3,003	3,749	3,031	1,095	2,234
78	2,891	3,107	3,877	3,134	1,133	2,307
79	2,978	3,205	4,000	3,231	1,167	2,381
80	3,072	3,304	4,125	3,334	1,204	2,459
81	3,172	3,409	4,254	3,439	1,243	2,536
82	3,264	3,509	4,383	3,540	1,278	2,614
83	3,364	3,619	4,516	3,649	1,318	2,693
84	3,461	3,726	4,647	3,757	1,358	2,773
85	3,590	3,860	4,816	3,895	1,407	2,873
86	3,691	3,971	4,954	4,004	1,447	2,956
87	3,798	4,083	5,093	4,117	1,488	3,041
88	3,903	4,197	5,239	4,231	1,529	3,125
89	4,011	4,313	5,380	4,348	1,571	3,211
90	4,124	4,431	5,531	4,471	1,615	3,302
91	4,234	4,554	5,682	4,590	1,658	3,389
92	4,348	4,675	5,832	4,715	1,704	3,482
93	4,462	4,799	5,992	4,843	1,748	3,574
94	4,583	4,928	6,148	4,969	1,796	3,670
95	4,701	5,056	6,307	5,099	1,843	3,767
96	4,824	5,187	6,471	5,231	1,890	3,861
97	4,947	5,317	6,636	5,362	1,939	3,959
98	5,073	5,453	6,806	5,500	1,986	4,062
99+	5,199	5,588	6,974	5,637	2,038	4,163

The above rates do not include the $6 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 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