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: 03/2024 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 2024[2]					**$7,060[2]**	**$3,530[2]**				

[1] Plans F and G also have a high deductible option, which require first paying a plan deductible of **$2,800** 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 3/1/2024

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	6,622	7,121	8,886	7,183	2,596	5,316
65	1,566	1,685	2,103	1,700	615	1,188
66	1,566	1,685	2,103	1,700	615	1,188
67	1,566	1,685	2,103	1,700	615	1,188
68	1,584	1,703	2,127	1,719	620	1,229
69	1,620	1,742	2,175	1,757	635	1,280
70	1,664	1,790	2,232	1,805	652	1,329
71	1,714	1,843	2,298	1,859	671	1,376
72	1,765	1,900	2,371	1,915	693	1,423
73	1,824	1,961	2,448	1,979	714	1,469
74	1,888	2,029	2,533	2,049	740	1,520
75	1,955	2,102	2,624	2,120	766	1,568
76	2,024	2,175	2,715	2,193	793	1,618
77	2,094	2,250	2,810	2,271	820	1,674
78	2,166	2,329	2,905	2,348	849	1,729
79	2,233	2,400	2,997	2,422	875	1,784
80	2,303	2,477	3,092	2,498	903	1,844
81	2,375	2,555	3,189	2,578	931	1,902
82	2,446	2,630	3,284	2,653	958	1,958
83	2,521	2,712	3,384	2,735	988	2,019
84	2,596	2,791	3,482	2,816	1,017	2,078
85	2,688	2,892	3,609	2,918	1,054	2,153
86	2,766	2,975	3,713	3,000	1,084	2,216
87	2,845	3,058	3,818	3,085	1,114	2,279
88	2,924	3,145	3,927	3,173	1,147	2,341
89	3,008	3,232	4,034	3,260	1,177	2,407
90	3,089	3,322	4,146	3,350	1,210	2,474
91	3,173	3,411	4,258	3,441	1,243	2,541
92	3,258	3,504	4,371	3,534	1,277	2,610
93	3,345	3,597	4,489	3,628	1,311	2,678
94	3,433	3,693	4,607	3,723	1,346	2,749
95	3,522	3,789	4,729	3,821	1,381	2,822
96	3,614	3,886	4,850	3,920	1,417	2,895
97	3,705	3,986	4,972	4,019	1,452	2,969
98	3,801	4,087	5,101	4,121	1,489	3,043
99+	3,896	4,188	5,226	4,225	1,527	3,120

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	7,359	7,913	9,875	7,981	2,884	5,908
65	1,741	1,872	2,337	1,888	683	1,319
66	1,741	1,872	2,337	1,888	683	1,319
67	1,741	1,872	2,337	1,888	683	1,319
68	1,761	1,893	2,363	1,910	689	1,367
69	1,801	1,936	2,415	1,953	706	1,423
70	1,848	1,988	2,479	2,006	724	1,476
71	1,904	2,045	2,554	2,065	747	1,529
72	1,961	2,111	2,635	2,130	768	1,580
73	2,027	2,179	2,720	2,198	793	1,633
74	2,098	2,257	2,816	2,276	823	1,688
75	2,173	2,336	2,914	2,356	851	1,742
76	2,249	2,417	3,016	2,437	881	1,797
77	2,327	2,501	3,122	2,523	912	1,860
78	2,407	2,588	3,228	2,610	944	1,921
79	2,480	2,668	3,330	2,691	972	1,982
80	2,559	2,753	3,433	2,775	1,002	2,049
81	2,641	2,839	3,541	2,863	1,035	2,112
82	2,719	2,923	3,649	2,948	1,064	2,176
83	2,802	3,014	3,760	3,040	1,097	2,243
84	2,883	3,103	3,870	3,129	1,131	2,310
85	2,989	3,214	4,010	3,242	1,172	2,393
86	3,075	3,306	4,127	3,334	1,205	2,462
87	3,162	3,398	4,242	3,430	1,240	2,531
88	3,251	3,494	4,364	3,523	1,274	2,601
89	3,340	3,591	4,480	3,622	1,309	2,674
90	3,432	3,692	4,606	3,721	1,345	2,749
91	3,523	3,791	4,731	3,822	1,381	2,823
92	3,622	3,893	4,858	3,926	1,419	2,900
93	3,717	3,997	4,989	4,032	1,455	2,975
94	3,817	4,103	5,119	4,137	1,495	3,054
95	3,914	4,209	5,252	4,247	1,535	3,136
96	4,015	4,319	5,388	4,355	1,574	3,216
97	4,118	4,428	5,526	4,466	1,614	3,297
98	4,224	4,540	5,668	4,580	1,654	3,382
99+	4,328	4,653	5,807	4,695	1,696	3,466

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 3/1/2024

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	7,614	8,191	10,220	8,261	2,984	6,114
65	1,802	1,939	2,418	1,954	707	1,366
66	1,802	1,939	2,418	1,954	707	1,366
67	1,802	1,939	2,418	1,954	707	1,366
68	1,823	1,959	2,446	1,974	714	1,414
69	1,863	2,006	2,502	2,019	730	1,472
70	1,913	2,058	2,567	2,075	749	1,528
71	1,971	2,118	2,643	2,136	772	1,583
72	2,031	2,184	2,726	2,204	796	1,636
73	2,098	2,257	2,815	2,276	822	1,689
74	2,173	2,335	2,914	2,356	851	1,748
75	2,248	2,417	3,015	2,437	880	1,805
76	2,327	2,501	3,122	2,522	913	1,861
77	2,408	2,589	3,232	2,611	944	1,926
78	2,489	2,678	3,341	2,701	975	1,989
79	2,568	2,762	3,447	2,787	1,007	2,052
80	2,650	2,849	3,555	2,874	1,038	2,121
81	2,733	2,939	3,666	2,964	1,070	2,187
82	2,814	3,025	3,776	3,052	1,103	2,253
83	2,900	3,120	3,892	3,146	1,136	2,322
84	2,984	3,210	4,007	3,239	1,171	2,391
85	3,094	3,326	4,150	3,356	1,212	2,477
86	3,183	3,423	4,270	3,450	1,246	2,547
87	3,272	3,518	4,390	3,548	1,283	2,619
88	3,365	3,615	4,515	3,649	1,319	2,694
89	3,459	3,719	4,639	3,748	1,354	2,767
90	3,554	3,821	4,767	3,853	1,392	2,845
91	3,649	3,923	4,896	3,956	1,428	2,921
92	3,747	4,028	5,027	4,063	1,469	3,000
93	3,845	4,137	5,163	4,173	1,507	3,080
94	3,950	4,245	5,297	4,283	1,548	3,162
95	4,053	4,357	5,438	4,395	1,588	3,244
96	4,156	4,470	5,579	4,508	1,629	3,328
97	4,262	4,583	5,719	4,623	1,670	3,413
98	4,370	4,700	5,867	4,739	1,712	3,500
99+	4,479	4,816	6,012	4,859	1,755	3,588

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	8,461	9,100	11,357	9,178	3,315	6,792
65	2,001	2,152	2,686	2,172	784	1,518
66	2,001	2,152	2,686	2,172	784	1,518
67	2,001	2,152	2,686	2,172	784	1,518
68	2,025	2,178	2,718	2,194	793	1,573
69	2,071	2,227	2,778	2,244	811	1,636
70	2,124	2,284	2,850	2,305	833	1,697
71	2,190	2,354	2,938	2,375	859	1,757
72	2,255	2,426	3,028	2,448	885	1,818
73	2,330	2,507	3,130	2,528	913	1,878
74	2,413	2,594	3,239	2,618	946	1,941
75	2,498	2,687	3,352	2,710	980	2,002
76	2,585	2,779	3,470	2,805	1,014	2,068
77	2,677	2,876	3,590	2,903	1,049	2,139
78	2,769	2,975	3,713	3,001	1,085	2,209
79	2,852	3,069	3,831	3,094	1,118	2,280
80	2,941	3,164	3,950	3,192	1,153	2,355
81	3,037	3,265	4,074	3,293	1,190	2,428
82	3,126	3,361	4,197	3,390	1,224	2,503
83	3,222	3,466	4,325	3,494	1,262	2,579
84	3,314	3,569	4,450	3,598	1,301	2,656
85	3,437	3,696	4,612	3,730	1,347	2,752
86	3,535	3,802	4,744	3,834	1,385	2,831
87	3,637	3,910	4,877	3,943	1,425	2,912
88	3,738	4,019	5,017	4,052	1,464	2,992
89	3,841	4,130	5,152	4,164	1,504	3,075
90	3,949	4,243	5,296	4,282	1,547	3,162
91	4,054	4,361	5,441	4,396	1,588	3,245
92	4,164	4,477	5,584	4,515	1,632	3,335
93	4,273	4,596	5,738	4,638	1,674	3,423
94	4,389	4,719	5,887	4,758	1,720	3,514
95	4,502	4,842	6,040	4,883	1,765	3,607
96	4,619	4,967	6,197	5,009	1,810	3,697
97	4,737	5,092	6,355	5,135	1,857	3,791
98	4,858	5,222	6,518	5,267	1,902	3,889
99+	4,979	5,352	6,678	5,398	1,952	3,987

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 3/1/2024

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	5,860	6,302	7,864	6,357	2,297	4,704
65	1,386	1,491	1,861	1,504	544	1,051
66	1,386	1,491	1,861	1,504	544	1,051
67	1,386	1,491	1,861	1,504	544	1,051
68	1,402	1,507	1,882	1,521	549	1,088
69	1,434	1,542	1,925	1,555	562	1,133
70	1,473	1,584	1,975	1,597	577	1,176
71	1,517	1,631	2,034	1,645	594	1,218
72	1,562	1,681	2,098	1,695	613	1,259
73	1,614	1,735	2,166	1,751	632	1,300
74	1,671	1,796	2,242	1,813	655	1,345
75	1,730	1,860	2,322	1,876	678	1,388
76	1,791	1,925	2,403	1,941	702	1,432
77	1,853	1,991	2,487	2,010	726	1,481
78	1,917	2,061	2,571	2,078	751	1,530
79	1,976	2,124	2,652	2,143	774	1,579
80	2,038	2,192	2,736	2,211	799	1,632
81	2,102	2,261	2,822	2,281	824	1,683
82	2,165	2,327	2,906	2,348	848	1,733
83	2,231	2,400	2,995	2,420	874	1,787
84	2,297	2,470	3,081	2,492	900	1,839
85	2,379	2,559	3,194	2,582	933	1,905
86	2,448	2,633	3,286	2,655	959	1,961
87	2,518	2,706	3,379	2,730	986	2,017
88	2,588	2,783	3,475	2,808	1,015	2,072
89	2,662	2,860	3,570	2,885	1,042	2,130
90	2,734	2,940	3,669	2,965	1,071	2,189
91	2,808	3,019	3,768	3,045	1,100	2,249
92	2,883	3,101	3,868	3,127	1,130	2,310
93	2,960	3,183	3,973	3,211	1,160	2,370
94	3,038	3,268	4,077	3,295	1,191	2,433
95	3,117	3,353	4,185	3,381	1,222	2,497
96	3,198	3,439	4,292	3,469	1,254	2,562
97	3,279	3,527	4,400	3,557	1,285	2,627
98	3,364	3,617	4,514	3,647	1,318	2,693
99+	3,448	3,706	4,625	3,739	1,351	2,761

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	6,512	7,003	8,739	7,063	2,552	5,228
65	1,541	1,657	2,068	1,671	604	1,167
66	1,541	1,657	2,068	1,671	604	1,167
67	1,541	1,657	2,068	1,671	604	1,167
68	1,558	1,675	2,091	1,690	610	1,210
69	1,594	1,713	2,137	1,728	625	1,259
70	1,635	1,759	2,194	1,775	641	1,306
71	1,685	1,810	2,260	1,827	661	1,353
72	1,735	1,868	2,332	1,885	680	1,398
73	1,794	1,928	2,407	1,945	702	1,445
74	1,857	1,997	2,492	2,014	728	1,494
75	1,923	2,067	2,579	2,085	753	1,542
76	1,990	2,139	2,669	2,157	780	1,590
77	2,059	2,213	2,763	2,233	807	1,646
78	2,130	2,290	2,857	2,310	835	1,700
79	2,195	2,361	2,947	2,381	860	1,754
80	2,265	2,436	3,038	2,456	887	1,813
81	2,337	2,512	3,134	2,534	916	1,869
82	2,406	2,587	3,229	2,609	942	1,926
83	2,480	2,667	3,327	2,690	971	1,985
84	2,551	2,746	3,425	2,769	1,001	2,044
85	2,645	2,844	3,549	2,869	1,037	2,118
86	2,721	2,926	3,652	2,950	1,066	2,179
87	2,798	3,007	3,754	3,035	1,097	2,240
88	2,877	3,092	3,862	3,118	1,127	2,302
89	2,956	3,178	3,965	3,205	1,158	2,366
90	3,037	3,267	4,076	3,293	1,190	2,433
91	3,118	3,355	4,187	3,382	1,222	2,498
92	3,205	3,445	4,299	3,474	1,256	2,566
93	3,289	3,537	4,415	3,568	1,288	2,633
94	3,378	3,631	4,530	3,661	1,323	2,703
95	3,464	3,725	4,648	3,758	1,358	2,775
96	3,553	3,822	4,768	3,854	1,393	2,846
97	3,644	3,919	4,890	3,952	1,428	2,918
98	3,738	4,018	5,016	4,053	1,464	2,993
99+	3,830	4,118	5,139	4,155	1,501	3,067

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 3/1/2024

ATTAINED AGE	PREFERRED					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	6,738	7,249	9,044	7,311	2,641	5,411
65	1,595	1,716	2,140	1,729	626	1,209
66	1,595	1,716	2,140	1,729	626	1,209
67	1,595	1,716	2,140	1,729	626	1,209
68	1,613	1,734	2,165	1,747	632	1,251
69	1,649	1,775	2,214	1,787	646	1,303
70	1,693	1,821	2,272	1,836	663	1,352
71	1,744	1,874	2,339	1,890	683	1,401
72	1,797	1,933	2,412	1,950	704	1,448
73	1,857	1,997	2,491	2,014	727	1,495
74	1,923	2,066	2,579	2,085	753	1,547
75	1,989	2,139	2,668	2,157	779	1,597
76	2,059	2,213	2,763	2,232	808	1,647
77	2,131	2,291	2,860	2,311	835	1,704
78	2,203	2,370	2,957	2,390	863	1,760
79	2,273	2,444	3,050	2,466	891	1,816
80	2,345	2,521	3,146	2,543	919	1,877
81	2,419	2,601	3,244	2,623	947	1,935
82	2,490	2,677	3,342	2,701	976	1,994
83	2,566	2,761	3,444	2,784	1,005	2,055
84	2,641	2,841	3,546	2,866	1,036	2,116
85	2,738	2,943	3,673	2,970	1,073	2,192
86	2,817	3,029	3,779	3,053	1,103	2,254
87	2,896	3,113	3,885	3,140	1,135	2,318
88	2,978	3,199	3,996	3,229	1,167	2,384
89	3,061	3,291	4,105	3,317	1,198	2,449
90	3,145	3,381	4,219	3,410	1,232	2,518
91	3,229	3,472	4,333	3,501	1,264	2,585
92	3,316	3,565	4,449	3,596	1,300	2,655
93	3,403	3,661	4,569	3,693	1,334	2,726
94	3,496	3,757	4,688	3,790	1,370	2,798
95	3,587	3,856	4,812	3,889	1,405	2,871
96	3,678	3,956	4,937	3,989	1,442	2,945
97	3,772	4,056	5,061	4,091	1,478	3,020
98	3,867	4,159	5,192	4,194	1,515	3,097
99+	3,964	4,262	5,320	4,300	1,553	3,175

ATTAINED AGE	STANDARD					
	Plan A	Plan B	Plan F	Plan G	Plan HG	Plan N
Under 65	7,488	8,053	10,050	8,122	2,934	6,011
65	1,771	1,904	2,377	1,922	694	1,343
66	1,771	1,904	2,377	1,922	694	1,343
67	1,771	1,904	2,377	1,922	694	1,343
68	1,792	1,927	2,405	1,942	702	1,392
69	1,833	1,971	2,458	1,986	718	1,448
70	1,880	2,021	2,522	2,040	737	1,502
71	1,938	2,083	2,600	2,102	760	1,555
72	1,996	2,147	2,680	2,166	783	1,609
73	2,062	2,219	2,770	2,237	808	1,662
74	2,135	2,296	2,866	2,317	837	1,718
75	2,211	2,378	2,966	2,398	867	1,772
76	2,288	2,459	3,071	2,482	897	1,830
77	2,369	2,545	3,177	2,569	928	1,893
78	2,450	2,633	3,286	2,656	960	1,955
79	2,524	2,716	3,390	2,738	989	2,018
80	2,603	2,800	3,496	2,825	1,020	2,084
81	2,688	2,889	3,605	2,914	1,053	2,149
82	2,766	2,974	3,714	3,000	1,083	2,215
83	2,851	3,067	3,827	3,092	1,117	2,282
84	2,933	3,158	3,938	3,184	1,151	2,350
85	3,042	3,271	4,081	3,301	1,192	2,435
86	3,128	3,365	4,198	3,393	1,226	2,505
87	3,219	3,460	4,316	3,489	1,261	2,577
88	3,308	3,557	4,440	3,586	1,296	2,648
89	3,399	3,655	4,559	3,685	1,331	2,721
90	3,495	3,755	4,687	3,789	1,369	2,798
91	3,588	3,859	4,815	3,890	1,405	2,872
92	3,685	3,962	4,942	3,996	1,444	2,951
93	3,781	4,067	5,078	4,104	1,481	3,029
94	3,884	4,176	5,210	4,211	1,522	3,110
95	3,984	4,285	5,345	4,321	1,562	3,192
96	4,088	4,396	5,484	4,433	1,602	3,272
97	4,192	4,506	5,624	4,544	1,643	3,355
98	4,299	4,621	5,768	4,661	1,683	3,442
99+	4,406	4,736	5,910	4,777	1,727	3,528

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 $1,632	$0	$1,632 (Part A Deductible)
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after While using 60 lifetime reserve days	All but $816 a day	$816 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 $204 a day	$0	Up to $204 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 $240 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 $240 of Medicare-Approved amounts*	$0	$0	$240 (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 $240 of Medicare-Approved amounts*	$0	$0	$240 (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 $240 of Medicare-Approved amounts*	$0	$0	$240 (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 $1,632	$1,632 (Part A Deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after While using 60 lifetime reserve days	All but $816 a day	$816 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 $204 a day	$0	Up to $204 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 $240 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 $240 of Medicare-Approved amounts*	$0	$0	$240 (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 $240 of Medicare-Approved amounts*	$0	$0	$240 (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 $240 of Medicare-Approved amounts*	$0	$0	$240 (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 $1,632	$1,632 (Part A Deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after While using 60 lifetime reserve days	All but $816 a day	$816 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 $204 a day	Up to $204 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 $240 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 $240 of Medicare-Approved amounts*	$0	$240 (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 $240 of Medicare-Approved amounts*	$0	$240 (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 $240 of Medicare-Approved amounts*	$0	$240 (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 $1,632	$1,632 (Part A Deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after While using 60 lifetime reserve days	All but $816 a day	$816 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 $204 a day	Up to $204 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 $240 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 $240 of Medicare-Approved amounts*	$0	$0	$240 (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 $240 of Medicare-Approved amounts*	$0	$0	$240 (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 $240 of Medicare-Approved amounts*	$0	$0	$240 (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 $2,800 deductible. Benefits from High Deductible Plan G will not begin until out-of-pocket expenses are $2,800. 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 $2,800 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2,800 DEDUCTIBLE*** YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,632	$1,632 (Part A Deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after While using 60 lifetime reserve days	All but $816 a day	$816 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 $204 a day	Up to $204 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 $240 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 $2,800 deductible. Benefits from High Deductible Plan G will not begin until out-of-pocket expenses are $2,800. 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 $2,800 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2,800 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 $240 of Medicare-Approved amounts*	$0	$0	$240 (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 $240 of Medicare-Approved amounts*	$0	$0	$240 (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 $2,800 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2,800 DEDUCTIBLE*** YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
First $240 of Medicare-Approved amounts*	$0	$0	$240 (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 $2,800 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2,800 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 $1,632	$1,632 (Part A Deductible)	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after While using 60 lifetime reserve days	All but $816 a day	$816 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 $204 a day	Up to $204 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 $240 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 $240 of Medicare-Approved amounts*	$0	$0	$240 (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 $240 of Medicare-Approved amounts*	$0	$0	$240 (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 $240 of Medicare-Approved amounts*	$0	$0	$240 (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