Continental Life Insurance Company of Brentwood, Tennessee
An Aetna Company

800 Crescent Centre Dr.
Suite 200
Franklin, TN 37067
800 264.4000
aetnaseniorproducts.com

Outline of Coverage

Medicare Supplement Insurance

BENEFIT PLANS A, B, F, High Deductible F, G, N

Underwritten by

An Aetna Company **Continental Life Insurance Company of Brentwood, Tennessee**

Indiana

©2019 Aetna Inc.
Rates Effective: 09/2018 B

CONTINENTAL LIFE INSURANCE COMPANY OF BRENTWOOD, TENNESSEE
OUTLINE OF MEDICARE SUPPLEMENT COVERAGE COVER PAGE: Page 1 of 2
BENEFIT PLANS AVAILABLE: A, B, F, HIGH DEDUCTIBLE F, G, N

These charts show the benefits included in each of the standard Medicare supplement plans. Every company must make available Plan "A". Some plans may not be available in your state.

Basic Benefits:
Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
Medical Expenses: Part B coinsurance (generally 20% of Medicare-Approved expenses) or, copayments for hospital outpatient services.
Plans K, L, and N require insureds to pay a portion of coinsurance or copayments
Blood: First three pints of blood each year.
Hospice: Part A coinsurance

A	B	C	D	F/F*	G	K	L	M	N
Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance, except up to $20 copayment for office visit, and up to $50 copayment for ER
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Part B Deductible		Part B Deductible					
				Part B Excess (100%)	Part B Excess (100%)				
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency			Foreign Travel Emergency	Foreign Travel Emergency
						Out-of-pocket limit $5560; paid at 100% after limit reached	Out-of-pocket limit $2780; paid at 100% after limit reached		

*Plan F also has an option called a high deductible plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2300 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed $2300. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

Continental Life Insurance Company of Brentwood, Tennessee

Annual Attained Age Premiums
For Use in ZIP Codes: 462-464
Female Rates

Rates Effective 9/1/2018

Attained	Preferred					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,343	1,489	2,093	647	1,409	1,207
66	1,383	1,540	2,168	670	1,460	1,253
67	1,422	1,591	2,242	693	1,513	1,300
68	1,461	1,642	2,315	716	1,562	1,344
69	1,500	1,691	2,390	738	1,612	1,388
70	1,539	1,739	2,462	761	1,661	1,431
71	1,577	1,789	2,533	782	1,709	1,474
72	1,615	1,838	2,604	804	1,759	1,517
73	1,649	1,888	2,680	828	1,814	1,567
74	1,682	1,938	2,755	852	1,866	1,615
75	1,716	1,988	2,830	875	1,920	1,661
76	1,749	2,037	2,907	897	1,971	1,709
77	1,783	2,087	2,980	921	2,024	1,756
78	1,798	2,125	3,044	940	2,070	1,798
79	1,812	2,162	3,105	959	2,115	1,840
80	1,829	2,200	3,166	978	2,159	1,883
81	1,843	2,237	3,228	998	2,204	1,925
82	1,857	2,273	3,288	1,016	2,246	1,967
83	1,877	2,308	3,350	1,035	2,293	2,012
84	1,897	2,344	3,414	1,054	2,341	2,058
85	1,912	2,372	3,467	1,072	2,383	2,099
86	1,926	2,400	3,521	1,088	2,425	2,141
87	1,940	2,430	3,574	1,106	2,466	2,184
88	1,955	2,457	3,632	1,122	2,511	2,228
89	1,969	2,487	3,687	1,138	2,554	2,271
90	1,984	2,517	3,743	1,157	2,596	2,314
91	2,000	2,544	3,797	1,172	2,637	2,356
92	2,015	2,572	3,849	1,190	2,679	2,397
93	2,029	2,597	3,903	1,206	2,720	2,439
94	2,045	2,625	3,955	1,221	2,761	2,480
95	2,060	2,652	4,006	1,238	2,801	2,520
96	2,074	2,678	4,055	1,253	2,841	2,560
97	2,092	2,704	4,106	1,269	2,879	2,599
98	2,107	2,728	4,155	1,285	2,918	2,637
99	2,122	2,753	4,204	1,299	2,954	2,676

Attained	Standard					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,492	1,653	2,326	720	1,565	1,342
66	1,535	1,712	2,408	745	1,623	1,392
67	1,581	1,768	2,493	770	1,679	1,444
68	1,625	1,823	2,575	796	1,735	1,493
69	1,667	1,879	2,655	820	1,791	1,542
70	1,709	1,933	2,734	845	1,846	1,590
71	1,753	1,987	2,812	869	1,901	1,638
72	1,795	2,040	2,892	893	1,955	1,686
73	1,831	2,098	2,978	920	2,016	1,740
74	1,870	2,153	3,062	948	2,073	1,795
75	1,908	2,208	3,146	972	2,132	1,846
76	1,943	2,265	3,230	998	2,191	1,899
77	1,981	2,319	3,312	1,023	2,249	1,952
78	1,998	2,361	3,381	1,045	2,301	1,998
79	2,014	2,402	3,449	1,066	2,351	2,044
80	2,031	2,445	3,519	1,087	2,399	2,092
81	2,049	2,486	3,586	1,109	2,449	2,139
82	2,064	2,526	3,653	1,129	2,497	2,184
83	2,086	2,565	3,724	1,150	2,548	2,236
84	2,107	2,604	3,793	1,171	2,602	2,286
85	2,125	2,634	3,850	1,191	2,648	2,333
86	2,140	2,666	3,911	1,209	2,695	2,380
87	2,155	2,699	3,971	1,229	2,741	2,427
88	2,172	2,732	4,035	1,246	2,789	2,476
89	2,188	2,762	4,097	1,266	2,838	2,524
90	2,205	2,795	4,157	1,286	2,885	2,573
91	2,222	2,827	4,218	1,302	2,931	2,618
92	2,238	2,857	4,278	1,322	2,976	2,664
93	2,256	2,886	4,336	1,340	3,022	2,711
94	2,272	2,917	4,395	1,358	3,069	2,755
95	2,290	2,948	4,451	1,375	3,112	2,801
96	2,307	2,975	4,506	1,393	3,157	2,844
97	2,324	3,005	4,562	1,410	3,200	2,888
98	2,340	3,033	4,617	1,427	3,241	2,931
99	2,360	3,058	4,671	1,444	3,284	2,973

Modal Factors: Semi-Annual: 0.5200 Quarterly: 0.2650 Monthly: 0.08330

The above rates do not include the $20 application fee.

To calculate a Household discount:

Annual premium x modal factor = modal premium (round to nearest whole cent)
Modal premium x .95 = discounted premium

If applying during Open Enrollment or Guaranteed Issue Period, use Preferred rates.

Continental Life Insurance Company of Brentwood, Tennessee

Annual Attained Age Premiums
For Use in ZIP Codes: 462-464
Male Rates

Rates Effective 9/1/2018

Attained	Preferred					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,543	1,713	2,407	745	1,620	1,389
66	1,589	1,770	2,494	770	1,679	1,441
67	1,634	1,830	2,581	797	1,740	1,494
68	1,681	1,888	2,663	823	1,797	1,546
69	1,725	1,945	2,748	849	1,854	1,596
70	1,769	2,001	2,830	875	1,911	1,645
71	1,814	2,057	2,910	899	1,968	1,695
72	1,856	2,113	2,994	924	2,023	1,746
73	1,895	2,172	3,081	952	2,085	1,801
74	1,935	2,229	3,170	979	2,147	1,857
75	1,974	2,286	3,256	1,006	2,207	1,911
76	2,012	2,344	3,344	1,033	2,267	1,966
77	2,051	2,400	3,428	1,059	2,327	2,021
78	2,067	2,444	3,499	1,081	2,381	2,069
79	2,085	2,487	3,572	1,102	2,432	2,115
80	2,102	2,530	3,642	1,126	2,483	2,165
81	2,118	2,573	3,710	1,148	2,534	2,212
82	2,136	2,614	3,781	1,168	2,583	2,262
83	2,157	2,655	3,853	1,191	2,638	2,314
84	2,182	2,696	3,923	1,212	2,695	2,367
85	2,197	2,726	3,985	1,232	2,739	2,414
86	2,215	2,759	4,051	1,251	2,789	2,463
87	2,232	2,794	4,110	1,272	2,837	2,512
88	2,248	2,827	4,176	1,291	2,888	2,562
89	2,265	2,861	4,241	1,310	2,938	2,611
90	2,283	2,893	4,304	1,330	2,986	2,662
91	2,299	2,926	4,365	1,349	3,034	2,710
92	2,318	2,957	4,426	1,368	3,081	2,758
93	2,334	2,988	4,488	1,388	3,129	2,806
94	2,353	3,019	4,547	1,405	3,175	2,852
95	2,369	3,051	4,607	1,423	3,221	2,897
96	2,387	3,081	4,664	1,441	3,265	2,944
97	2,406	3,110	4,722	1,459	3,311	2,989
98	2,423	3,137	4,779	1,478	3,354	3,033
99	2,441	3,166	4,833	1,494	3,399	3,077

Attained	Standard					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,715	1,901	2,675	828	1,801	1,543
66	1,766	1,968	2,769	856	1,865	1,602
67	1,816	2,033	2,867	886	1,932	1,660
68	1,870	2,097	2,960	915	1,995	1,718
69	1,916	2,161	3,053	943	2,060	1,773
70	1,966	2,223	3,144	971	2,122	1,829
71	2,015	2,285	3,234	999	2,186	1,884
72	2,064	2,347	3,326	1,027	2,248	1,939
73	2,106	2,413	3,425	1,057	2,318	2,001
74	2,149	2,478	3,521	1,089	2,386	2,064
75	2,194	2,540	3,619	1,119	2,451	2,124
76	2,236	2,604	3,714	1,148	2,520	2,183
77	2,278	2,666	3,807	1,176	2,588	2,244
78	2,297	2,716	3,890	1,202	2,644	2,298
79	2,315	2,761	3,967	1,226	2,702	2,351
80	2,336	2,810	4,047	1,250	2,759	2,406
81	2,355	2,859	4,124	1,275	2,815	2,461
82	2,373	2,905	4,200	1,299	2,871	2,512
83	2,399	2,950	4,281	1,322	2,931	2,570
84	2,423	2,994	4,362	1,348	2,992	2,630
85	2,443	3,028	4,427	1,369	3,044	2,682
86	2,461	3,065	4,500	1,390	3,098	2,737
87	2,479	3,104	4,568	1,412	3,152	2,790
88	2,497	3,141	4,639	1,433	3,207	2,847
89	2,517	3,178	4,713	1,455	3,264	2,903
90	2,537	3,215	4,783	1,479	3,317	2,959
91	2,554	3,251	4,850	1,498	3,370	3,010
92	2,575	3,285	4,919	1,521	3,423	3,063
93	2,594	3,320	4,987	1,541	3,476	3,118
94	2,615	3,354	5,054	1,562	3,528	3,170
95	2,633	3,391	5,118	1,581	3,580	3,220
96	2,652	3,422	5,182	1,602	3,631	3,271
97	2,672	3,455	5,245	1,622	3,678	3,320
98	2,691	3,487	5,309	1,642	3,729	3,371
99	2,712	3,518	5,369	1,660	3,777	3,419

Modal Factors: Semi-Annual: 0.5200 Quarterly: 0.2650 Monthly: 0.08330

The above rates do not include the $20 application fee.

To calculate a Household discount:

Annual premium x modal factor = modal premium (round to nearest whole cent)
Modal premium x .95 = discounted premium

If applying during Open Enrollment or Guaranteed Issue Period, use Preferred rates.

Continental Life Insurance Company of Brentwood, Tennessee

Annual Attained Age Premiums
For Use in ZIP Codes: Rest of state
Female Rates

Rates Effective 9/1/2018

Attained	Preferred					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,148	1,273	1,789	553	1,204	1,032
66	1,182	1,316	1,853	573	1,248	1,071
67	1,215	1,360	1,916	592	1,293	1,111
68	1,249	1,403	1,979	612	1,335	1,149
69	1,282	1,445	2,043	631	1,378	1,186
70	1,315	1,486	2,104	650	1,420	1,223
71	1,348	1,529	2,165	668	1,461	1,260
72	1,380	1,571	2,226	687	1,503	1,297
73	1,409	1,614	2,291	708	1,550	1,339
74	1,438	1,656	2,355	728	1,595	1,380
75	1,467	1,699	2,419	748	1,641	1,420
76	1,495	1,741	2,485	767	1,685	1,461
77	1,524	1,784	2,547	787	1,730	1,501
78	1,537	1,816	2,602	803	1,769	1,537
79	1,549	1,848	2,654	820	1,808	1,573
80	1,563	1,880	2,706	836	1,845	1,609
81	1,575	1,912	2,759	853	1,884	1,645
82	1,587	1,943	2,810	868	1,920	1,681
83	1,604	1,973	2,863	885	1,960	1,720
84	1,621	2,003	2,918	901	2,001	1,759
85	1,634	2,027	2,963	916	2,037	1,794
86	1,646	2,051	3,009	930	2,073	1,830
87	1,658	2,077	3,055	945	2,108	1,867
88	1,671	2,100	3,104	959	2,146	1,904
89	1,683	2,126	3,151	973	2,183	1,941
90	1,696	2,151	3,199	989	2,219	1,978
91	1,709	2,174	3,245	1,002	2,254	2,014
92	1,722	2,198	3,290	1,017	2,290	2,049
93	1,734	2,220	3,336	1,031	2,325	2,085
94	1,748	2,244	3,380	1,044	2,360	2,120
95	1,761	2,267	3,424	1,058	2,394	2,154
96	1,773	2,289	3,466	1,071	2,428	2,188
97	1,788	2,311	3,509	1,085	2,461	2,221
98	1,801	2,332	3,551	1,098	2,494	2,254
99	1,814	2,353	3,593	1,110	2,525	2,287

Attained	Standard					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,275	1,413	1,988	615	1,338	1,147
66	1,312	1,463	2,058	637	1,387	1,190
67	1,351	1,511	2,131	658	1,435	1,234
68	1,389	1,558	2,201	680	1,483	1,276
69	1,425	1,606	2,269	701	1,531	1,318
70	1,461	1,652	2,337	722	1,578	1,359
71	1,498	1,698	2,403	743	1,625	1,400
72	1,534	1,744	2,472	763	1,671	1,441
73	1,565	1,793	2,545	786	1,723	1,487
74	1,598	1,840	2,617	810	1,772	1,534
75	1,631	1,887	2,689	831	1,822	1,578
76	1,661	1,936	2,761	853	1,873	1,623
77	1,693	1,982	2,831	874	1,922	1,668
78	1,708	2,018	2,890	893	1,967	1,708
79	1,721	2,053	2,948	911	2,009	1,747
80	1,736	2,090	3,008	929	2,050	1,788
81	1,751	2,125	3,065	948	2,093	1,828
82	1,764	2,159	3,122	965	2,134	1,867
83	1,783	2,192	3,183	983	2,178	1,911
84	1,801	2,226	3,242	1,001	2,224	1,954
85	1,816	2,251	3,291	1,018	2,263	1,994
86	1,829	2,279	3,343	1,033	2,303	2,034
87	1,842	2,307	3,394	1,050	2,343	2,074
88	1,856	2,335	3,449	1,065	2,384	2,116
89	1,870	2,361	3,502	1,082	2,426	2,157
90	1,885	2,389	3,553	1,099	2,466	2,199
91	1,899	2,416	3,605	1,113	2,505	2,238
92	1,913	2,442	3,656	1,130	2,544	2,277
93	1,928	2,467	3,706	1,145	2,583	2,317
94	1,942	2,493	3,756	1,161	2,623	2,355
95	1,957	2,520	3,804	1,175	2,660	2,394
96	1,972	2,543	3,851	1,191	2,698	2,431
97	1,986	2,568	3,899	1,205	2,735	2,468
98	2,000	2,592	3,946	1,220	2,770	2,505
99	2,017	2,614	3,992	1,234	2,807	2,541

Modal Factors: Semi-Annual: 0.5200 Quarterly: 0.2650 Monthly: 0.08330

The above rates do not include the $20 application fee.

To calculate a Household discount:

Annual premium x modal factor = modal premium (round to nearest whole cent)
Modal premium x .95 = discounted premium

If applying during Open Enrollment or Guaranteed Issue Period, use Preferred rates.

Continental Life Insurance Company of Brentwood, Tennessee

Annual Attained Age Premiums
For Use in ZIP Codes: Rest of state
Male Rates

Rates Effective 9/1/2018

Attained	Preferred					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,319	1,464	2,057	637	1,385	1,187
66	1,358	1,513	2,132	658	1,435	1,232
67	1,397	1,564	2,206	681	1,487	1,277
68	1,437	1,614	2,276	703	1,536	1,321
69	1,474	1,662	2,349	726	1,585	1,364
70	1,512	1,710	2,419	748	1,633	1,406
71	1,550	1,758	2,487	768	1,682	1,449
72	1,586	1,806	2,559	790	1,729	1,492
73	1,620	1,856	2,633	814	1,782	1,539
74	1,654	1,905	2,709	837	1,835	1,587
75	1,687	1,954	2,783	860	1,886	1,633
76	1,720	2,003	2,858	883	1,938	1,680
77	1,753	2,051	2,930	905	1,989	1,727
78	1,767	2,089	2,991	924	2,035	1,768
79	1,782	2,126	3,053	942	2,079	1,808
80	1,797	2,162	3,113	962	2,122	1,850
81	1,810	2,199	3,171	981	2,166	1,891
82	1,826	2,234	3,232	998	2,208	1,933
83	1,844	2,269	3,293	1,018	2,255	1,978
84	1,865	2,304	3,353	1,036	2,303	2,023
85	1,878	2,330	3,406	1,053	2,341	2,063
86	1,893	2,358	3,462	1,069	2,384	2,105
87	1,908	2,388	3,513	1,087	2,425	2,147
88	1,921	2,416	3,569	1,103	2,468	2,190
89	1,936	2,445	3,625	1,120	2,511	2,232
90	1,951	2,473	3,679	1,137	2,552	2,275
91	1,965	2,501	3,731	1,153	2,593	2,316
92	1,981	2,527	3,783	1,169	2,633	2,357
93	1,995	2,554	3,836	1,186	2,674	2,398
94	2,011	2,580	3,886	1,201	2,714	2,438
95	2,025	2,608	3,938	1,216	2,753	2,476
96	2,040	2,633	3,986	1,232	2,791	2,516
97	2,056	2,658	4,036	1,247	2,830	2,555
98	2,071	2,681	4,085	1,263	2,867	2,592
99	2,086	2,706	4,131	1,277	2,905	2,630

Attained	Standard					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,466	1,625	2,286	708	1,539	1,319
66	1,509	1,682	2,367	732	1,594	1,369
67	1,552	1,738	2,450	757	1,651	1,419
68	1,598	1,792	2,530	782	1,705	1,468
69	1,638	1,847	2,609	806	1,761	1,515
70	1,680	1,900	2,687	830	1,814	1,563
71	1,722	1,953	2,764	854	1,868	1,610
72	1,764	2,006	2,843	878	1,921	1,657
73	1,800	2,062	2,927	903	1,981	1,710
74	1,837	2,118	3,009	931	2,039	1,764
75	1,875	2,171	3,093	956	2,095	1,815
76	1,911	2,226	3,174	981	2,154	1,866
77	1,947	2,279	3,254	1,005	2,212	1,918
78	1,963	2,321	3,325	1,027	2,260	1,964
79	1,979	2,360	3,391	1,048	2,309	2,009
80	1,997	2,402	3,459	1,068	2,358	2,056
81	2,013	2,444	3,525	1,090	2,406	2,103
82	2,028	2,483	3,590	1,110	2,454	2,147
83	2,050	2,521	3,659	1,130	2,505	2,197
84	2,071	2,559	3,728	1,152	2,557	2,248
85	2,088	2,588	3,784	1,170	2,602	2,292
86	2,103	2,620	3,846	1,188	2,648	2,339
87	2,119	2,653	3,904	1,207	2,694	2,385
88	2,134	2,685	3,965	1,225	2,741	2,433
89	2,151	2,716	4,028	1,244	2,790	2,481
90	2,168	2,748	4,088	1,264	2,835	2,529
91	2,183	2,779	4,145	1,280	2,880	2,573
92	2,201	2,808	4,204	1,300	2,926	2,618
93	2,217	2,838	4,262	1,317	2,971	2,665
94	2,235	2,867	4,320	1,335	3,015	2,709
95	2,250	2,898	4,374	1,351	3,060	2,752
96	2,267	2,925	4,429	1,369	3,103	2,796
97	2,284	2,953	4,483	1,386	3,144	2,838
98	2,300	2,980	4,538	1,403	3,187	2,881
99	2,318	3,007	4,589	1,419	3,228	2,922

Modal Factors: Semi-Annual: 0.5200 Quarterly: 0.2650 Monthly: 0.08330

The above rates do not include the $20 application fee.

To calculate a Household discount:

Annual premium x modal factor = modal premium (round to nearest whole cent)
Modal premium x .95 = discounted premium

If applying during Open Enrollment or Guaranteed Issue Period, use Preferred rates.

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 be covered by a Continental Life Insurance Company of Brentwood, Tennessee Medicare supplement policy. The Medicare eligible adult must be either (a) your spouse; (b) be someone with whom you are in a civil union partnership; or (c) be a permanent resident in your home. The household discount will only be applicable if a policy for each applicant is issued. The discounted rate will be 5 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, HIGH DEDUCTIBLE F, 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 $1364	$0	$1364 (Part A Deductible)
61st thru 90th day	All but $341 a day	$341 a day	$0
91st day and after •While using 60 lifetime reserve days	All but $682 a day	$682 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 $170.50 a day	$0	Up to $170.50 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 $185 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic test, durable medical equipment First $185 of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	 $0 Generally 80%	 $0 Generally 20%	 $185 (Part B Deductible) $0
Part B Excess Charges (Above Medicare-Approved amounts)	$0	$0	All costs
BLOOD First 3 pints Next $185 of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	 $0 $0 80%	 All costs $0 20%	 $0 $185 (Part B Deductible) $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 $185of Medicare Approved amounts*	$0	$0	$185 (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 $1364	$1364 (Part A Deductible)	$0
61st thru 90th day	All but $341 a day	$341 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $682 a day	$682 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 $170.50 a day	$0	Up to $170.50 a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN B

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

* Once you have been billed $185 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic test, durable medical equipment First $185 of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	$0 Generally 80%	$0 Generally 20%	$185 (Part B Deductible) $0
Part B Excess Charges (Above Medicare-Approved amounts)	$0	$0	All costs
BLOOD First 3 pints Next $185 of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	$0 $0 80%	All costs $0 20%	$0 $185 (Part B Deductible) $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 $185 of Medicare Approved amounts*	$0	$0	$185 (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 $1364	$1364 (Part A Deductible)	$0
61st thru 90th day	All but $341 a day	$341 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $682 a day	$682 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 $170.50 a day	Up to $170.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare’s requirements, including a doctor’s certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to 365 days as provided in the policy’s “Core Benefits.” During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN F

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

*Once you have been billed $185 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic test, durable medical equipment			
First $185 of Medicare-Approved amounts*	$0	$185 (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 $185 of Medicare-Approved amounts*	$0	$185 (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 $185 of Medicare Approved amounts*	$0	$185 (Part B Deductible)	$0
•Remainder of Medicare Approved amounts	80%	20%	$0

PLAN F

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

HIGH DEDUCTIBLE PLAN F

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

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

*****This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2300 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses are $2300. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.**

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2300 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2300 DEDUCTIBLE*** YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1364	$1364 (Part A Deductible)	$0
61st thru 90th day	All but $341 a day	$341 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $682 a day	$682 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 $170.50 a day	Up to $170.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0

HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

HIGH DEDUCTIBLE PLAN F

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

*Once you have been billed $185 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

*****This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2300 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses are $2300. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.**

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2300 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2300 DEDUCTIBLE*** YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic test, durable medical equipment First $185 of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	$0 Generally 80%	$185 (Part B Deductible) Generally 20%	$0 $0
Part B Excess Charges (Above Medicare-Approved amounts)	$0	100%	$0
BLOOD First 3 pints Next $185 of Medicare-Approved amounts* Remainder of Medicare-Approved amounts	$0 $0 80%	All costs $185 (Part B Deductible) 20%	$0 $0 $0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

HIGH DEDUCTIBLE PLAN F

PARTS A & B

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2300 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2300 DEDUCTIBLE*** YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
•Medically necessary skilled care services and medical supplies	100%	$0	$0
•Durable medical equipment			
•First $185 of Medicare Approved amounts*	$0	$185 (Part B Deductible)	$0
•Remainder of Medicare Approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2300 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2300 DEDUCTIBLE** YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN G

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1364	$1364 (Part A Deductible)	$0
61st thru 90th day	All but $341 a day	$341 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $682 a day	$682 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 $170.50 a day	Up to $170.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness services	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN G

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

*Once you have been billed $185 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic test, durable medical equipment			
First $185 of Medicare-Approved amounts*	$0	$0	$185 (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 $185 of Medicare-Approved amounts*	$0	$0	$185 (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 $185 of Medicare Approved amounts*	$0	$0	$185 (Part B Deductible)
•Remainder of Medicare Approved amounts	80%	20%	$0

PLAN G

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN N

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1364	$1364 (Part A Deductible)	$0
61st thru 90th day	All but $341 a day	$341 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $682 a day	$682 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 $170.50 a day	Up to $170.50 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness services	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN N

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

*Once you have been billed $185 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic test, durable medical equipment			
First $185 of Medicare-Approved amounts*	$0	$0	$185 (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 $185 of Medicare-Approved amounts*	$0	$0	$185 (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 $185 of Medicare Approved amounts*	$0	$0	$185 (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