800 Crescent Centre Dr.
Suite 200
Franklin, TN 37067
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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

CLIMS02244IN

Rates Effective: 09/2016 A

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, co-payments 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 $4960; paid at 100% after limit reached	Out-of-pocket limit $2480; 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 $2180 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed $2180. 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 09/01/2016

Attained	Preferred					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,232	1,489	1,722	647	1,243	1,108
66	1,268	1,540	1,784	670	1,288	1,150
67	1,305	1,591	1,845	693	1,334	1,192
68	1,341	1,642	1,906	716	1,377	1,233
69	1,376	1,691	1,967	738	1,422	1,273
70	1,411	1,739	2,025	761	1,465	1,313
71	1,447	1,789	2,084	782	1,508	1,353
72	1,481	1,838	2,142	804	1,551	1,392
73	1,513	1,888	2,205	828	1,599	1,437
74	1,543	1,938	2,267	852	1,646	1,481
75	1,575	1,988	2,328	875	1,693	1,525
76	1,605	2,037	2,393	897	1,739	1,568
77	1,636	2,087	2,452	921	1,785	1,611
78	1,650	2,125	2,505	940	1,825	1,650
79	1,663	2,162	2,555	959	1,865	1,688
80	1,678	2,200	2,606	978	1,904	1,727
81	1,691	2,237	2,656	998	1,943	1,766
82	1,704	2,273	2,705	1,016	1,981	1,804
83	1,722	2,308	2,757	1,035	2,023	1,846
84	1,740	2,344	2,809	1,054	2,065	1,888
85	1,754	2,372	2,852	1,072	2,101	1,926
86	1,767	2,400	2,897	1,088	2,139	1,964
87	1,780	2,430	2,941	1,106	2,175	2,004
88	1,794	2,457	2,988	1,122	2,214	2,044
89	1,806	2,487	3,034	1,138	2,252	2,084
90	1,821	2,517	3,079	1,157	2,290	2,124
91	1,835	2,544	3,124	1,172	2,326	2,162
92	1,849	2,572	3,167	1,190	2,362	2,200
93	1,861	2,597	3,212	1,206	2,399	2,238
94	1,877	2,625	3,254	1,221	2,435	2,276
95	1,891	2,652	3,296	1,238	2,470	2,312
96	1,904	2,678	3,337	1,253	2,505	2,348
97	1,919	2,704	3,378	1,269	2,539	2,384
98	1,933	2,728	3,419	1,285	2,573	2,420
99	1,947	2,753	3,459	1,299	2,606	2,455

Modal Factors: Semi-Annual: 0.5200

Attained	Standard					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,369	1,653	1,914	720	1,381	1,231
66	1,409	1,712	1,981	745	1,431	1,278
67	1,450	1,768	2,051	770	1,481	1,324
68	1,491	1,823	2,119	796	1,530	1,370
69	1,529	1,879	2,184	820	1,580	1,415
70	1,568	1,933	2,250	845	1,627	1,459
71	1,608	1,987	2,314	869	1,677	1,502
72	1,646	2,040	2,380	893	1,723	1,547
73	1,680	2,098	2,450	920	1,777	1,596
74	1,715	2,153	2,519	948	1,829	1,646
75	1,750	2,208	2,589	972	1,880	1,694
76	1,783	2,265	2,658	998	1,932	1,742
77	1,817	2,319	2,725	1,023	1,983	1,790
78	1,833	2,361	2,782	1,045	2,029	1,833
79	1,847	2,402	2,838	1,066	2,072	1,876
80	1,864	2,445	2,896	1,087	2,115	1,919
81	1,879	2,486	2,951	1,109	2,160	1,962
82	1,893	2,526	3,006	1,129	2,202	2,004
83	1,914	2,565	3,064	1,150	2,248	2,051
84	1,933	2,604	3,120	1,171	2,294	2,098
85	1,949	2,634	3,168	1,191	2,334	2,140
86	1,963	2,666	3,219	1,209	2,375	2,183
87	1,977	2,699	3,268	1,229	2,417	2,227
88	1,993	2,732	3,320	1,246	2,459	2,271
89	2,008	2,762	3,372	1,266	2,503	2,315
90	2,023	2,795	3,421	1,286	2,544	2,360
91	2,038	2,827	3,470	1,302	2,585	2,402
92	2,053	2,857	3,519	1,322	2,625	2,444
93	2,070	2,886	3,567	1,340	2,665	2,487
94	2,085	2,917	3,616	1,358	2,706	2,528
95	2,100	2,948	3,662	1,375	2,745	2,569
96	2,117	2,975	3,708	1,393	2,783	2,609
97	2,132	3,005	3,753	1,410	2,821	2,649
98	2,147	3,033	3,799	1,427	2,858	2,689
99	2,165	3,058	3,842	1,444	2,896	2,727

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 09/01/2016

Attained	Preferred					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,416	1,713	1,980	745	1,429	1,274
66	1,458	1,770	2,052	770	1,481	1,322
67	1,500	1,830	2,124	797	1,534	1,371
68	1,542	1,888	2,191	823	1,584	1,418
69	1,582	1,945	2,262	849	1,636	1,464
70	1,623	2,001	2,328	875	1,685	1,509
71	1,664	2,057	2,395	899	1,735	1,555
72	1,702	2,113	2,464	924	1,784	1,602
73	1,739	2,172	2,535	952	1,838	1,652
74	1,775	2,229	2,608	979	1,893	1,704
75	1,811	2,286	2,679	1,006	1,946	1,753
76	1,846	2,344	2,752	1,033	2,000	1,803
77	1,881	2,400	2,821	1,059	2,052	1,853
78	1,897	2,444	2,879	1,081	2,099	1,898
79	1,913	2,487	2,939	1,102	2,145	1,941
80	1,929	2,530	2,996	1,126	2,189	1,985
81	1,943	2,573	3,053	1,148	2,235	2,030
82	1,960	2,614	3,111	1,168	2,278	2,074
83	1,980	2,655	3,170	1,191	2,327	2,124
84	2,002	2,696	3,228	1,212	2,375	2,172
85	2,016	2,726	3,280	1,232	2,416	2,215
86	2,032	2,759	3,332	1,251	2,459	2,259
87	2,048	2,794	3,382	1,272	2,501	2,305
88	2,062	2,827	3,435	1,291	2,546	2,351
89	2,078	2,861	3,490	1,310	2,590	2,396
90	2,094	2,893	3,542	1,330	2,633	2,442
91	2,110	2,926	3,592	1,349	2,676	2,486
92	2,126	2,957	3,642	1,368	2,717	2,530
93	2,141	2,988	3,693	1,388	2,759	2,574
94	2,159	3,019	3,740	1,405	2,800	2,617
95	2,174	3,051	3,791	1,423	2,841	2,658
96	2,190	3,081	3,838	1,441	2,879	2,700
97	2,207	3,110	3,886	1,459	2,919	2,742
98	2,223	3,137	3,932	1,478	2,959	2,782
99	2,239	3,166	3,977	1,494	2,998	2,823

Attained	Standard					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,574	1,901	2,201	828	1,588	1,416
66	1,619	1,968	2,279	856	1,645	1,470
67	1,666	2,033	2,359	886	1,704	1,523
68	1,715	2,097	2,436	915	1,760	1,576
69	1,759	2,161	2,512	943	1,817	1,626
70	1,803	2,223	2,587	971	1,872	1,678
71	1,849	2,285	2,661	999	1,928	1,728
72	1,893	2,347	2,737	1,027	1,982	1,778
73	1,932	2,413	2,817	1,057	2,044	1,836
74	1,971	2,478	2,897	1,089	2,104	1,893
75	2,012	2,540	2,978	1,119	2,162	1,948
76	2,051	2,604	3,056	1,148	2,222	2,003
77	2,090	2,666	3,132	1,176	2,282	2,059
78	2,107	2,716	3,200	1,202	2,332	2,108
79	2,125	2,761	3,264	1,226	2,382	2,156
80	2,143	2,810	3,330	1,250	2,432	2,207
81	2,161	2,859	3,393	1,275	2,483	2,257
82	2,177	2,905	3,456	1,299	2,532	2,305
83	2,201	2,950	3,523	1,322	2,585	2,359
84	2,223	2,994	3,588	1,348	2,638	2,413
85	2,242	3,028	3,643	1,369	2,684	2,461
86	2,257	3,065	3,702	1,390	2,732	2,511
87	2,274	3,104	3,759	1,412	2,779	2,560
88	2,291	3,141	3,818	1,433	2,828	2,611
89	2,308	3,178	3,877	1,455	2,878	2,663
90	2,327	3,215	3,935	1,479	2,925	2,714
91	2,344	3,251	3,991	1,498	2,972	2,762
92	2,362	3,285	4,047	1,521	3,019	2,810
93	2,380	3,320	4,103	1,541	3,065	2,861
94	2,399	3,354	4,158	1,562	3,111	2,907
95	2,415	3,391	4,211	1,581	3,157	2,954
96	2,434	3,422	4,263	1,602	3,201	3,001
97	2,451	3,455	4,316	1,622	3,243	3,047
98	2,469	3,487	4,369	1,642	3,288	3,092
99	2,489	3,518	4,418	1,660	3,331	3,137

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 09/01/2016

Attained Age	Preferred					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,053	1,273	1,472	553	1,062	947
66	1,084	1,316	1,525	573	1,101	983
67	1,115	1,360	1,577	592	1,140	1,019
68	1,146	1,403	1,629	612	1,177	1,054
69	1,176	1,445	1,681	631	1,215	1,088
70	1,206	1,486	1,731	650	1,252	1,122
71	1,237	1,529	1,781	668	1,289	1,156
72	1,266	1,571	1,831	687	1,326	1,190
73	1,293	1,614	1,885	708	1,367	1,228
74	1,319	1,656	1,938	728	1,407	1,266
75	1,346	1,699	1,990	748	1,447	1,303
76	1,372	1,741	2,045	767	1,486	1,340
77	1,398	1,784	2,096	787	1,526	1,377
78	1,410	1,816	2,141	803	1,560	1,410
79	1,421	1,848	2,184	820	1,594	1,443
80	1,434	1,880	2,227	836	1,627	1,476
81	1,445	1,912	2,270	853	1,661	1,509
82	1,456	1,943	2,312	868	1,693	1,542
83	1,472	1,973	2,356	885	1,729	1,578
84	1,487	2,003	2,401	901	1,765	1,614
85	1,499	2,027	2,438	916	1,796	1,646
86	1,510	2,051	2,476	930	1,828	1,679
87	1,521	2,077	2,514	945	1,859	1,713
88	1,533	2,100	2,554	959	1,892	1,747
89	1,544	2,126	2,593	973	1,925	1,781
90	1,556	2,151	2,632	989	1,957	1,815
91	1,568	2,174	2,670	1,002	1,988	1,848
92	1,580	2,198	2,707	1,017	2,019	1,880
93	1,591	2,220	2,745	1,031	2,050	1,913
94	1,604	2,244	2,781	1,044	2,081	1,945
95	1,616	2,267	2,817	1,058	2,111	1,976
96	1,627	2,289	2,852	1,071	2,141	2,007
97	1,640	2,311	2,887	1,085	2,170	2,038
98	1,652	2,332	2,922	1,098	2,199	2,068
99	1,664	2,353	2,956	1,110	2,227	2,098

Attained Age	Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,170	1,413	1,636	615	1,180	1,052
66	1,204	1,463	1,693	637	1,223	1,092
67	1,239	1,511	1,753	658	1,266	1,132
68	1,274	1,558	1,811	680	1,308	1,171
69	1,307	1,606	1,867	701	1,350	1,209
70	1,340	1,652	1,923	722	1,391	1,247
71	1,374	1,698	1,978	743	1,433	1,284
72	1,407	1,744	2,034	763	1,473	1,322
73	1,436	1,793	2,094	786	1,519	1,364
74	1,466	1,840	2,153	810	1,563	1,407
75	1,496	1,887	2,213	831	1,607	1,448
76	1,524	1,936	2,272	853	1,651	1,489
77	1,553	1,982	2,329	874	1,695	1,530
78	1,567	2,018	2,378	893	1,734	1,567
79	1,579	2,053	2,426	911	1,771	1,603
80	1,593	2,090	2,475	929	1,808	1,640
81	1,606	2,125	2,522	948	1,846	1,677
82	1,618	2,159	2,569	965	1,882	1,713
83	1,636	2,192	2,619	983	1,921	1,753
84	1,652	2,226	2,667	1,001	1,961	1,793
85	1,666	2,251	2,708	1,018	1,995	1,829
86	1,678	2,279	2,751	1,033	2,030	1,866
87	1,690	2,307	2,793	1,050	2,066	1,903
88	1,703	2,335	2,838	1,065	2,102	1,941
89	1,716	2,361	2,882	1,082	2,139	1,979
90	1,729	2,389	2,924	1,099	2,174	2,017
91	1,742	2,416	2,966	1,113	2,209	2,053
92	1,755	2,442	3,008	1,130	2,244	2,089
93	1,769	2,467	3,049	1,145	2,278	2,126
94	1,782	2,493	3,091	1,161	2,313	2,161
95	1,795	2,520	3,130	1,175	2,346	2,196
96	1,809	2,543	3,169	1,191	2,379	2,230
97	1,822	2,568	3,208	1,205	2,411	2,264
98	1,835	2,592	3,247	1,220	2,443	2,298
99	1,850	2,614	3,284	1,234	2,475	2,331

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 09/01/2016

Attained Age	Preferred					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,210	1,464	1,692	637	1,221	1,089
66	1,246	1,513	1,754	658	1,266	1,130
67	1,282	1,564	1,815	681	1,311	1,172
68	1,318	1,614	1,873	703	1,354	1,212
69	1,352	1,662	1,933	726	1,398	1,251
70	1,387	1,710	1,990	748	1,440	1,290
71	1,422	1,758	2,047	768	1,483	1,329
72	1,455	1,806	2,106	790	1,525	1,369
73	1,486	1,856	2,167	814	1,571	1,412
74	1,517	1,905	2,229	837	1,618	1,456
75	1,548	1,954	2,290	860	1,663	1,498
76	1,578	2,003	2,352	883	1,709	1,541
77	1,608	2,051	2,411	905	1,754	1,584
78	1,621	2,089	2,461	924	1,794	1,622
79	1,635	2,126	2,512	942	1,833	1,659
80	1,649	2,162	2,561	962	1,871	1,697
81	1,661	2,199	2,609	981	1,910	1,735
82	1,675	2,234	2,659	998	1,947	1,773
83	1,692	2,269	2,709	1,018	1,989	1,815
84	1,711	2,304	2,759	1,036	2,030	1,856
85	1,723	2,330	2,803	1,053	2,065	1,893
86	1,737	2,358	2,848	1,069	2,102	1,931
87	1,750	2,388	2,891	1,087	2,138	1,970
88	1,762	2,416	2,936	1,103	2,176	2,009
89	1,776	2,445	2,983	1,120	2,214	2,048
90	1,790	2,473	3,027	1,137	2,250	2,087
91	1,803	2,501	3,070	1,153	2,287	2,125
92	1,817	2,527	3,113	1,169	2,322	2,162
93	1,830	2,554	3,156	1,186	2,358	2,200
94	1,845	2,580	3,197	1,201	2,393	2,237
95	1,858	2,608	3,240	1,216	2,428	2,272
96	1,872	2,633	3,280	1,232	2,461	2,308
97	1,886	2,658	3,321	1,247	2,495	2,344
98	1,900	2,681	3,361	1,263	2,529	2,378
99	1,914	2,706	3,399	1,277	2,562	2,413

Attained Age	Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,345	1,625	1,881	708	1,357	1,210
66	1,384	1,682	1,948	732	1,406	1,256
67	1,424	1,738	2,016	757	1,456	1,302
68	1,466	1,792	2,082	782	1,504	1,347
69	1,503	1,847	2,147	806	1,553	1,390
70	1,541	1,900	2,211	830	1,600	1,434
71	1,580	1,953	2,274	854	1,648	1,477
72	1,618	2,006	2,339	878	1,694	1,520
73	1,651	2,062	2,408	903	1,747	1,569
74	1,685	2,118	2,476	931	1,798	1,618
75	1,720	2,171	2,545	956	1,848	1,665
76	1,753	2,226	2,612	981	1,899	1,712
77	1,786	2,279	2,677	1,005	1,950	1,760
78	1,801	2,321	2,735	1,027	1,993	1,802
79	1,816	2,360	2,790	1,048	2,036	1,843
80	1,832	2,402	2,846	1,068	2,079	1,886
81	1,847	2,444	2,900	1,090	2,122	1,929
82	1,861	2,483	2,954	1,110	2,164	1,970
83	1,881	2,521	3,011	1,130	2,209	2,016
84	1,900	2,559	3,067	1,152	2,255	2,062
85	1,916	2,588	3,114	1,170	2,294	2,103
86	1,929	2,620	3,164	1,188	2,335	2,146
87	1,944	2,653	3,213	1,207	2,375	2,188
88	1,958	2,685	3,263	1,225	2,417	2,232
89	1,973	2,716	3,314	1,244	2,460	2,276
90	1,989	2,748	3,363	1,264	2,500	2,320
91	2,003	2,779	3,411	1,280	2,540	2,361
92	2,019	2,808	3,459	1,300	2,580	2,402
93	2,034	2,838	3,507	1,317	2,620	2,445
94	2,050	2,867	3,554	1,335	2,659	2,485
95	2,064	2,898	3,599	1,351	2,698	2,525
96	2,080	2,925	3,644	1,369	2,736	2,565
97	2,095	2,953	3,689	1,386	2,772	2,604
98	2,110	2,980	3,734	1,403	2,810	2,643
99	2,127	3,007	3,776	1,419	2,847	2,681

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 CALENDAR YEAR

*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 $1288	$0	$1288 (Part A Deductible)
61st thru 90th day	All but $322 a day	$322 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $644 a day	$644 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 $161 a day	$0	Up to $161 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 $166 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 $166 of Medicare-Approved amounts*	$0	$0	$166 (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 $166 of Medicare-Approved amounts*	$0	$0	$166 (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 $166of Medicare Approved amounts*	$0	$0	$166 (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 $1288	$1288 (Part A Deductible)	$0
61st thru 90th day	All but $322 a day	$322 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $644 a day	$644 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 $161 a day	$0	Up to $161 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 $166 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 $166 of Medicare-Approved amounts*	$0	$0	$166 (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 $166 of Medicare-Approved amounts*	$0	$0	$166 (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 $166 of Medicare Approved amounts*	$0	$0	$166 (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 $1288	$1288 (Part A Deductible)	$0
61st thru 90th day	All but $322 a day	$322 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $644 a day	$644 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 $161 a day	Up to $161 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 $166 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 $166 of Medicare-Approved amounts*	$0	$166 (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 $166 of Medicare-Approved amounts*	$0	$166 (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 $166 of Medicare Approved amounts*	$0	$166 (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 $2180 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses are $2180. 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 $2180 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2180 DEDUCTIBLE*** YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1288	$1288 (Part A Deductible)	$0
61st thru 90th day	All but $322 a day	$322 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $644 a day	$644 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 $161 a day	Up to $161 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 $166 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 $2180 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses are $2180. 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 $2180 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2180 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 $166 of Medicare-Approved amounts*	$0	$166 (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 $166 of Medicare-Approved amounts*	$0	$166 (Part B Deductible)	$0
Remainder of Medicare-Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

HIGH DEDUCTIBLE PLAN F

PARTS A & B

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2180 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2180 DEDUCTIBLE*** YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
•Medically necessary skilled care services and medical supplies	100%	$0	$0
•Durable medical equipment			
•First $166 of Medicare Approved amounts*	$0	$166 (Part B Deductible)	$0
•Remainder of Medicare Approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2180 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2180 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 $1288	$1288 (Part A Deductible)	$0
61st thru 90th day	All but $322 a day	$322 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $644 a day	$644 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 $161 a day	Up to $161 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 $166 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 $166 of Medicare-Approved amounts*	$0	$0	$166 (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 $166 of Medicare-Approved amounts*	$0	$0	$166 (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 $166 of Medicare Approved amounts*	$0	$0	$166 (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 $1288	$1288 (Part A Deductible)	$0
61st thru 90th day	All but $322 a day	$322 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $644 a day	$644 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 $161 a day	Up to $161 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 co-payment/ 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 $166 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 $166 of Medicare-Approved amounts*	$0	$0	$166 (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 $166 of Medicare-Approved amounts*	$0	$0	$166 (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 $166 of Medicare Approved amounts*	$0	$0	$166 (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