



# OUTLINE OF COVERAGE AND RATES FOR NORTH CAROLINA RESIDENTS

Medicare Supplement benefit plans A, F, High-Deductible F, G, and N

**Together, all the way.®**



**Cigna Medicare Supplement Insurance**  
Cigna Health and Life Insurance Company

CHLIC-OC-2020-NC

902464 02/21



## CIGNA HEALTH AND LIFE INSURANCE COMPANY

PO Box 5700, Scranton, PA 18505 • 866-459-4272

### Outline of Medicare Supplement Coverage – Benefit Plans A, F, High-Deductible F, G, and 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 in your state. Only Applicants first eligible for Medicare before 2020 may purchase Plans C, F, and high-deductible F.

Benefits	Note: A ✓ means 100% of the benefit is paid									Plans available only if first Medicare eligible before 2020		
	Plans available									C	F <sup>1</sup>	HDF <sup>1</sup>
	A	B	D	G <sup>1</sup>	HDG <sup>1</sup>	K	L	M	N			
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 <sup>3</sup>	✓	✓
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 2021 <sup>2</sup>						\$6,220 <sup>2</sup>	\$3,110 <sup>2</sup>					

<sup>1</sup>Plans F and G also have a high-deductible option which requires first paying a plan deductible of \$2,370 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. These expenses include the Medicare deductibles for Part A and Part B, but do not include the Plan's separate foreign travel emergency deductible.

<sup>2</sup>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.

<sup>3</sup>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.

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**Locate appropriate Area according to the Applicant's ZIP Code in the ZIP Code chart below.**

**NORTH CAROLINA ZIP CODES**

**Area    3-digit ZIP Codes**

Area I    270-289

**Cigna Health and Life Insurance Company**  
**MEDICARE SUPPLEMENT**  
**North Carolina**  
**Attained Age Rates -- Effective 2/1/2021 -- Area I (270-289)**  
**PREFERRED ANNUAL & MONTHLY BANK DRAFT RATES**

FEMALE RATES										Attained Age	MALE RATES										
Plan A		Plan F		Plan HDF		Plan G		Plan N			Under 65	Plan A		Plan F		Plan HDF		Plan G		Plan N	
Annual	Monthly	Annual	Monthly	Annual	Monthly	Annual	Monthly	Annual	Monthly			Annual	Monthly	Annual	Monthly	Annual	Monthly	Annual	Monthly	Annual	Monthly
9,440.94	786.43	11,466.80	955.18							65	10,696.58	891.03	12,991.89	1,082.22							
1,573.49	131.07	1,911.14	159.20	551.63	45.95	1,513.38	126.06	1,237.80	103.11	66	1,782.76	148.50	2,165.31	180.37	624.99	52.06	1,714.65	142.83	1,402.44	116.82	
1,573.49	131.07	1,911.14	159.20	551.63	45.95	1,513.38	126.06	1,237.80	103.11	67	1,782.76	148.50	2,165.31	180.37	624.99	52.06	1,714.65	142.83	1,402.44	116.82	
1,573.49	131.07	1,911.14	159.20	551.63	45.95	1,513.38	126.06	1,237.80	103.11	68	1,782.76	148.50	2,165.31	180.37	624.99	52.06	1,714.65	142.83	1,402.44	116.82	
1,584.14	131.96	1,924.07	160.28	555.36	46.26	1,545.09	128.71	1,244.43	103.66	69	1,794.83	149.51	2,179.97	181.59	629.22	52.41	1,750.59	145.82	1,409.93	117.45	
1,644.05	136.95	1,996.84	166.34	576.36	48.01	1,603.91	133.61	1,292.56	107.67	70	1,862.71	155.16	2,262.43	188.46	653.01	54.40	1,817.22	151.37	1,464.47	121.99	
1,702.04	141.78	2,067.25	172.20	596.68	49.70	1,652.30	137.64	1,329.81	110.77	71	1,928.40	160.64	2,342.20	195.11	676.04	56.31	1,872.06	155.94	1,506.67	125.51	
1,756.51	146.32	2,133.43	177.71	615.79	51.29	1,705.77	142.09	1,375.13	114.55	72	1,990.13	165.78	2,417.18	201.35	697.68	58.12	1,932.64	160.99	1,558.02	129.78	
1,810.99	150.86	2,199.60	183.23	634.88	52.89	1,759.22	146.54	1,418.16	118.13	73	2,051.85	170.92	2,492.14	207.60	719.32	59.92	1,993.20	166.03	1,606.78	133.85	
1,865.45	155.39	2,265.75	188.74	653.98	54.48	1,812.64	150.99	1,461.19	121.72	74	2,113.56	176.06	2,567.10	213.84	740.95	61.72	2,053.73	171.08	1,655.53	137.91	
1,919.91	159.93	2,331.90	194.25	673.07	56.07	1,866.06	155.44	1,504.23	125.30	75	2,175.26	181.20	2,642.04	220.08	762.59	63.52	2,114.24	176.12	1,704.28	141.97	
1,984.01	165.27	2,409.75	200.73	695.54	57.94	1,930.71	160.83	1,547.25	128.89	76	2,247.89	187.25	2,730.25	227.43	788.05	65.64	2,187.50	182.22	1,753.05	146.03	
2,048.81	170.67	2,488.45	207.29	718.25	59.83	1,998.60	166.48	1,591.89	132.60	77	2,321.31	193.37	2,819.42	234.86	813.79	67.79	2,264.42	188.63	1,803.61	150.24	
2,106.92	175.51	2,569.63	214.05	741.68	61.78	2,061.91	171.76	1,657.77	138.09	78	2,387.14	198.85	2,911.39	242.52	840.33	70.00	2,336.14	194.60	1,878.25	156.46	
2,160.37	179.96	2,651.14	220.84	765.21	63.74	2,119.09	176.52	1,721.31	143.39	79	2,447.71	203.89	3,003.74	250.21	866.99	72.22	2,400.92	200.00	1,950.25	162.46	
2,216.16	184.61	2,736.18	227.92	789.76	65.79	2,174.06	181.10	1,784.55	148.65	80	2,510.91	209.16	3,100.10	258.24	894.80	74.54	2,463.21	205.19	2,021.89	168.42	
2,272.17	189.27	2,821.82	235.06	814.48	67.85	2,231.33	185.87	1,845.46	153.73	81	2,574.37	214.45	3,197.13	266.32	922.80	76.87	2,528.09	210.59	2,090.91	174.17	
2,302.30	191.78	2,885.43	240.36	832.83	69.38	2,275.71	189.57	1,875.24	156.21	82	2,608.51	217.29	3,269.19	272.32	943.60	78.60	2,578.39	214.78	2,124.66	176.98	
2,333.54	194.38	2,950.84	245.80	851.72	70.95	2,312.64	192.64	1,910.70	159.16	83	2,643.91	220.24	3,343.30	278.50	965.00	80.38	2,620.23	218.27	2,164.82	180.33	
2,363.81	196.91	3,014.61	251.12	870.12	72.48	2,352.64	195.97	1,969.45	164.06	84	2,678.19	223.09	3,415.56	284.52	985.85	82.12	2,665.54	222.04	2,231.39	185.87	
2,406.85	200.49	3,077.18	256.33	888.19	73.99	2,398.24	199.77	2,012.12	167.61	85	2,726.97	227.16	3,486.45	290.42	1,006.32	83.83	2,717.21	226.34	2,279.73	189.90	
2,453.03	204.34	3,136.23	261.25	905.22	75.41	2,444.57	203.63	2,043.60	170.23	86	2,779.29	231.52	3,553.34	295.99	1,025.62	85.43	2,769.70	230.72	2,315.40	192.87	
2,507.00	208.83	3,205.23	267.00	925.14	77.06	2,501.97	208.41	2,094.41	174.46	87	2,840.43	236.61	3,631.52	302.51	1,048.18	87.31	2,834.73	236.13	2,372.96	197.67	
2,562.15	213.43	3,275.73	272.87	945.50	78.76	2,560.65	213.30	2,146.27	178.78	88	2,902.93	241.81	3,711.41	309.16	1,071.24	89.23	2,901.21	241.67	2,431.72	202.56	
2,618.53	218.12	3,347.81	278.87	966.30	80.49	2,620.64	218.30	2,199.20	183.19	89	2,966.79	247.13	3,793.06	315.96	1,094.81	91.20	2,969.19	247.33	2,491.69	207.56	
2,676.13	222.92	3,421.46	285.01	987.56	82.26	2,681.98	223.41	2,253.24	187.70	90	3,032.06	252.57	3,876.51	322.91	1,118.90	93.20	3,038.68	253.12	2,552.92	212.66	
2,735.00	227.83	3,496.72	291.28	1,009.28	84.07	2,744.69	228.63	2,308.42	192.29	91	3,098.76	258.13	3,961.80	330.02	1,143.51	95.25	3,109.73	259.04	2,615.44	217.87	
2,795.17	232.84	3,573.65	297.69	1,031.48	85.92	2,807.78	233.89	2,365.16	197.02	92	3,166.94	263.81	4,048.96	337.28	1,168.67	97.35	3,181.20	264.99	2,679.73	223.22	
2,856.67	237.96	3,652.28	304.24	1,054.17	87.81	2,872.29	239.26	2,423.06	201.84	93	3,236.60	269.61	4,138.02	344.70	1,194.39	99.49	3,254.30	271.08	2,745.34	228.69	
2,919.51	243.20	3,732.62	310.93	1,077.36	89.74	2,938.27	244.76	2,482.17	206.77	94	3,307.81	275.54	4,229.07	352.28	1,220.65	101.68	3,329.06	277.31	2,812.30	234.26	
2,983.75	248.55	3,814.75	317.77	1,101.07	91.72	3,005.74	250.38	2,542.49	211.79	95	3,380.58	281.60	4,322.11	360.03	1,247.52	103.92	3,405.50	283.68	2,880.65	239.96	
3,049.38	254.01	3,898.67	324.76	1,125.29	93.74	3,074.75	256.13	2,604.06	216.92	96	3,454.96	287.80	4,417.19	367.95	1,274.96	106.20	3,483.69	290.19	2,950.40	245.77	
3,049.38	254.01	3,898.67	324.76	1,125.29	93.74	3,074.75	256.13	2,604.06	216.92	97	3,454.96	287.80	4,417.19	367.95	1,274.96	106.20	3,483.69	290.19	2,950.40	245.77	
3,049.38	254.01	3,898.67	324.76	1,125.29	93.74	3,074.75	256.13	2,604.06	216.92	98	3,454.96	287.80	4,417.19	367.95	1,274.96	106.20	3,483.69	290.19	2,950.40	245.77	
3,049.38	254.01	3,898.67	324.76	1,125.29	93.74	3,074.75	256.13	2,604.06	216.92	99	3,454.96	287.80	4,417.19	367.95	1,274.96	106.20	3,483.69	290.19	2,950.40	245.77	

Policies may be issued on an annual, semi-annual, quarterly or monthly mode.  
 To obtain semi-annual premiums, multiply the above-quoted annual premium by 0.52. To obtain quarterly premiums, multiply the above quoted premium by 0.265.

Applicants who qualify for Household Discount multiply above rates by 0.93.

**Cigna Health and Life Insurance Company**  
**MEDICARE SUPPLEMENT**  
**North Carolina**  
**Attained Age Rates -- Effective 2/1/2021 -- Area I (270-289)**  
**STANDARD ANNUAL & MONTHLY BANK DRAFT RATES**

FEMALE RATES										Attained Age	MALE RATES										
Plan A		Plan F		Plan HDF		Plan G		Plan N			Under 65	Plan A		Plan F		Plan HDF		Plan G		Plan N	
Annual	Monthly	Annual	Monthly	Annual	Monthly	Annual	Monthly	Annual	Monthly			Annual	Monthly	Annual	Monthly	Annual	Monthly	Annual	Monthly	Annual	Monthly
10,385.04	865.07	12,613.49	1,050.70									11,766.24	980.13	14,291.08	1,190.45						
1,730.84	144.18	2,102.25	175.12	606.79	50.55	1,664.71	138.67	1,361.58	113.42	65	1,961.04	163.35	2,381.85	198.41	687.49	57.27	1,886.11	157.11	1,542.68	128.51	
1,730.84	144.18	2,102.25	175.12	606.79	50.55	1,664.71	138.67	1,361.58	113.42	66	1,961.04	163.35	2,381.85	198.41	687.49	57.27	1,886.11	157.11	1,542.68	128.51	
1,730.84	144.18	2,102.25	175.12	606.79	50.55	1,664.71	138.67	1,361.58	113.42	67	1,961.04	163.35	2,381.85	198.41	687.49	57.27	1,886.11	157.11	1,542.68	128.51	
1,742.56	145.16	2,116.47	176.30	610.90	50.89	1,699.60	141.58	1,368.87	114.03	68	1,974.31	164.46	2,397.97	199.75	692.14	57.66	1,925.65	160.41	1,550.92	129.19	
1,808.46	150.64	2,196.53	182.97	633.99	52.81	1,764.30	146.97	1,421.82	118.44	69	2,048.98	170.68	2,488.66	207.31	718.32	59.84	1,998.95	166.51	1,610.92	134.19	
1,872.23	155.96	2,273.98	189.42	656.36	54.67	1,817.53	151.40	1,462.79	121.85	70	2,121.24	176.70	2,576.42	214.62	743.65	61.95	2,059.26	171.54	1,657.35	138.06	
1,932.17	160.95	2,346.78	195.49	677.36	56.42	1,876.34	156.30	1,512.64	126.00	71	2,189.14	182.36	2,658.90	221.49	767.46	63.93	2,125.90	177.09	1,713.82	142.76	
1,992.08	165.94	2,419.55	201.55	698.37	58.17	1,935.13	161.20	1,559.98	129.95	72	2,257.04	188.01	2,741.36	228.36	791.25	65.91	2,192.51	182.64	1,767.46	147.23	
2,051.99	170.93	2,492.32	207.61	719.38	59.92	1,993.91	166.09	1,607.31	133.89	73	2,324.91	193.66	2,823.80	235.22	815.05	67.89	2,259.10	188.18	1,821.09	151.70	
2,111.91	175.92	2,565.08	213.67	740.38	61.67	2,052.66	170.99	1,654.65	137.83	74	2,392.78	199.32	2,906.23	242.09	838.85	69.88	2,325.67	193.73	1,874.71	156.16	
2,182.42	181.80	2,650.73	220.81	765.09	63.73	2,123.79	176.91	1,701.99	141.78	75	2,472.68	205.97	3,003.28	250.17	866.85	72.21	2,406.25	200.44	1,928.35	160.63	
2,253.70	187.73	2,737.30	228.02	790.08	65.81	2,198.47	183.13	1,751.08	145.86	76	2,553.43	212.70	3,101.36	258.34	895.17	74.57	2,490.85	207.49	1,983.98	165.27	
2,317.61	193.06	2,826.59	235.46	815.85	67.96	2,268.10	188.93	1,823.54	151.90	77	2,625.86	218.73	3,202.53	266.77	924.36	77.00	2,569.75	214.06	2,066.08	172.10	
2,376.41	197.95	2,916.25	242.92	841.73	70.12	2,331.00	194.17	1,893.45	157.72	78	2,692.48	224.28	3,304.10	275.23	953.68	79.44	2,641.02	220.00	2,145.27	178.70	
2,437.78	203.07	3,009.80	250.72	868.73	72.37	2,391.46	199.21	1,963.01	163.52	79	2,762.00	230.07	3,410.10	284.06	984.27	81.99	2,709.53	225.70	2,224.08	185.27	
2,499.39	208.20	3,104.01	258.56	895.93	74.63	2,454.46	204.46	2,030.01	169.10	80	2,831.81	235.89	3,516.84	292.95	1,015.09	84.56	2,780.90	231.65	2,299.99	191.59	
2,532.53	210.96	3,173.98	264.39	916.12	76.31	2,503.29	208.52	2,062.77	171.83	81	2,869.36	239.02	3,596.11	299.56	1,037.97	86.46	2,836.22	236.26	2,337.13	194.68	
2,566.90	213.82	3,245.93	270.39	936.89	78.04	2,543.91	211.91	2,101.76	175.08	82	2,908.29	242.26	3,677.64	306.35	1,061.50	88.42	2,882.26	240.09	2,381.29	198.36	
2,600.19	216.60	3,316.07	276.23	957.14	79.73	2,587.90	215.57	2,166.40	180.46	83	2,946.01	245.40	3,757.11	312.97	1,084.44	90.33	2,932.09	244.24	2,454.53	204.46	
2,647.54	220.54	3,384.90	281.96	977.01	81.38	2,638.06	219.75	2,213.33	184.37	84	2,999.66	249.87	3,835.09	319.46	1,106.95	92.21	2,988.93	248.98	2,507.70	208.89	
2,698.33	224.77	3,449.85	287.37	995.75	82.95	2,689.03	224.00	2,247.96	187.26	85	3,057.22	254.67	3,908.68	325.59	1,128.18	93.98	3,046.67	253.79	2,546.94	212.16	
2,757.71	229.72	3,525.75	293.69	1,017.66	84.77	2,752.16	229.25	2,303.85	191.91	86	3,124.47	260.27	3,994.67	332.76	1,153.00	96.05	3,118.20	259.75	2,610.26	217.43	
2,818.37	234.77	3,603.31	300.16	1,040.04	86.64	2,816.71	234.63	2,360.89	196.66	87	3,193.22	265.99	4,082.55	340.08	1,178.37	98.16	3,191.34	265.84	2,674.89	222.82	
2,880.38	239.94	3,682.58	306.76	1,062.92	88.54	2,882.70	240.13	2,419.12	201.51	88	3,263.47	271.85	4,172.37	347.56	1,204.30	100.32	3,266.11	272.07	2,740.86	228.31	
2,943.74	245.21	3,763.60	313.51	1,086.31	90.49	2,950.18	245.75	2,478.57	206.46	89	3,335.26	277.83	4,264.16	355.20	1,230.79	102.52	3,342.55	278.43	2,808.22	233.92	
3,008.51	250.61	3,846.40	320.40	1,110.21	92.48	3,019.16	251.50	2,539.26	211.52	90	3,408.64	283.94	4,357.97	363.02	1,257.87	104.78	3,420.70	284.94	2,876.98	239.65	
3,074.69	256.12	3,931.03	327.45	1,134.64	94.52	3,088.55	257.28	2,601.68	216.72	91	3,483.63	290.19	4,453.84	371.01	1,285.54	107.09	3,499.33	291.49	2,947.70	245.54	
3,142.34	261.76	4,017.50	334.66	1,159.59	96.59	3,159.52	263.19	2,665.38	222.03	92	3,560.27	296.57	4,551.83	379.17	1,313.82	109.44	3,579.73	298.19	3,019.87	251.55	
3,211.46	267.51	4,105.89	342.02	1,185.10	98.72	3,232.09	269.23	2,730.38	227.44	93	3,638.59	303.09	4,651.97	387.51	1,342.73	111.85	3,661.96	305.04	3,093.52	257.69	
3,282.12	273.40	4,196.22	349.55	1,211.18	100.89	3,306.32	275.42	2,796.74	232.97	94	3,718.64	309.76	4,754.32	396.03	1,372.27	114.31	3,746.06	312.05	3,168.71	263.95	
3,354.33	279.42	4,288.53	357.23	1,237.83	103.11	3,382.22	281.74	2,864.47	238.61	95	3,800.45	316.58	4,858.91	404.75	1,402.46	116.82	3,832.06	319.21	3,245.45	270.35	
3,354.33	279.42	4,288.53	357.23	1,237.83	103.11	3,382.22	281.74	2,864.47	238.61	96	3,800.45	316.58	4,858.91	404.75	1,402.46	116.82	3,832.06	319.21	3,245.45	270.35	
3,354.33	279.42	4,288.53	357.23	1,237.83	103.11	3,382.22	281.74	2,864.47	238.61	97	3,800.45	316.58	4,858.91	404.75	1,402.46	116.82	3,832.06	319.21	3,245.45	270.35	
3,354.33	279.42	4,288.53	357.23	1,237.83	103.11	3,382.22	281.74	2,864.47	238.61	98	3,800.45	316.58	4,858.91	404.75	1,402.46	116.82	3,832.06	319.21	3,245.45	270.35	
3,354.33	279.42	4,288.53	357.23	1,237.83	103.11	3,382.22	281.74	2,864.47	238.61	99	3,800.45	316.58	4,858.91	404.75	1,402.46	116.82	3,832.06	319.21	3,245.45	270.35	

Policies may be issued on an annual, semi-annual, quarterly or monthly mode.  
 To obtain semi-annual premiums, multiply the above-quoted annual premium by 0.52. To obtain quarterly premiums, multiply the above quoted premium by 0.265.

Applicants who qualify for Household Discount multiply above rates by 0.93.

## **PREMIUM INFORMATION**

Your premium will increase each year because of the increase in your attained age. We, Cigna Health and Life Insurance Company, can also raise your premium if (a) We change the rates or discounts which apply to all policies of this form issued by us and in force in the state where your policy was issued; or (b) coverage under Medicare changes. We will send you a written notice at least forty-five (45) days in advance when we change the premium rates or discounts for all policies of this form issued by us and in force in the state where your policy was issued. Premium rates will be guaranteed for a period of not less than twelve (12) months.

## **DISCLOSURES**

Use this Outline to compare benefits and premiums 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 Cigna Health and Life Insurance Company.

## **30-DAY RIGHT TO RETURN POLICY**

If you find that you are not satisfied with your policy, you may return it to Cigna Health and Life Insurance Company, PO Box 5700, Scranton, PA 18505. If you send the policy back to us within thirty (30) days after you receive it, we will treat the policy as if it had never been issued and return all of your premiums.

## **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 fully cover all of your medical costs. Neither Cigna Health and Life Insurance Company 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 the *Medicare and You* for more details.

## **EXCLUSIONS AND LIMITATIONS**

The benefits of a policy will not duplicate any benefits paid by Medicare. The combined benefits of a policy and the benefits paid by Medicare may not exceed one hundred percent (100%) of the Medicare Eligible Expenses incurred. A policy will not pay benefits for the following:

1. the Medicare Part B deductible (not applicable for Plans F and C);
2. any expense which you are not legally obligated to pay or services for which no charge is normally made in the absence of insurance;
3. any services that are not medically necessary as determined by Medicare;
4. any portion of any expense for which payment is made by Medicare or other government programs (except Medicaid) or for which payment would have been made by Medicare if you were enrolled in Parts A and B of Medicare;
5. any type of expense not a Medicare Eligible Expense except as provided previously in the policy;
6. any deductible, coinsurance, or copayment not covered by Medicare, unless such coverage is listed as a benefit in the policy; or
7. Pre-Existing Conditions: We will not pay for any expenses incurred for care or treatment of a Pre-Existing Condition for the first six (6) months from the effective date of coverage. This exclusion does not apply if you applied for and were issued a policy under guaranteed issue status; if on the date of application for a policy you had at least six (6) months of prior Creditable Coverage; or if the policy is replacing another Medicare Supplement policy and a six (6) month waiting period has already been satisfied. Evidence of prior coverage or replacement must have been disclosed on the application for a policy.



If you had less than six (6) months prior Creditable Coverage, the Pre-Existing Conditions limitation will be reduced by the aggregate amount of Creditable Coverage. If the policy is replacing another Medicare Supplement policy, credit will be given for any portion of the waiting period that has been satisfied.

**COMPLETE ANSWERS ARE VERY IMPORTANT**

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. We 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.

**RENEWABILITY**

The policy is guaranteed renewable for life.

**HOUSEHOLD DISCOUNT**

Affiliate means an insurance company that is under common ownership or control with Cigna Health and Life Insurance Company and that is a member of the same insurance holding company system.

Household Discount is a discount that is available when more than one member of your household enrolls or is enrolled in a Medicare Supplement policy provided by or through an Affiliate of Cigna Health and Life Insurance Company. Household is defined as a condominium unit, a single-family home, or an apartment unit within an apartment complex. Assisted Living facilities, Group Homes, Adult Day Care facilities and Nursing Homes, or any other health residential facility are not included in the definition of "Household."

The household premium discount will be removed if the other Medicare Supplement policyholder whose policy status entitles you to the discount no longer resides with you or no longer has a Medicare Supplement policy through Cigna Health and Life Insurance Company or an Affiliate of Cigna Health and Life Insurance Company. However, if that person becomes deceased, your discount will still apply. The addition or removal of the discount will occur on the billing cycle following the date we learn your eligibility has changed.

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**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 A PAYS	YOU PAY
<b>HOSPITALIZATION*</b> Semi-private room and board, general nursing, and miscellaneous services and supplies First 60 days 61 <sup>st</sup> through 90 <sup>th</sup> day 91 <sup>st</sup> day and after: – while using 60 lifetime reserve days – once lifetime reserve days are used, additional 365 days – beyond the additional 365 days	All but \$1,484 All but \$371 per day  All but \$742 per day \$0 \$0	\$0 \$371 per day  \$742 per day 100% of Medicare eligible expenses \$0	\$1,484 (Part A deductible) \$0  \$0 \$0** All costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare’s requirements, including having been in a hospital for at least 3 days and entering a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21 <sup>st</sup> through 100 <sup>th</sup> day 101 <sup>st</sup> day and after	All approved amounts All but \$185.50 per day \$0	\$0 \$0 \$0	\$0 Up to \$185.50 per day All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> 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 \$203 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.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN A PAYS</b>	<b>YOU PAY</b>
<b>MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> such as physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First \$203 of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 Generally 80%	\$0 Generally 20%	\$203 (Part B deductible) \$0
<b>PART B EXCESS CHARGES</b> (above Medicare-approved amounts)	\$0	\$0	All costs
<b>BLOOD</b> First 3 pints Next \$203 of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$203 (Part B deductible) \$0
<b>CLINICAL LABORATORY SERVICES</b> Tests for diagnostic services	100%	\$0	\$0

**PARTS A & B**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN A PAYS</b>	<b>YOU PAY</b>
<b>HOME HEALTH CARE MEDICARE-APPROVED SERVICES</b> Medically-necessary skilled care services and medical supplies Durable medical equipment First \$203 of Medicare-approved amounts* Remainder of Medicare-approved amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$203 (Part B deductible) \$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 F PAYS	YOU PAY
<b>HOSPITALIZATION*</b> Semi-private room and board, general nursing, and miscellaneous services and supplies First 60 days 61 <sup>st</sup> through 90 <sup>th</sup> day 91 <sup>st</sup> day and after: – while using 60 lifetime reserve days – once lifetime reserve days are used, additional 365 days – beyond the additional 365 days	All but \$1,484 All but \$371 per day  All but \$742 per day \$0 \$0	\$1,484 (Part A deductible) \$371 per day  \$742 per day 100% of Medicare eligible expenses \$0	\$0 \$0  \$0 \$0** All costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare’s requirements, including having been in a hospital for at least 3 days and entering a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21 <sup>st</sup> through 100 <sup>th</sup> day 101 <sup>st</sup> day and after	All approved amounts All but \$185.50 per day \$0	\$0 Up to \$185.50 per day \$0	\$0 \$0 All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> 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 \$203 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.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN F PAYS</b>	<b>YOU PAY</b>
<b>MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> such as physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First \$203 of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 Generally 80%	\$203 (Part B deductible) Generally 20%	\$0 \$0
<b>PART B EXCESS CHARGES</b> (above Medicare-approved amounts)	\$0	100%	\$0
<b>BLOOD</b> First 3 pints Next \$203 of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 \$0 80%	All costs \$203 (Part B deductible) 20%	\$0 \$0 \$0
<b>CLINICAL LABORATORY SERVICES</b> Tests for diagnostic services	100%	\$0	\$0

**PARTS A & B**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN F PAYS</b>	<b>YOU PAY</b>
<b>HOME HEALTH CARE MEDICARE-APPROVED SERVICES</b> Medically-necessary skilled care services and medical supplies Durable medical equipment First \$203 of Medicare-approved amounts* Remainder of Medicare-approved amounts	100% \$0 80%	\$0 \$203 (Part B deductible) 20%	\$0 \$0 \$0

**PLAN F**  
**MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR (cont'd.)**

**OTHER BENEFITS – NOT COVERED BY MEDICARE**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN F PAYS</b>	<b>YOU PAY</b>
<b>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</b> Medically-necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of charges	\$0 \$0	\$0 80% to a lifetime maximum benefit of \$50,000	\$250 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 \$2,370 deductible. Benefits from the high-deductible Plan F will not begin until out-of-pocket expenses are \$2,370. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductible for Part A and Part B, but does not include the plan’s separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$2,370 DEDUCTIBLE**, PLAN PAYS	IN ADDITION TO \$2,370 DEDUCTIBLE**, YOU PAY
<b>HOSPITALIZATION*</b> Semi-private room and board, general nursing, and miscellaneous services and supplies First 60 days 61 <sup>st</sup> through 90 <sup>th</sup> day 91 <sup>st</sup> day and after: – while using 60 lifetime reserve days – once lifetime reserve days are used, additional 365 days – beyond the additional 365 days	All but \$1,484 All but \$371 per day All but \$742 per day \$0 \$0	\$1,484 (Part A deductible) \$371 per day \$742 per day 100% of Medicare eligible expenses \$0	\$0 \$0 \$0 \$0*** All costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare’s requirements, including having been in a hospital for at least 3 days and entering a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21 <sup>st</sup> through 100 <sup>th</sup> day 101 <sup>st</sup> day and after	All approved amounts All but \$185.50 per day \$0	\$0 Up to \$185.50 per day \$0	\$0 \$0 All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> 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 F  
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR**

\*Once you have been billed \$203 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 \$2,370 deductible. Benefits from the high-deductible Plan F will not begin until out-of-pocket expenses are \$2,370. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductible for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>AFTER YOU PAY \$2,370 DEDUCTIBLE**, PLAN PAYS</b>	<b>IN ADDITION TO \$2,370 DEDUCTIBLE**, YOU PAY</b>
<b>MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First \$203 of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 Generally 80%	\$203 (Part B deductible) Generally 20%	\$0 \$0
<b>PART B EXCESS CHARGES</b> (above Medicare-approved amounts)	\$0	100%	\$0
<b>BLOOD</b> First 3 pints Next \$203 of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 \$0 80%	All costs \$203 (Part B deductible) 20%	\$0 \$0 \$0
<b>CLINICAL LABORATORY SERVICES</b> Tests for diagnostic services	100%	\$0	\$0

**PARTS A & B**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>AFTER YOU PAY \$2,370 DEDUCTIBLE**, PLAN PAYS</b>	<b>IN ADDITION TO \$2,370 DEDUCTIBLE**, YOU PAY</b>
<b>HOME HEALTH CARE MEDICARE-APPROVED SERVICES</b> Medically-necessary skilled care services and medical supplies Durable medical equipment First \$203 of Medicare-approved amounts* Remainder of Medicare-approved amounts	100% \$0 80%	\$0 \$203 (Part B deductible) 20%	\$0 \$0 \$0

**HIGH-DEDUCTIBLE PLAN F  
 MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR (cont'd.)**

**OTHER BENEFITS – NOT COVERED BY MEDICARE**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>AFTER YOU PAY \$2,370 DEDUCTIBLE**, PLAN PAYS</b>	<b>IN ADDITION TO \$2,370 DEDUCTIBLE**, YOU PAY</b>
<b>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</b> Medically-necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of charges	\$0 \$0	\$0 80% to a lifetime maximum benefit of \$50,000	\$250 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 G PAYS	YOU PAY
<b>HOSPITALIZATION*</b> Semi-private room and board, general nursing, and miscellaneous services and supplies First 60 days 61 <sup>st</sup> through 90 <sup>th</sup> day 91 <sup>st</sup> day and after: – while using 60 lifetime reserve days – once lifetime reserve days are used, additional 365 days – beyond the additional 365 days	All but \$1,484 All but \$371 per day  All but \$742 per day \$0 \$0	\$1,484 (Part A deductible) \$371 per day  \$742 per day 100% of Medicare eligible expenses \$0	\$0 \$0  \$0 \$0** All costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare’s requirements, including having been in a hospital for at least 3 days and entering a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21 <sup>st</sup> through 100 <sup>th</sup> day 101 <sup>st</sup> day and after	All approved amounts All but \$185.50 per day \$0	\$0 Up to \$185.50 per day \$0	\$0 \$0 All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> 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 \$203 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.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN G PAYS</b>	<b>YOU PAY</b>
<b>MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> such as physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First \$203 of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 Generally 80%	\$0 Generally 20%	\$203 (Part B deductible) \$0
<b>PART B EXCESS CHARGES</b> (above Medicare-approved amounts)	\$0	100%	\$0
<b>BLOOD</b> First 3 pints Next \$203 of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$203 (Part B deductible) \$0
<b>CLINICAL LABORATORY SERVICES</b> Tests for diagnostic services	100%	\$0	\$0

**PARTS A & B**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN G PAYS</b>	<b>YOU PAY</b>
<b>HOME HEALTH CARE MEDICARE-APPROVED SERVICES</b> Medically-necessary skilled care services and medical supplies Durable medical equipment First \$203 of Medicare-approved amounts* Remainder of Medicare-approved amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$203 (Part B deductible) \$0

**PLAN G  
 MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR (cont'd.)**

**OTHER BENEFITS – NOT COVERED BY MEDICARE**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN G PAYS</b>	<b>YOU PAY</b>
<b>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</b> Medically-necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of charges	\$0 \$0	\$0 80% to a lifetime maximum benefit of \$50,000	\$250 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 N PAYS	YOU PAY
<b>HOSPITALIZATION*</b> Semi-private room and board, general nursing, and miscellaneous services and supplies First 60 days 61 <sup>st</sup> through 90 <sup>th</sup> day 91 <sup>st</sup> day and after: – while using 60 lifetime reserve days – once lifetime reserve days are used, additional 365 days – beyond the additional 365 days	All but \$1,484 All but \$371 per day  All but \$742 per day \$0 \$0	\$1,484 (Part A deductible) \$371 per day  \$742 per day 100% of Medicare eligible expenses \$0	\$0 \$0  \$0 \$0** All costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare’s requirements, including having been in a hospital for at least 3 days and entering a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21 <sup>st</sup> through 100 <sup>th</sup> day 101 <sup>st</sup> day and after	All approved amounts All but \$185.50 per day \$0	\$0 Up to \$185.50 per day \$0	\$0 \$0 All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> 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 \$203 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 N PAYS	YOU PAY
<b>MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> such as physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First \$203 of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 Generally 80%	\$0 Balance, other than 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.	\$203 (Part B deductible) 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.
<b>PART B EXCESS CHARGES</b> (above Medicare-approved amounts)	\$0	\$0	All costs
<b>BLOOD</b> First 3 pints Next \$203 of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$203 (Part B deductible) \$0
<b>CLINICAL LABORATORY SERVICES</b> Tests for diagnostic services	100%	\$0	\$0

**PARTS A & B**

SERVICES	MEDICARE PAYS	PLAN N PAYS	YOU PAY
<b>HOME HEALTH CARE MEDICARE-APPROVED SERVICES</b> Medically-necessary skilled care services and medical supplies Durable medical equipment First \$203 of Medicare-approved amounts* Remainder of Medicare-approved amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$203 (Part B deductible) \$0

**PLAN N  
 MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR (cont'd.)**

**OTHER BENEFITS – NOT COVERED BY MEDICARE**

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