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Outline of Coverage

Medicare Supplement Insurance

BENEFIT PLANS A, B, F, HIGH DEDUCTIBLE F, G, N

Underwritten by

An Aetna Company **American Continental Insurance Company**

Louisiana

AMERICAN CONTINENTAL INSURANCE COMPANY
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 $4960; paid at 100% after limit reached	Out-of-pocket limit $2470; paid at 100% after limit reached		

*Plans 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.

American Continental Insurance Company

Annual Attained Age Premiums

For Use in ZIP Codes: 700-702, 706-709

Female Rates

Attained Age	Preferred					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	3,821	4,812	5,272	2,074	4,897	3,888
65	1,249	1,577	1,855	720	1,296	1,175
66	1,249	1,577	1,855	720	1,296	1,175
67	1,249	1,577	1,855	720	1,296	1,175
68	1,304	1,643	1,933	749	1,351	1,225
69	1,360	1,716	2,009	779	1,412	1,279
70	1,415	1,786	2,082	808	1,466	1,330
71	1,470	1,852	2,155	835	1,523	1,381
72	1,520	1,919	2,221	862	1,577	1,429
73	1,568	1,979	2,284	886	1,628	1,475
74	1,615	2,035	2,341	908	1,673	1,516
75	1,656	2,087	2,394	929	1,715	1,556
76	1,693	2,132	2,442	947	1,756	1,592
77	1,730	2,177	2,483	964	1,792	1,625
78	1,762	2,222	2,520	980	1,829	1,656
79	1,794	2,260	2,556	992	1,860	1,684
80	1,824	2,296	2,588	1,004	1,890	1,714
81	1,849	2,327	2,623	1,019	1,916	1,736
82	1,873	2,360	2,656	1,030	1,942	1,759
83	1,898	2,392	2,688	1,043	1,967	1,783
84	1,922	2,420	2,719	1,055	1,992	1,806
85	1,942	2,449	2,749	1,068	2,016	1,825
86	1,966	2,477	2,777	1,078	2,039	1,847
87	1,986	2,503	2,806	1,088	2,059	1,866
88	2,006	2,530	2,831	1,100	2,081	1,885
89	2,024	2,554	2,855	1,106	2,099	1,902
90	2,044	2,574	2,880	1,118	2,118	1,920
91	2,060	2,597	2,902	1,126	2,136	1,936
92	2,075	2,617	2,918	1,133	2,150	1,949
93	2,089	2,636	2,940	1,140	2,167	1,963
94	2,105	2,652	2,954	1,146	2,182	1,976
95	2,117	2,666	2,969	1,151	2,195	1,988
96	2,129	2,682	2,986	1,159	2,207	1,999
97	2,142	2,698	3,001	1,164	2,220	2,010
98	2,153	2,712	3,017	1,171	2,233	2,022
99	2,167	2,729	3,029	1,176	2,245	2,034

Attained Age	Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	4,249	5,352	5,860	2,304	5,442	4,322
65	1,388	1,753	2,063	800	1,441	1,307
66	1,388	1,753	2,063	800	1,441	1,307
67	1,388	1,753	2,063	800	1,441	1,307
68	1,450	1,824	2,147	833	1,502	1,361
69	1,513	1,907	2,233	866	1,568	1,423
70	1,573	1,982	2,314	898	1,631	1,480
71	1,633	2,059	2,394	929	1,693	1,534
72	1,690	2,130	2,468	958	1,753	1,585
73	1,742	2,197	2,538	985	1,807	1,638
74	1,794	2,260	2,602	1,010	1,860	1,686
75	1,838	2,318	2,660	1,032	1,907	1,728
76	1,880	2,370	2,711	1,051	1,949	1,766
77	1,924	2,420	2,760	1,070	1,993	1,806
78	1,961	2,467	2,800	1,087	2,032	1,841
79	1,993	2,513	2,840	1,102	2,065	1,871
80	2,024	2,554	2,875	1,116	2,099	1,902
81	2,053	2,588	2,914	1,130	2,130	1,930
82	2,081	2,624	2,952	1,146	2,159	1,955
83	2,108	2,657	2,987	1,159	2,186	1,981
84	2,134	2,692	3,020	1,174	2,213	2,005
85	2,159	2,723	3,054	1,186	2,239	2,029
86	2,184	2,753	3,085	1,198	2,264	2,051
87	2,208	2,780	3,115	1,208	2,288	2,074
88	2,230	2,808	3,145	1,220	2,311	2,093
89	2,251	2,834	3,172	1,232	2,334	2,114
90	2,270	2,862	3,197	1,241	2,353	2,132
91	2,288	2,885	3,221	1,249	2,372	2,149
92	2,308	2,905	3,246	1,261	2,390	2,167
93	2,322	2,927	3,265	1,267	2,410	2,182
94	2,338	2,946	3,282	1,274	2,423	2,197
95	2,352	2,963	3,298	1,280	2,436	2,210
96	2,365	2,980	3,317	1,286	2,450	2,221
97	2,380	2,999	3,332	1,295	2,466	2,233
98	2,393	3,014	3,352	1,300	2,480	2,248
99	2,408	3,034	3,367	1,306	2,496	2,261

Modal Factors: Semi-Annual: 0.5200 Quarterly: 0.2650 Monthly: 0.0833

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.

American Continental Insurance Company

Annual Attained Age Premiums

For Use in ZIP Codes: 700-702, 706-709

Male Rates

Attained Age	Preferred					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	4,394	5,537	6,065	2,384	5,630	4,472
65	1,439	1,813	2,134	829	1,490	1,351
66	1,439	1,813	2,134	829	1,490	1,351
67	1,439	1,813	2,134	829	1,490	1,351
68	1,498	1,891	2,221	862	1,554	1,408
69	1,566	1,974	2,311	898	1,624	1,472
70	1,628	2,051	2,396	930	1,688	1,530
71	1,691	2,130	2,479	964	1,753	1,585
72	1,748	2,204	2,556	992	1,813	1,644
73	1,804	2,273	2,626	1,019	1,870	1,694
74	1,856	2,340	2,693	1,046	1,925	1,744
75	1,904	2,398	2,753	1,068	1,973	1,787
76	1,948	2,453	2,806	1,088	2,017	1,828
77	1,987	2,506	2,855	1,106	2,062	1,867
78	2,029	2,555	2,902	1,126	2,100	1,906
79	2,062	2,598	2,941	1,140	2,137	1,938
80	2,098	2,641	2,977	1,157	2,171	1,968
81	2,126	2,680	3,017	1,171	2,203	1,996
82	2,155	2,714	3,054	1,186	2,233	2,023
83	2,183	2,752	3,091	1,199	2,263	2,050
84	2,209	2,783	3,126	1,213	2,291	2,075
85	2,236	2,816	3,161	1,226	2,317	2,101
86	2,260	2,848	3,193	1,240	2,342	2,123
87	2,284	2,878	3,226	1,250	2,369	2,146
88	2,309	2,906	3,256	1,264	2,390	2,168
89	2,327	2,935	3,283	1,274	2,414	2,189
90	2,351	2,960	3,308	1,284	2,435	2,207
91	2,370	2,984	3,334	1,295	2,458	2,225
92	2,388	3,007	3,356	1,302	2,474	2,242
93	2,404	3,030	3,379	1,312	2,492	2,258
94	2,419	3,049	3,400	1,318	2,508	2,273
95	2,432	3,066	3,415	1,326	2,522	2,285
96	2,448	3,084	3,432	1,331	2,537	2,299
97	2,461	3,101	3,449	1,339	2,552	2,314
98	2,477	3,120	3,467	1,345	2,567	2,326
99	2,491	3,139	3,486	1,352	2,581	2,340

Attained Age	Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	4,882	6,151	6,734	2,651	6,257	4,970
65	1,598	2,014	2,372	920	1,657	1,500
66	1,598	2,014	2,372	920	1,657	1,500
67	1,598	2,014	2,372	920	1,657	1,500
68	1,664	2,099	2,470	958	1,724	1,565
69	1,740	2,191	2,567	996	1,806	1,636
70	1,810	2,281	2,660	1,032	1,876	1,700
71	1,879	2,366	2,753	1,068	1,946	1,765
72	1,942	2,449	2,840	1,102	2,015	1,825
73	2,006	2,527	2,916	1,132	2,077	1,883
74	2,062	2,598	2,990	1,162	2,137	1,938
75	2,116	2,665	3,060	1,188	2,192	1,986
76	2,162	2,725	3,116	1,210	2,242	2,033
77	2,210	2,785	3,172	1,232	2,291	2,075
78	2,252	2,837	3,220	1,249	2,335	2,116
79	2,292	2,890	3,266	1,267	2,375	2,152
80	2,327	2,933	3,307	1,284	2,413	2,188
81	2,362	2,977	3,353	1,300	2,449	2,218
82	2,394	3,016	3,392	1,316	2,483	2,249
83	2,425	3,055	3,436	1,332	2,515	2,279
84	2,454	3,094	3,474	1,348	2,544	2,306
85	2,485	3,128	3,514	1,361	2,574	2,333
86	2,513	3,166	3,550	1,378	2,604	2,359
87	2,536	3,198	3,583	1,388	2,632	2,383
88	2,563	3,230	3,617	1,403	2,657	2,408
89	2,588	3,260	3,652	1,415	2,682	2,431
90	2,610	3,289	3,679	1,427	2,707	2,453
91	2,633	3,318	3,707	1,438	2,728	2,473
92	2,653	3,342	3,730	1,447	2,749	2,494
93	2,671	3,365	3,752	1,457	2,768	2,508
94	2,687	3,386	3,775	1,465	2,788	2,524
95	2,702	3,408	3,793	1,471	2,803	2,539
96	2,722	3,427	3,812	1,480	2,820	2,554
97	2,736	3,446	3,832	1,488	2,837	2,569
98	2,753	3,469	3,852	1,494	2,852	2,585
99	2,767	3,487	3,871	1,502	2,869	2,599

Modal Factors: Semi-Annual: 0.5200 Quarterly: 0.2650 Monthly: 0.0833

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.

American Continental Insurance Company

Annual Attained Age Premiums

For Use in ZIP Codes: Rest of State

Female Rates

Attained Age	Preferred					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	3,502	4,411	4,832	1,901	4,489	3,564
65	1,145	1,445	1,701	660	1,188	1,077
66	1,145	1,445	1,701	660	1,188	1,077
67	1,145	1,445	1,701	660	1,188	1,077
68	1,196	1,506	1,772	686	1,239	1,123
69	1,246	1,573	1,841	714	1,295	1,173
70	1,297	1,637	1,909	740	1,344	1,219
71	1,348	1,697	1,976	766	1,396	1,266
72	1,394	1,759	2,036	790	1,445	1,310
73	1,438	1,814	2,093	812	1,493	1,352
74	1,481	1,866	2,146	833	1,533	1,389
75	1,518	1,913	2,195	851	1,572	1,427
76	1,552	1,955	2,239	868	1,609	1,460
77	1,586	1,995	2,276	883	1,642	1,489
78	1,615	2,037	2,310	899	1,676	1,518
79	1,645	2,071	2,343	910	1,705	1,543
80	1,672	2,104	2,373	921	1,733	1,571
81	1,695	2,133	2,405	934	1,757	1,592
82	1,717	2,164	2,434	944	1,780	1,613
83	1,740	2,192	2,464	956	1,803	1,635
84	1,762	2,219	2,493	967	1,826	1,656
85	1,780	2,245	2,520	979	1,848	1,673
86	1,802	2,270	2,545	988	1,869	1,693
87	1,821	2,295	2,572	998	1,888	1,711
88	1,839	2,319	2,595	1,009	1,907	1,728
89	1,856	2,341	2,617	1,014	1,924	1,744
90	1,873	2,360	2,640	1,025	1,942	1,760
91	1,889	2,380	2,660	1,032	1,958	1,774
92	1,902	2,399	2,675	1,038	1,971	1,786
93	1,915	2,417	2,695	1,045	1,987	1,800
94	1,929	2,431	2,708	1,051	2,000	1,812
95	1,940	2,444	2,721	1,055	2,012	1,823
96	1,951	2,459	2,737	1,063	2,023	1,833
97	1,964	2,473	2,751	1,067	2,035	1,843
98	1,973	2,486	2,765	1,074	2,047	1,854
99	1,987	2,501	2,776	1,078	2,058	1,865

Attained Age	Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	3,895	4,906	5,371	2,112	4,989	3,962
65	1,273	1,607	1,891	734	1,321	1,198
66	1,273	1,607	1,891	734	1,321	1,198
67	1,273	1,607	1,891	734	1,321	1,198
68	1,329	1,672	1,968	763	1,377	1,247
69	1,387	1,748	2,047	794	1,438	1,305
70	1,442	1,817	2,121	823	1,495	1,356
71	1,497	1,888	2,195	851	1,552	1,406
72	1,549	1,953	2,263	878	1,607	1,453
73	1,597	2,014	2,327	903	1,657	1,502
74	1,645	2,071	2,385	926	1,705	1,546
75	1,685	2,125	2,439	946	1,748	1,584
76	1,724	2,173	2,485	964	1,786	1,619
77	1,763	2,219	2,530	981	1,827	1,656
78	1,797	2,262	2,566	997	1,862	1,687
79	1,827	2,303	2,604	1,010	1,893	1,715
80	1,856	2,341	2,636	1,023	1,924	1,744
81	1,882	2,373	2,671	1,036	1,953	1,769
82	1,907	2,406	2,706	1,051	1,979	1,792
83	1,933	2,435	2,738	1,063	2,004	1,816
84	1,956	2,467	2,769	1,076	2,028	1,838
85	1,979	2,496	2,800	1,087	2,053	1,860
86	2,002	2,523	2,828	1,098	2,076	1,880
87	2,024	2,549	2,856	1,108	2,098	1,901
88	2,044	2,574	2,883	1,119	2,119	1,918
89	2,064	2,598	2,907	1,130	2,140	1,938
90	2,081	2,624	2,930	1,137	2,157	1,955
91	2,098	2,644	2,952	1,145	2,175	1,970
92	2,115	2,663	2,976	1,156	2,191	1,987
93	2,129	2,683	2,993	1,162	2,209	2,000
94	2,143	2,701	3,009	1,168	2,221	2,014
95	2,156	2,716	3,023	1,174	2,233	2,026
96	2,168	2,731	3,040	1,179	2,246	2,036
97	2,181	2,749	3,055	1,187	2,261	2,047
98	2,193	2,763	3,072	1,191	2,274	2,060
99	2,208	2,781	3,087	1,197	2,288	2,072

Modal Factors: Semi-Annual: 0.5200 Quarterly: 0.2650 Monthly: 0.0833

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.

American Continental Insurance Company

Annual Attained Age Premiums

For Use in ZIP Codes: Rest of State

Male Rates

Attained Age	Preferred					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	4,028	5,075	5,559	2,186	5,161	4,100
65	1,319	1,662	1,956	760	1,366	1,239
66	1,319	1,662	1,956	760	1,366	1,239
67	1,319	1,662	1,956	760	1,366	1,239
68	1,373	1,734	2,036	790	1,425	1,290
69	1,436	1,810	2,119	823	1,488	1,350
70	1,493	1,880	2,197	853	1,548	1,403
71	1,550	1,953	2,273	883	1,607	1,453
72	1,603	2,021	2,343	910	1,662	1,507
73	1,653	2,083	2,407	934	1,714	1,553
74	1,702	2,145	2,468	959	1,764	1,598
75	1,746	2,198	2,523	979	1,808	1,638
76	1,785	2,248	2,572	998	1,849	1,675
77	1,822	2,297	2,617	1,014	1,890	1,712
78	1,860	2,342	2,660	1,032	1,925	1,747
79	1,890	2,382	2,696	1,045	1,959	1,777
80	1,923	2,421	2,729	1,060	1,990	1,804
81	1,949	2,456	2,765	1,074	2,020	1,829
82	1,976	2,488	2,800	1,087	2,047	1,855
83	2,001	2,522	2,834	1,099	2,075	1,879
84	2,025	2,551	2,866	1,112	2,100	1,902
85	2,049	2,582	2,897	1,124	2,124	1,926
86	2,071	2,610	2,927	1,136	2,147	1,946
87	2,093	2,638	2,957	1,146	2,171	1,967
88	2,116	2,664	2,984	1,158	2,191	1,988
89	2,133	2,691	3,010	1,168	2,213	2,006
90	2,155	2,714	3,033	1,177	2,232	2,023
91	2,173	2,736	3,056	1,187	2,253	2,039
92	2,189	2,757	3,077	1,194	2,268	2,055
93	2,203	2,778	3,098	1,202	2,285	2,070
94	2,218	2,795	3,116	1,208	2,299	2,083
95	2,230	2,811	3,131	1,216	2,312	2,094
96	2,244	2,827	3,146	1,220	2,325	2,108
97	2,256	2,842	3,161	1,228	2,340	2,121
98	2,270	2,860	3,178	1,233	2,353	2,132
99	2,284	2,878	3,196	1,240	2,366	2,145

Attained Age	Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	4,475	5,639	6,173	2,430	5,735	4,556
65	1,465	1,846	2,175	844	1,519	1,375
66	1,465	1,846	2,175	844	1,519	1,375
67	1,465	1,846	2,175	844	1,519	1,375
68	1,526	1,924	2,264	878	1,581	1,434
69	1,595	2,009	2,353	913	1,656	1,499
70	1,659	2,091	2,439	946	1,719	1,559
71	1,723	2,169	2,523	979	1,784	1,618
72	1,780	2,245	2,604	1,010	1,847	1,673
73	1,839	2,317	2,673	1,037	1,904	1,726
74	1,890	2,382	2,741	1,065	1,959	1,777
75	1,939	2,443	2,805	1,089	2,010	1,821
76	1,982	2,498	2,857	1,109	2,055	1,863
77	2,026	2,553	2,907	1,130	2,100	1,902
78	2,065	2,600	2,951	1,145	2,141	1,939
79	2,101	2,649	2,994	1,162	2,177	1,972
80	2,133	2,688	3,032	1,177	2,212	2,005
81	2,165	2,729	3,073	1,191	2,245	2,033
82	2,195	2,764	3,110	1,207	2,276	2,061
83	2,223	2,801	3,149	1,221	2,306	2,089
84	2,250	2,836	3,185	1,235	2,332	2,114
85	2,278	2,868	3,221	1,247	2,360	2,138
86	2,303	2,902	3,254	1,263	2,387	2,163
87	2,324	2,932	3,285	1,273	2,412	2,185
88	2,350	2,961	3,315	1,286	2,435	2,208
89	2,373	2,989	3,347	1,297	2,459	2,229
90	2,393	3,015	3,373	1,308	2,482	2,248
91	2,413	3,042	3,398	1,318	2,500	2,267
92	2,432	3,064	3,419	1,327	2,520	2,286
93	2,449	3,084	3,440	1,335	2,538	2,299
94	2,463	3,104	3,461	1,343	2,555	2,313
95	2,477	3,124	3,477	1,349	2,570	2,328
96	2,495	3,142	3,495	1,356	2,585	2,341
97	2,508	3,159	3,512	1,364	2,600	2,355
98	2,523	3,180	3,531	1,370	2,615	2,369
99	2,537	3,197	3,549	1,377	2,630	2,383

Modal Factors: Semi-Annual: 0.5200 Quarterly: 0.2650 Monthly: 0.0833

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

American Continental Insurance Company 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 an American Continental Insurance Company 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 an American Continental Insurance Company 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 American Continental Insurance Company, P.O. Box 1188, Brentwood, Tennessee 37024. 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 American Continental 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 *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 AMERICAN CONTINENTAL INSURANCE COMPANY.

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 $166 of 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 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 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 $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 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.	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