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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**

Missouri

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.

See Outlines of Coverage sections for details about ALL Plans

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 $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.

American Continental Insurance Company

Annual Issue Age Premiums

For Use in ZIP Codes: Rest of State

Female Rates

Rates Effective 7/1/2016

Issue Age	Preferred					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	2,724	3,521	3,847	1,170	1,941	2,638
65	2,208	2,783	3,215	1,090	1,643	2,117
66	2,208	2,783	3,215	1,090	1,643	2,117
67	2,208	2,783	3,215	1,090	1,643	2,117
68	2,273	2,859	3,301	1,121	1,689	2,181
69	2,342	2,948	3,382	1,150	1,741	2,247
70	2,404	3,030	3,460	1,177	1,788	2,305
71	2,464	3,101	3,535	1,201	1,831	2,363
72	2,518	3,171	3,599	1,224	1,873	2,416
73	2,564	3,230	3,647	1,243	1,907	2,465
74	2,606	3,284	3,696	1,259	1,940	2,502
75	2,645	3,331	3,736	1,274	1,967	2,541
76	2,675	3,371	3,770	1,285	1,990	2,568
77	2,702	3,402	3,802	1,292	2,009	2,596
78	2,728	3,437	3,837	1,300	2,030	2,623
79	2,755	3,472	3,867	1,308	2,049	2,645
80	2,782	3,501	3,892	1,316	2,068	2,672
81	2,804	3,528	3,923	1,325	2,085	2,694
82	2,823	3,559	3,955	1,335	2,103	2,713
83	2,849	3,590	3,984	1,345	2,118	2,734
84	2,869	3,613	4,018	1,352	2,134	2,758
85	2,887	3,639	4,053	1,361	2,150	2,774
86	2,905	3,663	4,081	1,366	2,162	2,789
87	2,922	3,682	4,110	1,375	2,174	2,806
88	2,948	3,717	4,144	1,386	2,194	2,834
89	2,978	3,750	4,178	1,398	2,214	2,860
90	3,001	3,781	4,214	1,410	2,233	2,883
91	3,025	3,815	4,245	1,419	2,253	2,906
92	3,050	3,844	4,274	1,429	2,269	2,929
93	3,070	3,872	4,301	1,438	2,286	2,952
94	3,094	3,896	4,321	1,446	2,302	2,967
95	3,109	3,918	4,345	1,453	2,315	2,986
96	3,130	3,941	4,368	1,463	2,326	3,005
97	3,145	3,963	4,391	1,468	2,341	3,020
98	3,162	3,987	4,413	1,477	2,355	3,037
99	3,186	4,011	4,434	1,483	2,369	3,058

Issue Age	Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	N/A	N/A	N/A	N/A	N/A	N/A
65	2,452	3,091	3,571	1,213	1,825	2,354
66	2,452	3,091	3,571	1,213	1,825	2,354
67	2,452	3,091	3,571	1,213	1,825	2,354
68	2,521	3,175	3,665	1,245	1,876	2,424
69	2,599	3,274	3,762	1,279	1,935	2,497
70	2,669	3,362	3,846	1,307	1,985	2,565
71	2,734	3,447	3,928	1,335	2,035	2,624
72	2,793	3,524	3,999	1,361	2,081	2,684
73	2,846	3,591	4,055	1,382	2,120	2,737
74	2,897	3,649	4,108	1,400	2,156	2,782
75	2,937	3,701	4,153	1,415	2,186	2,817
76	2,969	3,746	4,189	1,427	2,212	2,851
77	3,004	3,781	4,222	1,436	2,233	2,886
78	3,034	3,821	4,263	1,446	2,257	2,913
79	3,061	3,856	4,296	1,453	2,278	2,938
80	3,088	3,893	4,322	1,459	2,296	2,966
81	3,112	3,923	4,358	1,470	2,317	2,992
82	3,138	3,955	4,392	1,483	2,337	3,016
83	3,166	3,987	4,425	1,493	2,355	3,039
84	3,188	4,018	4,464	1,503	2,372	3,060
85	3,208	4,044	4,500	1,511	2,389	3,079
86	3,228	4,068	4,534	1,520	2,403	3,099
87	3,247	4,087	4,565	1,527	2,417	3,119
88	3,276	4,129	4,606	1,541	2,439	3,146
89	3,307	4,165	4,643	1,554	2,461	3,176
90	3,336	4,204	4,677	1,566	2,484	3,203
91	3,362	4,238	4,714	1,578	2,504	3,228
92	3,388	4,271	4,752	1,588	2,522	3,254
93	3,413	4,300	4,778	1,598	2,541	3,276
94	3,435	4,328	4,805	1,607	2,556	3,301
95	3,457	4,356	4,828	1,615	2,570	3,320
96	3,473	4,379	4,853	1,622	2,586	3,336
97	3,496	4,403	4,878	1,633	2,601	3,356
98	3,515	4,430	4,905	1,640	2,617	3,376
99	3,538	4,456	4,929	1,648	2,632	3,397

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 Issue Age Premiums

For Use in ZIP Codes: Rest of State

Male Rates

Rates Effective 7/1/2016

Issue	Preferred					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	3,132	4,052	4,423	1,347	2,232	3,034
65	2,539	3,196	3,696	1,256	1,888	2,437
66	2,539	3,196	3,696	1,256	1,888	2,437
67	2,539	3,196	3,696	1,256	1,888	2,437
68	2,610	3,288	3,792	1,288	1,942	2,507
69	2,694	3,395	3,892	1,324	2,003	2,585
70	2,762	3,482	3,981	1,354	2,057	2,655
71	2,833	3,566	4,067	1,383	2,105	2,715
72	2,895	3,647	4,142	1,410	2,154	2,779
73	2,948	3,714	4,194	1,429	2,194	2,832
74	2,997	3,778	4,253	1,450	2,231	2,879
75	3,041	3,828	4,298	1,465	2,263	2,919
76	3,074	3,875	4,334	1,476	2,288	2,954
77	3,104	3,915	4,370	1,485	2,312	2,982
78	3,138	3,954	4,412	1,496	2,335	3,016
79	3,168	3,990	4,451	1,504	2,358	3,043
80	3,196	4,028	4,476	1,513	2,378	3,071
81	3,222	4,061	4,512	1,523	2,398	3,094
82	3,249	4,094	4,547	1,533	2,418	3,120
83	3,274	4,129	4,583	1,544	2,437	3,144
84	3,298	4,155	4,622	1,555	2,454	3,169
85	3,321	4,183	4,657	1,563	2,472	3,190
86	3,340	4,208	4,690	1,572	2,487	3,209
87	3,360	4,235	4,726	1,581	2,500	3,225
88	3,395	4,274	4,765	1,596	2,523	3,260
89	3,420	4,315	4,807	1,607	2,548	3,288
90	3,456	4,350	4,843	1,619	2,570	3,314
91	3,483	4,387	4,879	1,633	2,592	3,344
92	3,506	4,419	4,913	1,645	2,610	3,369
93	3,534	4,453	4,943	1,654	2,628	3,391
94	3,554	4,480	4,973	1,664	2,646	3,415
95	3,576	4,506	4,996	1,672	2,661	3,433
96	3,597	4,532	5,021	1,680	2,676	3,454
97	3,616	4,558	5,047	1,689	2,694	3,474
98	3,639	4,585	5,073	1,698	2,708	3,493
99	3,661	4,611	5,098	1,705	2,724	3,516

Issue	Standard					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	N/A	N/A	N/A	N/A	N/A	N/A
65	2,820	3,552	4,107	1,394	2,098	2,708
66	2,820	3,552	4,107	1,394	2,098	2,708
67	2,820	3,552	4,107	1,394	2,098	2,708
68	2,902	3,652	4,216	1,432	2,157	2,785
69	2,992	3,767	4,322	1,468	2,227	2,872
70	3,070	3,868	4,423	1,504	2,285	2,952
71	3,145	3,962	4,519	1,535	2,340	3,020
72	3,214	4,053	4,600	1,563	2,392	3,088
73	3,276	4,129	4,661	1,587	2,439	3,146
74	3,330	4,195	4,724	1,609	2,477	3,200
75	3,377	4,255	4,776	1,629	2,513	3,243
76	3,417	4,304	4,816	1,640	2,542	3,280
77	3,452	4,350	4,855	1,652	2,568	3,313
78	3,485	4,391	4,899	1,661	2,595	3,350
79	3,518	4,435	4,940	1,671	2,618	3,378
80	3,551	4,474	4,973	1,682	2,643	3,409
81	3,580	4,512	5,017	1,691	2,666	3,439
82	3,611	4,550	5,050	1,705	2,688	3,467
83	3,639	4,586	5,093	1,717	2,708	3,493
84	3,665	4,618	5,136	1,728	2,728	3,521
85	3,690	4,648	5,174	1,739	2,747	3,542
86	3,713	4,681	5,214	1,747	2,762	3,564
87	3,732	4,703	5,249	1,756	2,779	3,585
88	3,769	4,748	5,294	1,770	2,805	3,621
89	3,802	4,791	5,340	1,786	2,830	3,652
90	3,836	4,833	5,384	1,801	2,855	3,685
91	3,868	4,873	5,425	1,815	2,879	3,716
92	3,898	4,912	5,460	1,824	2,901	3,743
93	3,925	4,945	5,491	1,838	2,920	3,769
94	3,950	4,978	5,524	1,849	2,939	3,791
95	3,974	5,008	5,552	1,857	2,957	3,814
96	3,998	5,036	5,581	1,868	2,974	3,838
97	4,019	5,066	5,608	1,875	2,991	3,859
98	4,045	5,095	5,638	1,887	3,009	3,883
99	4,067	5,123	5,666	1,895	3,027	3,905

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 Issue Age Premiums

For Use in ZIP Codes: 630, 631, 633, 640, 641

Female Rates

Rates Effective 7/1/2016

Issue Age	Preferred					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	2,881	3,725	4,069	1,238	2,053	2,791
65	2,335	2,944	3,400	1,153	1,738	2,240
66	2,335	2,944	3,400	1,153	1,738	2,240
67	2,335	2,944	3,400	1,153	1,738	2,240
68	2,405	3,024	3,491	1,186	1,786	2,307
69	2,477	3,119	3,577	1,217	1,841	2,377
70	2,543	3,204	3,660	1,245	1,891	2,438
71	2,606	3,280	3,739	1,271	1,937	2,499
72	2,663	3,354	3,807	1,295	1,981	2,555
73	2,712	3,417	3,858	1,315	2,017	2,607
74	2,757	3,474	3,909	1,332	2,052	2,647
75	2,797	3,523	3,951	1,348	2,080	2,687
76	2,829	3,565	3,988	1,360	2,104	2,716
77	2,858	3,598	4,022	1,366	2,125	2,746
78	2,885	3,636	4,058	1,375	2,147	2,774
79	2,914	3,672	4,090	1,384	2,167	2,797
80	2,943	3,703	4,116	1,392	2,187	2,826
81	2,966	3,731	4,149	1,401	2,206	2,849
82	2,985	3,764	4,183	1,412	2,224	2,870
83	3,013	3,797	4,214	1,422	2,241	2,892
84	3,035	3,821	4,249	1,430	2,257	2,917
85	3,054	3,849	4,287	1,440	2,274	2,934
86	3,072	3,874	4,316	1,444	2,287	2,950
87	3,091	3,894	4,347	1,454	2,299	2,968
88	3,119	3,931	4,384	1,466	2,321	2,998
89	3,149	3,967	4,419	1,478	2,342	3,025
90	3,175	4,000	4,457	1,492	2,362	3,049
91	3,200	4,035	4,490	1,500	2,383	3,073
92	3,226	4,066	4,521	1,511	2,400	3,098
93	3,247	4,095	4,550	1,521	2,418	3,122
94	3,273	4,121	4,571	1,529	2,434	3,138
95	3,288	4,144	4,596	1,537	2,449	3,158
96	3,311	4,168	4,620	1,548	2,461	3,178
97	3,326	4,192	4,644	1,553	2,476	3,194
98	3,344	4,217	4,667	1,562	2,490	3,212
99	3,369	4,243	4,689	1,569	2,506	3,234

Issue Age	Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	N/A	N/A	N/A	N/A	N/A	N/A
65	2,594	3,269	3,777	1,283	1,931	2,489
66	2,594	3,269	3,777	1,283	1,931	2,489
67	2,594	3,269	3,777	1,283	1,931	2,489
68	2,666	3,358	3,876	1,317	1,984	2,564
69	2,749	3,463	3,979	1,353	2,047	2,641
70	2,823	3,556	4,068	1,383	2,100	2,713
71	2,892	3,645	4,155	1,412	2,153	2,775
72	2,955	3,727	4,230	1,440	2,201	2,839
73	3,011	3,798	4,289	1,462	2,242	2,895
74	3,065	3,860	4,345	1,481	2,280	2,943
75	3,106	3,915	4,392	1,497	2,312	2,980
76	3,141	3,962	4,431	1,509	2,340	3,015
77	3,177	4,000	4,466	1,519	2,362	3,053
78	3,209	4,041	4,509	1,529	2,387	3,081
79	3,237	4,079	4,544	1,537	2,409	3,108
80	3,266	4,117	4,572	1,543	2,429	3,137
81	3,291	4,149	4,609	1,554	2,451	3,165
82	3,319	4,183	4,645	1,569	2,472	3,190
83	3,348	4,217	4,681	1,580	2,490	3,214
84	3,372	4,249	4,721	1,590	2,509	3,236
85	3,394	4,277	4,760	1,598	2,527	3,257
86	3,414	4,303	4,796	1,608	2,542	3,278
87	3,434	4,323	4,828	1,615	2,556	3,299
88	3,465	4,367	4,872	1,630	2,580	3,328
89	3,498	4,406	4,910	1,643	2,603	3,359
90	3,529	4,446	4,947	1,657	2,627	3,388
91	3,556	4,483	4,986	1,669	2,649	3,414
92	3,584	4,518	5,026	1,680	2,668	3,442
93	3,610	4,549	5,053	1,691	2,687	3,465
94	3,633	4,578	5,082	1,700	2,704	3,491
95	3,656	4,607	5,106	1,708	2,718	3,511
96	3,673	4,632	5,133	1,716	2,736	3,529
97	3,698	4,657	5,159	1,727	2,751	3,550
98	3,718	4,686	5,188	1,735	2,768	3,571
99	3,742	4,714	5,213	1,744	2,784	3,593

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 Issue Age Premiums

For Use in ZIP Codes: 630, 631, 633, 640, 641

Male Rates

Rates Effective 7/1/2016

Issue	Preferred					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	3,313	4,286	4,678	1,425	2,361	3,209
65	2,685	3,380	3,909	1,329	1,997	2,577
66	2,685	3,380	3,909	1,329	1,997	2,577
67	2,685	3,380	3,909	1,329	1,997	2,577
68	2,761	3,478	4,011	1,362	2,054	2,652
69	2,849	3,590	4,116	1,400	2,119	2,735
70	2,922	3,683	4,211	1,432	2,176	2,808
71	2,996	3,772	4,302	1,463	2,226	2,872
72	3,062	3,858	4,381	1,492	2,278	2,939
73	3,119	3,928	4,436	1,511	2,321	2,995
74	3,170	3,996	4,498	1,533	2,360	3,045
75	3,216	4,049	4,546	1,550	2,394	3,088
76	3,252	4,099	4,584	1,561	2,420	3,124
77	3,284	4,140	4,622	1,571	2,445	3,154
78	3,319	4,182	4,666	1,582	2,470	3,190
79	3,351	4,221	4,708	1,591	2,494	3,219
80	3,380	4,260	4,734	1,601	2,516	3,248
81	3,408	4,296	4,772	1,610	2,537	3,273
82	3,436	4,331	4,809	1,621	2,558	3,300
83	3,463	4,367	4,848	1,634	2,577	3,325
84	3,488	4,395	4,888	1,645	2,596	3,352
85	3,512	4,424	4,926	1,653	2,615	3,374
86	3,533	4,451	4,961	1,663	2,630	3,395
87	3,554	4,479	4,998	1,672	2,644	3,411
88	3,590	4,521	5,040	1,689	2,669	3,449
89	3,617	4,564	5,084	1,700	2,695	3,478
90	3,655	4,601	5,123	1,713	2,718	3,506
91	3,684	4,640	5,160	1,727	2,741	3,537
92	3,708	4,674	5,196	1,740	2,761	3,563
93	3,738	4,710	5,228	1,749	2,780	3,587
94	3,759	4,739	5,260	1,760	2,798	3,612
95	3,782	4,766	5,284	1,769	2,815	3,631
96	3,805	4,794	5,311	1,777	2,830	3,653
97	3,825	4,821	5,338	1,786	2,849	3,674
98	3,849	4,850	5,366	1,796	2,864	3,695
99	3,872	4,877	5,392	1,803	2,881	3,719

Issue	Standard					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
Under 65	N/A	N/A	N/A	N/A	N/A	N/A
65	2,983	3,757	4,344	1,474	2,219	2,864
66	2,983	3,757	4,344	1,474	2,219	2,864
67	2,983	3,757	4,344	1,474	2,219	2,864
68	3,069	3,863	4,459	1,515	2,281	2,946
69	3,165	3,984	4,572	1,553	2,355	3,038
70	3,247	4,091	4,678	1,591	2,417	3,122
71	3,326	4,191	4,780	1,624	2,475	3,194
72	3,399	4,287	4,865	1,653	2,530	3,266
73	3,465	4,367	4,930	1,679	2,580	3,328
74	3,522	4,437	4,996	1,702	2,620	3,385
75	3,572	4,500	5,051	1,723	2,658	3,430
76	3,615	4,552	5,094	1,735	2,688	3,469
77	3,651	4,601	5,135	1,747	2,716	3,505
78	3,686	4,644	5,182	1,757	2,745	3,543
79	3,721	4,690	5,225	1,768	2,769	3,573
80	3,755	4,732	5,260	1,779	2,795	3,606
81	3,786	4,772	5,306	1,789	2,819	3,638
82	3,819	4,813	5,342	1,803	2,844	3,667
83	3,849	4,851	5,387	1,816	2,864	3,695
84	3,876	4,884	5,432	1,828	2,885	3,725
85	3,903	4,916	5,473	1,839	2,905	3,747
86	3,927	4,951	5,514	1,848	2,922	3,770
87	3,947	4,974	5,552	1,857	2,939	3,792
88	3,986	5,022	5,599	1,872	2,967	3,830
89	4,022	5,068	5,649	1,889	2,993	3,863
90	4,057	5,112	5,695	1,905	3,020	3,897
91	4,091	5,155	5,738	1,920	3,045	3,930
92	4,123	5,195	5,775	1,929	3,068	3,959
93	4,151	5,231	5,808	1,944	3,089	3,986
94	4,178	5,266	5,843	1,956	3,109	4,010
95	4,203	5,297	5,872	1,965	3,127	4,034
96	4,228	5,326	5,903	1,976	3,146	4,059
97	4,250	5,358	5,931	1,983	3,164	4,082
98	4,278	5,389	5,963	1,995	3,182	4,107
99	4,302	5,419	5,993	2,004	3,202	4,131

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 may be changed for this policy on any premium due date, provided premiums for all policies issued on this form number in your state are also changed. For every nonscheduled premium change, we will give you at least 30 days advance notice in writing of such premium change.

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 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 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 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 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