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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**

Arizona

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, co-payments for hospital outpatient services. Plans K, L, and N require insureds to pay a portion of coinsurance or copayments
Blood: First three pints of blood each year.
Hospice-Part A coinsurance

A	B	C	D	F/F*	G	K	L	M	N
Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance, except up to $20 copayment for office visit, and up to $50 copayment for ER
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Part B Deductible		Part B Deductible					
				Part B Excess (100%)	Part B Excess (100%)				
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency			Foreign Travel Emergency	Foreign Travel Emergency
						Out-of-pocket limit $4960; paid at 100% after limit reached	Out-of-pocket limit $2480; paid at 100% after limit reached		

*Plan F also has an option called a high deductible plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2180 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed $2180. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

American Continental Insurance Company

Annual Issue Age Premiums

For Use in ZIP Codes: 850

Female Rates

Issue Age	Preferred					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,487	1,875	2,201	878	1,482	1,269
66	1,487	1,875	2,201	878	1,482	1,269
67	1,487	1,875	2,201	878	1,482	1,269
68	1,528	1,926	2,260	903	1,522	1,305
69	1,577	1,986	2,318	927	1,571	1,346
70	1,618	2,040	2,372	949	1,612	1,382
71	1,658	2,089	2,422	968	1,651	1,415
72	1,695	2,136	2,466	986	1,689	1,446
73	1,728	2,175	2,501	1,001	1,723	1,474
74	1,756	2,214	2,534	1,014	1,751	1,498
75	1,782	2,243	2,560	1,027	1,774	1,520
76	1,801	2,269	2,583	1,037	1,796	1,537
77	1,820	2,292	2,606	1,040	1,812	1,554
78	1,836	2,317	2,630	1,049	1,832	1,570
79	1,855	2,339	2,651	1,055	1,848	1,583
80	1,874	2,358	2,669	1,062	1,865	1,599
81	1,888	2,377	2,688	1,068	1,880	1,612
82	1,902	2,395	2,710	1,076	1,896	1,625
83	1,920	2,416	2,729	1,084	1,913	1,637
84	1,931	2,433	2,753	1,089	1,925	1,651
85	1,944	2,452	2,776	1,096	1,940	1,660
86	1,957	2,467	2,795	1,103	1,952	1,670
87	1,967	2,480	2,817	1,107	1,960	1,678
88	1,986	2,503	2,839	1,118	1,980	1,697
89	2,004	2,526	2,864	1,125	1,997	1,712
90	2,023	2,547	2,888	1,135	2,015	1,726
91	2,039	2,568	2,910	1,143	2,031	1,741
92	2,053	2,589	2,927	1,152	2,047	1,753
93	2,067	2,606	2,946	1,159	2,061	1,767
94	2,083	2,621	2,960	1,164	2,076	1,778
95	2,094	2,638	2,975	1,171	2,089	1,787
96	2,106	2,655	2,994	1,176	2,100	1,798
97	2,119	2,670	3,010	1,184	2,114	1,809
98	2,131	2,685	3,025	1,191	2,125	1,818
99	2,145	2,702	3,038	1,194	2,136	1,831

Issue Age	Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,651	2,081	2,446	976	1,647	1,409
66	1,651	2,081	2,446	976	1,647	1,409
67	1,651	2,081	2,446	976	1,647	1,409
68	1,699	2,139	2,511	1,004	1,692	1,449
69	1,751	2,205	2,578	1,030	1,747	1,496
70	1,798	2,266	2,637	1,054	1,791	1,535
71	1,841	2,322	2,691	1,076	1,836	1,572
72	1,882	2,374	2,740	1,096	1,877	1,607
73	1,918	2,418	2,778	1,112	1,913	1,638
74	1,950	2,458	2,817	1,126	1,944	1,665
75	1,977	2,493	2,846	1,140	1,973	1,688
76	2,001	2,521	2,871	1,149	1,995	1,706
77	2,024	2,547	2,893	1,157	2,015	1,728
78	2,042	2,571	2,921	1,164	2,036	1,745
79	2,061	2,597	2,943	1,171	2,054	1,758
80	2,080	2,620	2,962	1,175	2,073	1,777
81	2,095	2,642	2,985	1,185	2,091	1,791
82	2,115	2,665	3,010	1,194	2,108	1,806
83	2,132	2,685	3,034	1,204	2,125	1,819
84	2,147	2,705	3,060	1,211	2,138	1,832
85	2,158	2,723	3,086	1,218	2,155	1,844
86	2,174	2,741	3,106	1,225	2,168	1,857
87	2,187	2,753	3,129	1,231	2,181	1,866
88	2,205	2,779	3,155	1,242	2,200	1,884
89	2,227	2,805	3,181	1,252	2,219	1,902
90	2,246	2,831	3,207	1,261	2,240	1,918
91	2,266	2,853	3,230	1,271	2,258	1,933
92	2,283	2,876	3,255	1,281	2,276	1,949
93	2,297	2,895	3,275	1,288	2,291	1,962
94	2,313	2,914	3,293	1,297	2,306	1,975
95	2,327	2,932	3,310	1,301	2,319	1,987
96	2,340	2,949	3,325	1,307	2,334	1,997
97	2,355	2,967	3,343	1,315	2,346	2,009
98	2,366	2,983	3,362	1,321	2,360	2,022
99	2,381	3,002	3,379	1,329	2,375	2,034

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: 850

Male Rates

Issue	Preferred					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,710	2,152	2,534	1,013	1,703	1,460
66	1,710	2,152	2,534	1,013	1,703	1,460
67	1,710	2,152	2,534	1,013	1,703	1,460
68	1,757	2,215	2,597	1,038	1,753	1,500
69	1,812	2,284	2,669	1,067	1,808	1,549
70	1,859	2,344	2,728	1,092	1,857	1,589
71	1,907	2,402	2,786	1,116	1,900	1,626
72	1,949	2,457	2,838	1,135	1,942	1,664
73	1,986	2,502	2,874	1,152	1,980	1,696
74	2,017	2,543	2,915	1,169	2,013	1,724
75	2,049	2,579	2,944	1,182	2,040	1,747
76	2,069	2,607	2,970	1,190	2,065	1,769
77	2,090	2,637	2,994	1,199	2,087	1,785
78	2,115	2,664	3,024	1,206	2,108	1,806
79	2,133	2,687	3,050	1,212	2,125	1,821
80	2,152	2,712	3,067	1,219	2,146	1,837
81	2,169	2,733	3,090	1,228	2,163	1,852
82	2,188	2,757	3,116	1,236	2,182	1,867
83	2,205	2,779	3,138	1,244	2,199	1,884
84	2,220	2,796	3,167	1,253	2,214	1,895
85	2,237	2,817	3,191	1,260	2,229	1,911
86	2,250	2,834	3,215	1,268	2,242	1,922
87	2,262	2,850	3,238	1,272	2,254	1,931
88	2,284	2,878	3,266	1,286	2,278	1,950
89	2,304	2,906	3,294	1,297	2,298	1,970
90	2,326	2,929	3,318	1,304	2,318	1,984
91	2,345	2,953	3,344	1,315	2,337	2,002
92	2,362	2,976	3,366	1,323	2,354	2,015
93	2,378	2,999	3,389	1,333	2,370	2,030
94	2,393	3,018	3,406	1,339	2,386	2,043
95	2,407	3,034	3,425	1,348	2,401	2,055
96	2,424	3,052	3,442	1,352	2,414	2,067
97	2,434	3,069	3,459	1,361	2,429	2,081
98	2,452	3,086	3,478	1,369	2,442	2,093
99	2,467	3,105	3,494	1,375	2,457	2,106

Modal Factors: Semi-Annual: 0.5200

Issue	Standard					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,900	2,392	2,816	1,123	1,893	1,621
66	1,900	2,392	2,816	1,123	1,893	1,621
67	1,900	2,392	2,816	1,123	1,893	1,621
68	1,955	2,460	2,888	1,155	1,946	1,666
69	2,013	2,537	2,962	1,184	2,009	1,718
70	2,067	2,605	3,032	1,212	2,060	1,767
71	2,119	2,669	3,097	1,238	2,112	1,809
72	2,165	2,729	3,151	1,260	2,158	1,849
73	2,205	2,779	3,196	1,281	2,199	1,884
74	2,242	2,827	3,237	1,298	2,235	1,916
75	2,276	2,865	3,272	1,313	2,267	1,943
76	2,301	2,897	3,300	1,321	2,293	1,966
77	2,325	2,929	3,327	1,331	2,317	1,983
78	2,347	2,956	3,357	1,337	2,340	2,006
79	2,371	2,985	3,386	1,347	2,362	2,022
80	2,391	3,014	3,406	1,354	2,382	2,041
81	2,409	3,039	3,438	1,363	2,404	2,058
82	2,430	3,064	3,461	1,375	2,424	2,074
83	2,452	3,088	3,491	1,386	2,442	2,093
84	2,468	3,109	3,518	1,392	2,461	2,108
85	2,485	3,130	3,548	1,402	2,478	2,121
86	2,501	3,151	3,572	1,408	2,493	2,134
87	2,513	3,167	3,597	1,415	2,508	2,146
88	2,538	3,197	3,629	1,427	2,529	2,168
89	2,560	3,227	3,659	1,440	2,553	2,186
90	2,582	3,255	3,688	1,449	2,576	2,206
91	2,605	3,282	3,717	1,462	2,596	2,225
92	2,624	3,307	3,742	1,472	2,615	2,241
93	2,644	3,330	3,764	1,482	2,634	2,256
94	2,660	3,352	3,784	1,489	2,652	2,271
95	2,676	3,372	3,803	1,497	2,668	2,284
96	2,692	3,392	3,825	1,503	2,684	2,297
97	2,708	3,411	3,843	1,512	2,699	2,312
98	2,725	3,432	3,863	1,518	2,713	2,325
99	2,740	3,452	3,882	1,527	2,730	2,338

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

Female Rates

Issue	Preferred					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,294	1,632	1,916	764	1,290	1,105
66	1,294	1,632	1,916	764	1,290	1,105
67	1,294	1,632	1,916	764	1,290	1,105
68	1,330	1,676	1,967	786	1,324	1,136
69	1,372	1,729	2,017	807	1,368	1,171
70	1,408	1,776	2,064	826	1,403	1,203
71	1,443	1,818	2,108	842	1,437	1,231
72	1,475	1,859	2,146	858	1,470	1,259
73	1,504	1,893	2,177	871	1,499	1,283
74	1,528	1,927	2,205	883	1,524	1,304
75	1,551	1,952	2,228	894	1,544	1,323
76	1,568	1,975	2,248	902	1,563	1,338
77	1,584	1,995	2,268	905	1,577	1,353
78	1,598	2,016	2,289	913	1,594	1,367
79	1,615	2,036	2,308	918	1,608	1,378
80	1,631	2,052	2,323	924	1,623	1,392
81	1,643	2,069	2,340	930	1,637	1,403
82	1,655	2,085	2,358	936	1,651	1,415
83	1,671	2,103	2,375	944	1,665	1,425
84	1,681	2,118	2,396	948	1,675	1,437
85	1,692	2,134	2,416	954	1,688	1,445
86	1,703	2,147	2,433	960	1,699	1,453
87	1,712	2,158	2,452	964	1,706	1,461
88	1,729	2,179	2,471	973	1,723	1,477
89	1,745	2,199	2,493	979	1,738	1,490
90	1,761	2,217	2,514	988	1,754	1,502
91	1,775	2,235	2,532	995	1,768	1,515
92	1,787	2,253	2,547	1,003	1,781	1,526
93	1,799	2,268	2,564	1,009	1,794	1,538
94	1,813	2,281	2,577	1,013	1,807	1,547
95	1,823	2,296	2,590	1,019	1,818	1,556
96	1,833	2,311	2,606	1,024	1,827	1,565
97	1,844	2,324	2,620	1,030	1,840	1,575
98	1,855	2,337	2,633	1,037	1,850	1,582
99	1,867	2,352	2,644	1,040	1,859	1,593

Issue	Standard					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,437	1,811	2,129	850	1,434	1,227
66	1,437	1,811	2,129	850	1,434	1,227
67	1,437	1,811	2,129	850	1,434	1,227
68	1,479	1,862	2,186	874	1,473	1,261
69	1,524	1,919	2,244	897	1,521	1,302
70	1,565	1,972	2,295	917	1,559	1,336
71	1,603	2,021	2,342	936	1,598	1,369
72	1,638	2,066	2,385	954	1,634	1,399
73	1,669	2,105	2,418	968	1,665	1,426
74	1,698	2,139	2,452	980	1,692	1,449
75	1,721	2,170	2,477	993	1,717	1,469
76	1,742	2,194	2,499	1,000	1,736	1,485
77	1,762	2,217	2,518	1,007	1,754	1,504
78	1,778	2,238	2,543	1,013	1,772	1,519
79	1,794	2,261	2,562	1,019	1,788	1,530
80	1,810	2,280	2,578	1,023	1,804	1,546
81	1,824	2,299	2,598	1,031	1,820	1,559
82	1,841	2,320	2,620	1,040	1,835	1,572
83	1,856	2,337	2,640	1,048	1,850	1,583
84	1,869	2,355	2,663	1,054	1,861	1,594
85	1,878	2,370	2,686	1,060	1,875	1,605
86	1,892	2,386	2,703	1,066	1,887	1,616
87	1,904	2,396	2,723	1,072	1,898	1,624
88	1,919	2,419	2,746	1,081	1,915	1,639
89	1,938	2,441	2,768	1,089	1,932	1,655
90	1,955	2,464	2,791	1,098	1,950	1,669
91	1,972	2,483	2,812	1,106	1,966	1,683
92	1,987	2,503	2,833	1,115	1,981	1,697
93	1,999	2,520	2,850	1,121	1,994	1,708
94	2,013	2,536	2,866	1,129	2,007	1,719
95	2,026	2,552	2,881	1,133	2,018	1,730
96	2,037	2,567	2,894	1,137	2,031	1,738
97	2,050	2,582	2,909	1,145	2,042	1,748
98	2,060	2,596	2,926	1,150	2,054	1,760
99	2,073	2,613	2,941	1,157	2,067	1,770

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

Issue	Preferred					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,488	1,873	2,205	882	1,482	1,271
66	1,488	1,873	2,205	882	1,482	1,271
67	1,488	1,873	2,205	882	1,482	1,271
68	1,529	1,928	2,261	903	1,526	1,306
69	1,577	1,988	2,323	929	1,574	1,348
70	1,618	2,040	2,374	950	1,616	1,383
71	1,660	2,091	2,425	971	1,653	1,416
72	1,697	2,139	2,470	988	1,690	1,449
73	1,729	2,178	2,501	1,003	1,723	1,476
74	1,756	2,214	2,537	1,017	1,752	1,500
75	1,783	2,245	2,562	1,028	1,776	1,521
76	1,801	2,269	2,585	1,036	1,797	1,540
77	1,819	2,295	2,606	1,043	1,816	1,554
78	1,841	2,319	2,632	1,050	1,835	1,572
79	1,857	2,339	2,655	1,055	1,850	1,585
80	1,873	2,360	2,670	1,061	1,868	1,599
81	1,888	2,379	2,689	1,069	1,883	1,612
82	1,904	2,400	2,712	1,075	1,899	1,625
83	1,919	2,419	2,732	1,083	1,914	1,639
84	1,933	2,434	2,756	1,090	1,927	1,650
85	1,947	2,452	2,778	1,097	1,940	1,663
86	1,958	2,467	2,798	1,104	1,951	1,673
87	1,968	2,481	2,818	1,107	1,962	1,681
88	1,988	2,505	2,843	1,120	1,982	1,698
89	2,005	2,530	2,867	1,129	2,000	1,715
90	2,025	2,549	2,888	1,135	2,017	1,727
91	2,041	2,570	2,910	1,145	2,034	1,743
92	2,056	2,591	2,930	1,152	2,049	1,754
93	2,070	2,610	2,950	1,160	2,062	1,767
94	2,083	2,626	2,965	1,166	2,076	1,778
95	2,095	2,640	2,981	1,173	2,090	1,789
96	2,109	2,656	2,996	1,177	2,101	1,799
97	2,119	2,671	3,011	1,184	2,114	1,811
98	2,134	2,686	3,027	1,192	2,125	1,822
99	2,147	2,703	3,041	1,197	2,139	1,833

Issue	Standard					
Age	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,653	2,082	2,451	978	1,648	1,411
66	1,653	2,082	2,451	978	1,648	1,411
67	1,653	2,082	2,451	978	1,648	1,411
68	1,701	2,141	2,514	1,005	1,694	1,450
69	1,752	2,208	2,578	1,030	1,748	1,496
70	1,799	2,267	2,639	1,055	1,793	1,538
71	1,844	2,323	2,696	1,077	1,839	1,575
72	1,885	2,375	2,743	1,097	1,878	1,609
73	1,919	2,419	2,781	1,115	1,914	1,639
74	1,951	2,461	2,817	1,130	1,945	1,668
75	1,981	2,494	2,848	1,143	1,973	1,691
76	2,003	2,521	2,873	1,150	1,996	1,711
77	2,024	2,549	2,896	1,158	2,016	1,726
78	2,043	2,573	2,922	1,164	2,037	1,746
79	2,063	2,598	2,947	1,172	2,056	1,760
80	2,081	2,624	2,965	1,179	2,074	1,777
81	2,097	2,645	2,992	1,186	2,092	1,792
82	2,115	2,667	3,013	1,197	2,109	1,805
83	2,134	2,687	3,038	1,206	2,125	1,822
84	2,148	2,706	3,062	1,212	2,142	1,835
85	2,163	2,724	3,088	1,220	2,156	1,846
86	2,177	2,743	3,109	1,226	2,170	1,857
87	2,187	2,756	3,131	1,231	2,183	1,868
88	2,209	2,782	3,158	1,242	2,201	1,887
89	2,228	2,809	3,185	1,253	2,222	1,903
90	2,248	2,833	3,210	1,261	2,242	1,920
91	2,267	2,857	3,235	1,273	2,260	1,936
92	2,284	2,878	3,257	1,281	2,276	1,951
93	2,301	2,898	3,276	1,290	2,293	1,964
94	2,315	2,918	3,294	1,296	2,309	1,977
95	2,329	2,935	3,310	1,303	2,322	1,988
96	2,343	2,953	3,329	1,308	2,336	1,999
97	2,357	2,969	3,345	1,316	2,349	2,013
98	2,372	2,987	3,362	1,322	2,361	2,024
99	2,385	3,004	3,378	1,329	2,376	2,035

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 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 co-payment/ coinsurance	$0

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

PLAN N

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

*Once you have been billed $166 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic test, durable medical equipment			
First $166 of Medicare-Approved amounts*	$0	$0	$166 (Part B Deductible)
Remainder of Medicare-Approved amounts	Generally 80%	Balance, other than up to $20 per office visit and up to $50 per emergency room visit. The co-payment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
Part B Excess Charges (Above Medicare-Approved amounts)	$0	0%	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $166 of Medicare-Approved amounts*	$0	$0	$166 (Part B Deductible)
Remainder of Medicare-Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PLAN N

PARTS A & B

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

OTHER BENEFITS – NOT COVERED BY MEDICARE

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