800 Crescent Centre Dr.
Suite 200
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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**

ALABAMA

ACIMS01063AL

Rates Effective: 06/2017 A

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 $5120; paid at 100% after limit reached	Out-of-pocket limit $2560; 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 $2200 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed $2200. 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: 350-352, 355

Female Rates

Rates Effective 6/1/2017

Attained Age	Preferred					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,300	1,637	1,956	683	1,498	1,140
66	1,313	1,656	1,976	691	1,514	1,152
67	1,326	1,673	1,996	697	1,530	1,162
68	1,382	1,741	2,079	727	1,593	1,213
69	1,445	1,820	2,160	755	1,666	1,265
70	1,502	1,895	2,241	783	1,733	1,317
71	1,558	1,964	2,317	809	1,798	1,367
72	1,612	2,034	2,392	835	1,860	1,414
73	1,663	2,096	2,455	857	1,919	1,458
74	1,710	2,157	2,518	879	1,974	1,499
75	1,755	2,213	2,576	899	2,024	1,539
76	1,794	2,261	2,626	920	2,071	1,575
77	1,838	2,311	2,670	933	2,114	1,610
78	1,867	2,357	2,711	947	2,157	1,639
79	1,903	2,398	2,749	961	2,195	1,666
80	1,933	2,436	2,783	974	2,229	1,696
81	1,962	2,469	2,820	986	2,261	1,719
82	1,987	2,503	2,855	1,000	2,291	1,742
83	2,013	2,537	2,890	1,011	2,322	1,765
84	2,037	2,566	2,923	1,020	2,350	1,788
85	2,060	2,598	2,956	1,034	2,377	1,808
86	2,085	2,628	2,986	1,044	2,405	1,828
87	2,105	2,655	3,018	1,055	2,429	1,847
88	2,127	2,683	3,045	1,066	2,455	1,866
89	2,147	2,707	3,070	1,072	2,476	1,884
90	2,166	2,731	3,099	1,082	2,497	1,901
91	2,183	2,755	3,119	1,089	2,521	1,916
92	2,201	2,773	3,140	1,096	2,538	1,930
93	2,217	2,794	3,162	1,106	2,556	1,944
94	2,231	2,810	3,175	1,109	2,574	1,955
95	2,246	2,827	3,193	1,115	2,589	1,968
96	2,255	2,843	3,209	1,122	2,603	1,979
97	2,271	2,860	3,228	1,128	2,620	1,991
98	2,283	2,877	3,245	1,134	2,633	2,002
99	2,298	2,894	3,259	1,138	2,648	2,015

Attained Age	Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,445	1,820	2,175	759	1,666	1,266
66	1,457	1,840	2,197	765	1,683	1,278
67	1,474	1,859	2,218	774	1,700	1,293
68	1,536	1,935	2,310	806	1,771	1,346
69	1,604	2,021	2,401	840	1,851	1,408
70	1,666	2,102	2,491	869	1,925	1,463
71	1,733	2,182	2,576	899	1,999	1,518
72	1,791	2,256	2,657	927	2,067	1,572
73	1,850	2,329	2,730	953	2,133	1,622
74	1,903	2,398	2,798	978	2,195	1,667
75	1,948	2,458	2,862	1,001	2,249	1,709
76	1,995	2,514	2,916	1,017	2,300	1,749
77	2,038	2,567	2,966	1,036	2,352	1,788
78	2,078	2,617	3,011	1,053	2,397	1,822
79	2,115	2,665	3,053	1,068	2,438	1,852
80	2,147	2,707	3,094	1,080	2,476	1,884
81	2,179	2,745	3,134	1,094	2,513	1,911
82	2,208	2,784	3,173	1,109	2,547	1,935
83	2,239	2,818	3,210	1,122	2,579	1,960
84	2,265	2,854	3,250	1,134	2,611	1,985
85	2,290	2,885	3,287	1,149	2,643	2,009
86	2,315	2,920	3,320	1,160	2,671	2,031
87	2,343	2,951	3,352	1,171	2,701	2,053
88	2,364	2,979	3,383	1,181	2,727	2,072
89	2,385	3,006	3,413	1,193	2,753	2,093
90	2,408	3,032	3,440	1,201	2,778	2,113
91	2,430	3,058	3,463	1,211	2,799	2,127
92	2,445	3,082	3,491	1,221	2,820	2,146
93	2,462	3,105	3,511	1,229	2,840	2,160
94	2,478	3,123	3,531	1,234	2,860	2,175
95	2,494	3,144	3,549	1,241	2,874	2,188
96	2,505	3,161	3,566	1,246	2,892	2,199
97	2,524	3,176	3,585	1,253	2,910	2,212
98	2,538	3,197	3,604	1,260	2,925	2,225
99	2,555	3,215	3,621	1,265	2,946	2,238

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: 350-352, 355

Male Rates

Rates Effective 6/1/2017

Attained Age	Preferred					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,496	1,885	2,250	786	1,723	1,310
66	1,510	1,903	2,274	795	1,742	1,325
67	1,527	1,923	2,293	802	1,759	1,338
68	1,589	2,002	2,392	835	1,832	1,394
69	1,661	2,093	2,484	868	1,915	1,456
70	1,727	2,177	2,576	900	1,991	1,514
71	1,792	2,256	2,666	931	2,067	1,572
72	1,855	2,337	2,749	961	2,139	1,626
73	1,913	2,409	2,822	986	2,208	1,678
74	1,969	2,481	2,898	1,013	2,270	1,727
75	2,019	2,541	2,962	1,035	2,328	1,769
76	2,064	2,601	3,018	1,055	2,381	1,810
77	2,107	2,658	3,070	1,072	2,434	1,849
78	2,150	2,710	3,116	1,089	2,478	1,886
79	2,186	2,758	3,164	1,106	2,523	1,918
80	2,223	2,800	3,200	1,119	2,563	1,948
81	2,253	2,840	3,245	1,134	2,601	1,977
82	2,284	2,878	3,287	1,149	2,634	2,003
83	2,313	2,919	3,325	1,160	2,668	2,030
84	2,343	2,952	3,361	1,176	2,702	2,054
85	2,371	2,986	3,400	1,188	2,733	2,080
86	2,398	3,022	3,434	1,201	2,765	2,101
87	2,422	3,051	3,471	1,212	2,794	2,123
88	2,447	3,083	3,501	1,224	2,821	2,147
89	2,469	3,112	3,531	1,234	2,848	2,167
90	2,493	3,140	3,561	1,244	2,873	2,185
91	2,513	3,166	3,586	1,253	2,899	2,202
92	2,532	3,190	3,612	1,261	2,919	2,220
93	2,550	3,211	3,634	1,269	2,939	2,235
94	2,565	3,234	3,657	1,276	2,959	2,250
95	2,581	3,251	3,674	1,284	2,978	2,264
96	2,597	3,270	3,693	1,289	2,993	2,275
97	2,611	3,289	3,710	1,297	3,012	2,290
98	2,628	3,308	3,726	1,302	3,029	2,303
99	2,642	3,329	3,749	1,309	3,047	2,316

Attained Age	Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,661	2,093	2,500	874	1,913	1,455
66	1,677	2,116	2,526	881	1,936	1,471
67	1,696	2,137	2,552	893	1,954	1,486
68	1,766	2,224	2,657	927	2,036	1,549
69	1,844	2,326	2,762	964	2,128	1,619
70	1,919	2,419	2,862	1,001	2,213	1,683
71	1,993	2,511	2,962	1,035	2,297	1,746
72	2,060	2,598	3,053	1,068	2,376	1,808
73	2,126	2,679	3,136	1,095	2,453	1,865
74	2,186	2,758	3,218	1,125	2,523	1,918
75	2,243	2,825	3,292	1,151	2,587	1,967
76	2,295	2,890	3,353	1,173	2,646	2,012
77	2,345	2,953	3,413	1,193	2,702	2,054
78	2,387	3,009	3,462	1,210	2,754	2,095
79	2,431	3,061	3,512	1,229	2,802	2,130
80	2,469	3,111	3,557	1,244	2,847	2,165
81	2,504	3,157	3,605	1,260	2,890	2,197
82	2,538	3,199	3,649	1,275	2,928	2,226
83	2,573	3,239	3,695	1,290	2,966	2,255
84	2,603	3,280	3,737	1,304	3,003	2,284
85	2,634	3,319	3,778	1,320	3,038	2,308
86	2,665	3,357	3,818	1,332	3,071	2,335
87	2,690	3,392	3,856	1,346	3,104	2,359
88	2,720	3,425	3,890	1,359	3,136	2,385
89	2,745	3,459	3,924	1,371	3,165	2,407
90	2,767	3,487	3,956	1,382	3,193	2,428
91	2,794	3,519	3,987	1,393	3,219	2,450
92	2,813	3,544	4,013	1,402	3,245	2,466
93	2,833	3,568	4,038	1,410	3,268	2,484
94	2,851	3,592	4,059	1,419	3,288	2,499
95	2,868	3,615	4,080	1,426	3,308	2,515
96	2,884	3,634	4,102	1,433	3,327	2,528
97	2,902	3,655	4,120	1,440	3,347	2,543
98	2,920	3,677	4,144	1,447	3,366	2,559
99	2,936	3,698	4,165	1,455	3,386	2,573

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

Rates Effective 6/1/2017

Attained Age	Preferred					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,176	1,481	1,770	618	1,356	1,032
66	1,188	1,498	1,788	625	1,370	1,042
67	1,200	1,513	1,806	631	1,384	1,052
68	1,250	1,575	1,881	657	1,441	1,097
69	1,307	1,646	1,954	683	1,508	1,145
70	1,359	1,715	2,027	709	1,568	1,191
71	1,410	1,777	2,097	732	1,626	1,237
72	1,458	1,840	2,164	755	1,682	1,280
73	1,505	1,896	2,221	775	1,737	1,320
74	1,548	1,951	2,278	795	1,786	1,357
75	1,587	2,003	2,330	813	1,832	1,393
76	1,624	2,045	2,376	832	1,873	1,425
77	1,663	2,091	2,416	845	1,912	1,456
78	1,689	2,133	2,453	857	1,951	1,483
79	1,721	2,170	2,487	869	1,986	1,508
80	1,749	2,204	2,518	882	2,017	1,534
81	1,776	2,233	2,552	892	2,045	1,555
82	1,797	2,265	2,583	904	2,073	1,576
83	1,821	2,295	2,614	915	2,100	1,597
84	1,843	2,322	2,645	922	2,126	1,618
85	1,864	2,350	2,674	936	2,151	1,636
86	1,887	2,378	2,702	944	2,176	1,654
87	1,905	2,403	2,730	955	2,197	1,671
88	1,925	2,427	2,755	964	2,221	1,688
89	1,943	2,449	2,778	970	2,240	1,704
90	1,960	2,471	2,803	979	2,259	1,720
91	1,975	2,493	2,822	985	2,281	1,734
92	1,991	2,509	2,841	992	2,296	1,746
93	2,005	2,528	2,860	1,000	2,312	1,758
94	2,019	2,542	2,873	1,003	2,328	1,769
95	2,032	2,557	2,889	1,009	2,343	1,780
96	2,041	2,573	2,903	1,016	2,355	1,791
97	2,055	2,588	2,920	1,020	2,370	1,801
98	2,065	2,603	2,936	1,026	2,383	1,812
99	2,080	2,618	2,949	1,030	2,396	1,823

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

Attained Age	Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,307	1,646	1,967	687	1,508	1,146
66	1,319	1,664	1,987	693	1,523	1,156
67	1,334	1,682	2,006	700	1,538	1,169
68	1,390	1,751	2,090	730	1,603	1,218
69	1,452	1,829	2,173	760	1,675	1,274
70	1,508	1,902	2,253	787	1,741	1,323
71	1,568	1,974	2,330	813	1,809	1,374
72	1,621	2,042	2,404	839	1,871	1,422
73	1,674	2,107	2,470	863	1,929	1,468
74	1,721	2,170	2,532	884	1,986	1,509
75	1,762	2,224	2,590	905	2,035	1,547
76	1,805	2,274	2,638	921	2,081	1,583
77	1,844	2,323	2,684	938	2,128	1,618
78	1,880	2,367	2,725	953	2,169	1,648
79	1,913	2,411	2,763	966	2,206	1,676
80	1,943	2,449	2,800	978	2,240	1,704
81	1,971	2,483	2,836	990	2,273	1,729
82	1,998	2,518	2,871	1,003	2,305	1,751
83	2,025	2,550	2,904	1,016	2,333	1,774
84	2,049	2,582	2,940	1,026	2,363	1,796
85	2,072	2,611	2,974	1,039	2,391	1,817
86	2,095	2,642	3,004	1,050	2,417	1,837
87	2,119	2,670	3,032	1,059	2,443	1,857
88	2,138	2,695	3,061	1,069	2,467	1,874
89	2,157	2,720	3,088	1,079	2,491	1,893
90	2,178	2,744	3,112	1,087	2,514	1,911
91	2,198	2,766	3,133	1,095	2,533	1,925
92	2,213	2,788	3,159	1,105	2,552	1,942
93	2,228	2,809	3,177	1,112	2,570	1,954
94	2,242	2,825	3,195	1,116	2,588	1,967
95	2,256	2,844	3,211	1,123	2,600	1,980
96	2,267	2,860	3,226	1,128	2,616	1,989
97	2,284	2,874	3,243	1,133	2,632	2,002
98	2,296	2,893	3,260	1,140	2,647	2,013
99	2,311	2,909	3,277	1,145	2,666	2,024

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

Rates Effective 6/1/2017

Attained Age	Preferred					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,354	1,705	2,036	712	1,559	1,186
66	1,366	1,721	2,058	719	1,576	1,199
67	1,381	1,739	2,075	726	1,591	1,210
68	1,437	1,812	2,164	755	1,658	1,262
69	1,503	1,893	2,248	786	1,733	1,318
70	1,563	1,969	2,330	814	1,801	1,370
71	1,622	2,042	2,412	843	1,871	1,422
72	1,679	2,115	2,487	869	1,935	1,472
73	1,731	2,179	2,554	892	1,998	1,518
74	1,781	2,245	2,622	917	2,054	1,563
75	1,827	2,299	2,680	937	2,106	1,601
76	1,868	2,353	2,730	955	2,155	1,638
77	1,907	2,404	2,778	970	2,202	1,673
78	1,946	2,452	2,820	985	2,242	1,706
79	1,978	2,496	2,862	1,000	2,283	1,736
80	2,011	2,534	2,896	1,013	2,319	1,762
81	2,039	2,570	2,936	1,026	2,353	1,789
82	2,066	2,604	2,974	1,039	2,384	1,813
83	2,093	2,641	3,009	1,050	2,414	1,836
84	2,119	2,670	3,041	1,064	2,444	1,858
85	2,145	2,702	3,076	1,074	2,473	1,882
86	2,170	2,734	3,107	1,087	2,501	1,901
87	2,192	2,761	3,141	1,096	2,528	1,921
88	2,214	2,789	3,167	1,108	2,553	1,943
89	2,233	2,816	3,195	1,116	2,576	1,961
90	2,255	2,841	3,221	1,126	2,599	1,977
91	2,273	2,864	3,244	1,133	2,623	1,992
92	2,290	2,886	3,268	1,141	2,641	2,008
93	2,308	2,905	3,288	1,149	2,659	2,023
94	2,321	2,926	3,309	1,154	2,677	2,036
95	2,335	2,941	3,324	1,162	2,694	2,048
96	2,349	2,958	3,341	1,167	2,708	2,059
97	2,363	2,975	3,356	1,173	2,726	2,072
98	2,378	2,993	3,372	1,178	2,741	2,083
99	2,390	3,012	3,392	1,185	2,757	2,096

Modal Factors: Semi-Annual: 0.5200

Attained Age	Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,503	1,893	2,262	790	1,731	1,317
66	1,517	1,914	2,286	797	1,752	1,331
67	1,534	1,933	2,309	808	1,768	1,344
68	1,598	2,012	2,404	839	1,842	1,401
69	1,668	2,104	2,499	872	1,926	1,465
70	1,737	2,189	2,590	905	2,003	1,523
71	1,803	2,271	2,680	937	2,079	1,580
72	1,864	2,350	2,763	966	2,150	1,636
73	1,924	2,423	2,838	991	2,219	1,687
74	1,978	2,496	2,912	1,017	2,283	1,736
75	2,029	2,556	2,978	1,041	2,341	1,779
76	2,077	2,614	3,033	1,061	2,394	1,820
77	2,121	2,671	3,088	1,079	2,444	1,858
78	2,159	2,723	3,132	1,094	2,492	1,895
79	2,199	2,769	3,178	1,112	2,536	1,928
80	2,233	2,815	3,219	1,126	2,575	1,959
81	2,266	2,857	3,261	1,140	2,614	1,987
82	2,296	2,895	3,301	1,153	2,650	2,014
83	2,328	2,931	3,343	1,168	2,684	2,041
84	2,355	2,968	3,381	1,180	2,717	2,066
85	2,384	3,003	3,418	1,194	2,748	2,088
86	2,411	3,037	3,454	1,206	2,779	2,113
87	2,434	3,069	3,488	1,218	2,808	2,135
88	2,461	3,099	3,520	1,229	2,838	2,157
89	2,483	3,129	3,550	1,241	2,863	2,177
90	2,503	3,155	3,580	1,250	2,889	2,196
91	2,528	3,183	3,607	1,261	2,913	2,216
92	2,545	3,206	3,631	1,268	2,936	2,232
93	2,563	3,228	3,654	1,276	2,956	2,248
94	2,579	3,250	3,673	1,283	2,974	2,261
95	2,594	3,271	3,692	1,290	2,993	2,275
96	2,610	3,288	3,712	1,297	3,011	2,288
97	2,626	3,307	3,728	1,302	3,029	2,301
98	2,642	3,327	3,750	1,309	3,046	2,315
99	2,656	3,346	3,769	1,317	3,064	2,328

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.

DISCLOSURES

Use this outline to compare benefits and premium among policies.

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.

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 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 $1316	$0	$1316 (Part A Deductible)
61st thru 90th day	All but $329 a day	$329 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $658 a day	$658 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 $164.50 a day	$0	Up to $164.50 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 $183 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 tests, durable medical equipment			
First $183 of Medicare-Approved amounts*	$0	$0	$183 (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 $183 of Medicare-Approved amounts*	$0	$0	$183 (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 $183 of Medicare Approved amounts*	$0	$0	$183 (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 $1316	$1316 (Part A Deductible)	$0
61st thru 90th day	All but $329 a day	$329 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $658 a day	$658 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 $164.50 a day	$0	Up to $164.50 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 $183 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 tests, durable medical equipment			
First $183 of Medicare-Approved amounts*	$0	$0	$183 (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 $183 of Medicare-Approved amounts*	$0	$0	$183 (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 $183 of Medicare Approved amounts*	$0	$0	$183 (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 $1316	$1316 (Part A Deductible)	$0
61st thru 90th day	All but $329 a day	$329 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $658 a day	$658 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 $164.50 a day	Up to $164.50 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 $183 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 tests, durable medical equipment			
First $183 of Medicare-Approved amounts*	$0	$183 (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 $183 of Medicare-Approved amounts*	$0	$183 (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 $183 of Medicare Approved amounts*	$0	$183 (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 $2200 deductible. Benefits from high deductible Plan F will not begin until out-of-pocket expenses are $2200. 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 $2200 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2200 DEDUCTIBLE*** YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1316	$1316 (Part A Deductible)	$0
61st thru 90th day	All but $329 a day	$329 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $658 a day	$658 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 $164.50 a day	Up to $164.50 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 $183 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 $2200 deductible. Benefits from high deductible Plan F will not begin until out-of-pocket expenses are $2200. 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 $2200 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2200 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 tests, durable medical equipment			
First $183 of Medicare-Approved amounts*	$0	$183 (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 $183 of Medicare-Approved amounts*	$0	$183 (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 $2200 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO $2200 DEDUCTIBLE*** YOU PAY
HOME HEALTH CARE – MEDICARE APPROVED SERVICES			
•Medically necessary skilled care services and medical supplies	100%	$0	$0
•Durable medical equipment			
•First $183 of Medicare Approved amounts*	$0	$183 (Part B Deductible)	$0
•Remainder of Medicare Approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2200 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2200 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 $1316	$1316 (Part A Deductible)	$0
61st thru 90th day	All but $329 a day	$329 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $658 a day	$658 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 $164.50 a day	Up to $164.50 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 $183 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 tests, durable medical equipment			
First $183 of Medicare-Approved amounts*	$0	$0	$183 (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 $183 of Medicare-Approved amounts*	$0	$0	$183 (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 $183 of Medicare Approved amounts*	$0	$0	$183 (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 $1316	$1316 (Part A Deductible)	$0
61st thru 90th day	All but $329 a day	$329 a day	$0
91st day and after			
•While using 60 lifetime reserve days	All but $658 a day	$658 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 $164.50 a day	Up to $164.50 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 $183 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 tests, durable medical equipment			
First $183 of Medicare-Approved amounts*	$0	$0	$183 (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 $183 of Medicare-Approved amounts*	$0	$0	$183 (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 $183 of Medicare Approved amounts*	$0	$0	$183 (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