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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**

Nevada

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 Attained Age Premiums

For Use in ZIP Codes: 889, 891

Female Rates

Rates Effective 6/1/2016

Attained Age	Preferred					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,544	1,948	2,281	888	1,562	1,435
66	1,544	1,948	2,281	888	1,562	1,435
67	1,544	1,948	2,281	888	1,562	1,435
68	1,610	2,027	2,377	925	1,626	1,494
69	1,681	2,119	2,467	962	1,699	1,562
70	1,748	2,203	2,560	996	1,766	1,622
71	1,817	2,286	2,646	1,031	1,835	1,686
72	1,876	2,365	2,730	1,063	1,900	1,744
73	1,936	2,441	2,806	1,093	1,958	1,800
74	1,994	2,512	2,876	1,121	2,014	1,852
75	2,042	2,574	2,942	1,147	2,065	1,900
76	2,092	2,634	3,000	1,170	2,114	1,943
77	2,135	2,687	3,052	1,189	2,159	1,985
78	2,174	2,741	3,098	1,208	2,201	2,023
79	2,215	2,789	3,142	1,224	2,239	2,056
80	2,250	2,834	3,181	1,241	2,274	2,092
81	2,281	2,874	3,222	1,256	2,308	2,120
82	2,311	2,914	3,265	1,273	2,339	2,149
83	2,344	2,951	3,302	1,288	2,369	2,177
84	2,372	2,987	3,342	1,302	2,398	2,206
85	2,400	3,023	3,378	1,316	2,426	2,230
86	2,426	3,058	3,413	1,331	2,454	2,254
87	2,452	3,090	3,449	1,344	2,479	2,278
88	2,477	3,121	3,480	1,357	2,504	2,302
89	2,500	3,151	3,509	1,366	2,527	2,323
90	2,521	3,176	3,539	1,380	2,550	2,344
91	2,543	3,205	3,565	1,390	2,572	2,363
92	2,562	3,229	3,587	1,397	2,591	2,380
93	2,578	3,252	3,612	1,409	2,609	2,396
94	2,599	3,272	3,628	1,414	2,627	2,413
95	2,612	3,290	3,649	1,422	2,641	2,426
96	2,629	3,311	3,667	1,429	2,656	2,442
97	2,644	3,329	3,689	1,438	2,674	2,456
98	2,656	3,349	3,706	1,445	2,688	2,468
99	2,676	3,370	3,722	1,451	2,705	2,485

Attained Age	Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,716	2,164	2,534	986	1,734	1,595
66	1,716	2,164	2,534	986	1,734	1,595
67	1,716	2,164	2,534	986	1,734	1,595
68	1,788	2,252	2,639	1,027	1,807	1,661
69	1,867	2,354	2,744	1,070	1,888	1,736
70	1,942	2,447	2,844	1,108	1,964	1,806
71	2,016	2,542	2,942	1,147	2,040	1,872
72	2,087	2,630	3,034	1,182	2,111	1,938
73	2,150	2,711	3,115	1,214	2,176	2,000
74	2,215	2,789	3,197	1,247	2,239	2,057
75	2,269	2,862	3,270	1,274	2,296	2,108
76	2,323	2,926	3,330	1,298	2,347	2,156
77	2,374	2,988	3,390	1,320	2,399	2,206
78	2,418	3,047	3,442	1,343	2,446	2,248
79	2,461	3,101	3,488	1,360	2,488	2,285
80	2,500	3,151	3,533	1,378	2,527	2,323
81	2,537	3,194	3,581	1,394	2,563	2,358
82	2,569	3,239	3,625	1,414	2,599	2,388
83	2,603	3,281	3,668	1,429	2,633	2,419
84	2,636	3,320	3,713	1,446	2,665	2,448
85	2,665	3,359	3,754	1,462	2,696	2,476
86	2,696	3,397	3,792	1,480	2,726	2,506
87	2,726	3,431	3,830	1,492	2,755	2,532
88	2,752	3,467	3,864	1,505	2,783	2,556
89	2,778	3,498	3,898	1,520	2,808	2,582
90	2,803	3,532	3,930	1,531	2,834	2,604
91	2,825	3,559	3,959	1,544	2,857	2,624
92	2,846	3,587	3,989	1,554	2,878	2,645
93	2,867	3,613	4,013	1,564	2,899	2,664
94	2,885	3,635	4,034	1,573	2,918	2,682
95	2,904	3,659	4,054	1,580	2,934	2,698
96	2,917	3,679	4,075	1,588	2,951	2,712
97	2,938	3,701	4,096	1,596	2,969	2,728
98	2,953	3,721	4,120	1,606	2,986	2,744
99	2,972	3,746	4,138	1,613	3,005	2,761

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: 889, 891

Male Rates

Rates Effective 6/1/2016

Attained Age	Preferred					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,775	2,237	2,624	1,022	1,795	1,650
66	1,775	2,237	2,624	1,022	1,795	1,650
67	1,775	2,237	2,624	1,022	1,795	1,650
68	1,850	2,332	2,730	1,063	1,871	1,720
69	1,933	2,436	2,839	1,106	1,955	1,798
70	2,009	2,532	2,944	1,148	2,033	1,868
71	2,088	2,630	3,046	1,188	2,111	1,938
72	2,160	2,722	3,142	1,224	2,182	2,006
73	2,227	2,806	3,224	1,256	2,252	2,070
74	2,292	2,888	3,311	1,290	2,317	2,129
75	2,350	2,959	3,384	1,318	2,376	2,182
76	2,404	3,028	3,449	1,344	2,430	2,232
77	2,453	3,094	3,509	1,366	2,483	2,280
78	2,503	3,154	3,564	1,390	2,530	2,326
79	2,545	3,208	3,614	1,409	2,574	2,366
80	2,588	3,259	3,660	1,426	2,615	2,404
81	2,622	3,307	3,706	1,445	2,654	2,437
82	2,659	3,352	3,754	1,462	2,688	2,470
83	2,695	3,396	3,799	1,481	2,723	2,502
84	2,728	3,433	3,841	1,498	2,758	2,534
85	2,758	3,476	3,886	1,516	2,790	2,563
86	2,789	3,516	3,925	1,530	2,821	2,592
87	2,819	3,553	3,966	1,546	2,852	2,620
88	2,848	3,588	4,000	1,560	2,879	2,646
89	2,874	3,624	4,036	1,573	2,908	2,672
90	2,900	3,656	4,068	1,584	2,933	2,693
91	2,924	3,685	4,097	1,596	2,958	2,717
92	2,945	3,713	4,126	1,609	2,980	2,737
93	2,969	3,739	4,153	1,620	3,001	2,758
94	2,986	3,764	4,176	1,627	3,019	2,774
95	3,004	3,784	4,195	1,636	3,037	2,791
96	3,022	3,805	4,217	1,643	3,055	2,807
97	3,038	3,828	4,237	1,654	3,074	2,826
98	3,058	3,851	4,261	1,661	3,090	2,840
99	3,076	3,874	4,283	1,668	3,109	2,857

Attained Age	Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,973	2,484	2,915	1,135	1,993	1,832
66	1,973	2,484	2,915	1,135	1,993	1,832
67	1,973	2,484	2,915	1,135	1,993	1,832
68	2,056	2,591	3,035	1,182	2,078	1,909
69	2,146	2,706	3,154	1,228	2,172	1,996
70	2,233	2,815	3,270	1,274	2,260	2,076
71	2,320	2,921	3,384	1,318	2,345	2,154
72	2,400	3,023	3,488	1,360	2,425	2,230
73	2,476	3,119	3,583	1,396	2,502	2,299
74	2,545	3,208	3,676	1,434	2,574	2,366
75	2,610	3,289	3,760	1,466	2,640	2,425
76	2,670	3,364	3,832	1,493	2,700	2,483
77	2,729	3,440	3,898	1,520	2,758	2,534
78	2,779	3,502	3,958	1,543	2,812	2,585
79	2,830	3,565	4,015	1,564	2,860	2,628
80	2,874	3,620	4,066	1,584	2,906	2,671
81	2,915	3,674	4,121	1,606	2,948	2,710
82	2,954	3,722	4,169	1,626	2,988	2,746
83	2,993	3,770	4,222	1,644	3,028	2,783
84	3,029	3,817	4,270	1,664	3,065	2,815
85	3,067	3,862	4,316	1,682	3,101	2,848
86	3,101	3,907	4,362	1,700	3,136	2,880
87	3,130	3,948	4,403	1,716	3,168	2,911
88	3,164	3,986	4,445	1,732	3,200	2,940
89	3,194	4,025	4,484	1,748	3,229	2,969
90	3,220	4,060	4,519	1,762	3,259	2,996
91	3,250	4,094	4,554	1,774	3,287	3,020
92	3,275	4,126	4,584	1,787	3,310	3,044
93	3,296	4,153	4,612	1,798	3,334	3,062
94	3,318	4,180	4,639	1,808	3,355	3,083
95	3,338	4,206	4,661	1,818	3,376	3,100
96	3,358	4,230	4,687	1,825	3,396	3,120
97	3,377	4,256	4,708	1,835	3,415	3,137
98	3,397	4,279	4,734	1,847	3,436	3,156
99	3,418	4,306	4,757	1,854	3,456	3,175

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 6/1/2016

Attained Age	Preferred					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,287	1,623	1,901	740	1,302	1,196
66	1,287	1,623	1,901	740	1,302	1,196
67	1,287	1,623	1,901	740	1,302	1,196
68	1,342	1,689	1,981	771	1,355	1,245
69	1,401	1,766	2,056	802	1,416	1,302
70	1,457	1,836	2,133	830	1,472	1,352
71	1,514	1,905	2,205	859	1,529	1,405
72	1,563	1,971	2,275	886	1,583	1,453
73	1,613	2,034	2,338	911	1,632	1,500
74	1,662	2,093	2,397	934	1,678	1,543
75	1,702	2,145	2,452	956	1,721	1,583
76	1,743	2,195	2,500	975	1,762	1,619
77	1,779	2,239	2,543	991	1,799	1,654
78	1,812	2,284	2,582	1,007	1,834	1,686
79	1,846	2,324	2,618	1,020	1,866	1,713
80	1,875	2,362	2,651	1,034	1,895	1,743
81	1,901	2,395	2,685	1,047	1,923	1,767
82	1,926	2,428	2,721	1,061	1,949	1,791
83	1,953	2,459	2,752	1,073	1,974	1,814
84	1,977	2,489	2,785	1,085	1,998	1,838
85	2,000	2,519	2,815	1,097	2,022	1,858
86	2,022	2,548	2,844	1,109	2,045	1,878
87	2,043	2,575	2,874	1,120	2,066	1,898
88	2,064	2,601	2,900	1,131	2,087	1,918
89	2,083	2,626	2,924	1,138	2,106	1,936
90	2,101	2,647	2,949	1,150	2,125	1,953
91	2,119	2,671	2,971	1,158	2,143	1,969
92	2,135	2,691	2,989	1,164	2,159	1,983
93	2,148	2,710	3,010	1,174	2,174	1,997
94	2,166	2,727	3,023	1,178	2,189	2,011
95	2,177	2,742	3,041	1,185	2,201	2,022
96	2,191	2,759	3,056	1,191	2,213	2,035
97	2,203	2,774	3,074	1,198	2,228	2,047
98	2,213	2,791	3,088	1,204	2,240	2,057
99	2,230	2,808	3,102	1,209	2,254	2,071

Attained Age	Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,430	1,803	2,112	822	1,445	1,329
66	1,430	1,803	2,112	822	1,445	1,329
67	1,430	1,803	2,112	822	1,445	1,329
68	1,490	1,877	2,199	856	1,506	1,384
69	1,556	1,962	2,287	892	1,573	1,447
70	1,618	2,039	2,370	923	1,637	1,505
71	1,680	2,118	2,452	956	1,700	1,560
72	1,739	2,192	2,528	985	1,759	1,615
73	1,792	2,259	2,596	1,012	1,813	1,667
74	1,846	2,324	2,664	1,039	1,866	1,714
75	1,891	2,385	2,725	1,062	1,913	1,757
76	1,936	2,438	2,775	1,082	1,956	1,797
77	1,978	2,490	2,825	1,100	1,999	1,838
78	2,015	2,539	2,868	1,119	2,038	1,873
79	2,051	2,584	2,907	1,133	2,073	1,904
80	2,083	2,626	2,944	1,148	2,106	1,936
81	2,114	2,662	2,984	1,162	2,136	1,965
82	2,141	2,699	3,021	1,178	2,166	1,990
83	2,169	2,734	3,057	1,191	2,194	2,016
84	2,197	2,767	3,094	1,205	2,221	2,040
85	2,221	2,799	3,128	1,218	2,247	2,063
86	2,247	2,831	3,160	1,233	2,272	2,088
87	2,272	2,859	3,192	1,243	2,296	2,110
88	2,293	2,889	3,220	1,254	2,319	2,130
89	2,315	2,915	3,248	1,267	2,340	2,152
90	2,336	2,943	3,275	1,276	2,362	2,170
91	2,354	2,966	3,299	1,287	2,381	2,187
92	2,372	2,989	3,324	1,295	2,398	2,204
93	2,389	3,011	3,344	1,303	2,416	2,220
94	2,404	3,029	3,362	1,311	2,432	2,235
95	2,420	3,049	3,378	1,317	2,445	2,248
96	2,431	3,066	3,396	1,323	2,459	2,260
97	2,448	3,084	3,413	1,330	2,474	2,273
98	2,461	3,101	3,433	1,338	2,488	2,287
99	2,477	3,122	3,448	1,344	2,504	2,301

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

The above rates do not include the $20 application fee.

To calculate a Household discount:

Annual premium x modal factor = modal premium (round to nearest whole cent)

Modal premium x .95 = discounted premium

If applying during Open Enrollment or Guaranteed Issue Period, use Preferred rates.

American Continental Insurance Company

Annual Attained Age Premiums

For Use in ZIP Codes: Rest of State

Male Rates

Rates Effective 6/1/2016

Attained Age	Preferred					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,479	1,864	2,187	852	1,496	1,375
66	1,479	1,864	2,187	852	1,496	1,375
67	1,479	1,864	2,187	852	1,496	1,375
68	1,542	1,943	2,275	886	1,559	1,433
69	1,611	2,030	2,366	922	1,629	1,498
70	1,674	2,110	2,453	957	1,694	1,557
71	1,740	2,192	2,538	990	1,759	1,615
72	1,800	2,268	2,618	1,020	1,818	1,672
73	1,856	2,338	2,687	1,047	1,877	1,725
74	1,910	2,407	2,759	1,075	1,931	1,774
75	1,958	2,466	2,820	1,098	1,980	1,818
76	2,003	2,523	2,874	1,120	2,025	1,860
77	2,044	2,578	2,924	1,138	2,069	1,900
78	2,086	2,628	2,970	1,158	2,108	1,938
79	2,121	2,673	3,012	1,174	2,145	1,972
80	2,157	2,716	3,050	1,188	2,179	2,003
81	2,185	2,756	3,088	1,204	2,212	2,031
82	2,216	2,793	3,128	1,218	2,240	2,058
83	2,246	2,830	3,166	1,234	2,269	2,085
84	2,273	2,861	3,201	1,248	2,298	2,112
85	2,298	2,897	3,238	1,263	2,325	2,136
86	2,324	2,930	3,271	1,275	2,351	2,160
87	2,349	2,961	3,305	1,288	2,377	2,183
88	2,373	2,990	3,333	1,300	2,399	2,205
89	2,395	3,020	3,363	1,311	2,423	2,227
90	2,417	3,047	3,390	1,320	2,444	2,244
91	2,437	3,071	3,414	1,330	2,465	2,264
92	2,454	3,094	3,438	1,341	2,483	2,281
93	2,474	3,116	3,461	1,350	2,501	2,298
94	2,488	3,137	3,480	1,356	2,516	2,312
95	2,503	3,153	3,496	1,363	2,531	2,326
96	2,518	3,171	3,514	1,369	2,546	2,339
97	2,532	3,190	3,531	1,378	2,562	2,355
98	2,548	3,209	3,551	1,384	2,575	2,367
99	2,563	3,228	3,569	1,390	2,591	2,381

Attained Age	Standard					
	Plan A	Plan B	Plan F	Plan HF	Plan G	Plan N
65	1,644	2,070	2,429	946	1,661	1,527
66	1,644	2,070	2,429	946	1,661	1,527
67	1,644	2,070	2,429	946	1,661	1,527
68	1,713	2,159	2,529	985	1,732	1,591
69	1,788	2,255	2,628	1,023	1,810	1,663
70	1,861	2,346	2,725	1,062	1,883	1,730
71	1,933	2,434	2,820	1,098	1,954	1,795
72	2,000	2,519	2,907	1,133	2,021	1,858
73	2,063	2,599	2,986	1,163	2,085	1,916
74	2,121	2,673	3,063	1,195	2,145	1,972
75	2,175	2,741	3,133	1,222	2,200	2,021
76	2,225	2,803	3,193	1,244	2,250	2,069
77	2,274	2,867	3,248	1,267	2,298	2,112
78	2,316	2,918	3,298	1,286	2,343	2,154
79	2,358	2,971	3,346	1,303	2,383	2,190
80	2,395	3,017	3,388	1,320	2,422	2,226
81	2,429	3,062	3,434	1,338	2,457	2,258
82	2,462	3,102	3,474	1,355	2,490	2,288
83	2,494	3,142	3,518	1,370	2,523	2,319
84	2,524	3,181	3,558	1,387	2,554	2,346
85	2,556	3,218	3,597	1,402	2,584	2,373
86	2,584	3,256	3,635	1,417	2,613	2,400
87	2,608	3,290	3,669	1,430	2,640	2,426
88	2,637	3,322	3,704	1,443	2,667	2,450
89	2,662	3,354	3,737	1,457	2,691	2,474
90	2,683	3,383	3,766	1,468	2,716	2,497
91	2,708	3,412	3,795	1,478	2,739	2,517
92	2,729	3,438	3,820	1,489	2,758	2,537
93	2,747	3,461	3,843	1,498	2,778	2,552
94	2,765	3,483	3,866	1,507	2,796	2,569
95	2,782	3,505	3,884	1,515	2,813	2,583
96	2,798	3,525	3,906	1,521	2,830	2,600
97	2,814	3,547	3,923	1,529	2,846	2,614
98	2,831	3,566	3,945	1,539	2,863	2,630
99	2,848	3,588	3,964	1,545	2,880	2,646

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

The above rates do not include the $20 application fee.

To calculate a Household discount:

Annual premium x modal factor = modal premium (round to nearest whole cent)

Modal premium x .95 = discounted premium

If applying during Open Enrollment or Guaranteed Issue Period, use Preferred rates.

PREMIUM INFORMATION

American Continental Insurance Company can only raise your premium if we raise the premium for all policies like yours in this state. Premiums for this policy will increase due to the increase in your age. Upon attainment of an age requiring a rate increase, the renewal premium for the policy will be the renewal premium then in effect for your attained age. Other policies may be provided with Issue Age rating and do not increase with age. You should compare Issue Age with Attained Age policies.

Premiums payable other than annually will be determined according to the following factors:

Semi-annual: 0.5200 Quarterly: 0.2650 Monthly EFT: 0.0833.

HOUSEHOLD DISCOUNT

In order to be eligible for the Household discount under an American Continental Insurance Company Medicare supplement plan, you must apply for a Medicare supplement plan at the same time as another Medicare eligible adult or the other Medicare eligible adult must currently be covered by an American Continental Insurance Company Medicare supplement policy. The Medicare eligible adult must be either (a) your spouse; (b) be someone with whom you are in a civil union partnership; or (c) be a permanent resident in your home. The household discount will only be applicable if a policy for each applicant is issued. The discounted rate will be 5 percent lower than the individual rates and will apply as long as both policies remain in force.

DISCLOSURES

Use this outline to compare benefits and premium among policies.

READ YOUR POLICY VERY CAREFULLY

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to American Continental Insurance Company, P.O. Box 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 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