

**Benefit Plans A, C, F, G and N****Benefit Chart of Medicare Supplement Plans Sold for Effective Dates on or After June 1, 2010**

This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plan “A” available. Some plans may not be available in your state. Plans E, H, I and J are no longer available for sale.

**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 copayment for hospital outpatient services. Plans K, L and N require insured to pay a portion of Part B coinsurance or copayments.

**Blood:** First three pints of blood each year.

**Hospice:** Part A coinsurance.

<b>A</b>	<b>B</b>	<b>C</b>	<b>D</b>	<b>F*</b>	<b>G</b>
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
		Skilled Nursing Facility coinsurance	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
		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

<b>K</b>	<b>L</b>	<b>M</b>	<b>N</b>
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
50% Skilled Nursing Facility coinsurance	75% Skilled Nursing Facility coinsurance	Skilled Nursing Facility coinsurance	Skilled Nursing Facility coinsurance
50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Foreign Travel Emergency	Foreign Travel Emergency
Out-of-Pocket limit \$4660 paid at 100% after limit reached	Out-of-Pocket limit \$2330; 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 \$2,070 deductible. Benefits from high deductible Plan F will not begin until out-of-pocket expenses exceed \$2,070. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

## **PREMIUM INFORMATION**

Your premium will increase each year because of the increase in your attained age. We, Forethought Life Insurance Company, can also raise your premium if (a) we change the premium rates which apply to all policies of this form issued by us and in-force in your state; (b) coverage under Medicare changes; or (c) you move to a different ZIP code location.

There will be a one-time enrollment fee of \$25.00 added to the first premium.

## **DISCLOSURES**

Use this Outline to compare benefits and premiums among policies.

**This outline shows benefits and premiums of policies sold for effective dates on or after June 1, 2010. Policies sold for effective dates prior to June 1, 2010 have different benefits and premiums. Plans E, H, I and J are no longer available for sale.**

## **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 Forethought Life Insurance Company.

## **RIGHT TO RETURN POLICY**

If you find that you are not satisfied with your policy, you may return it to Forethought Life Insurance Company, P.O. Box 14659, Clearwater, FL 33766-4659. 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 of your premiums.

## **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**

This policy may not fully cover all of your medical costs. Neither Forethought Life 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 and 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 all 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.

# FORETHOUGHT LIFE INSURANCE COMPANY - Monthly Premium Rates \*

These rates apply to ZIP codes starting with: 460, 461, 465 through 469, 472 through 479

## Standard Plans - Nonsmoker

<i>Female</i>					<i>Attained Age</i>	<i>Male</i>				
<i>Plan A</i>	<i>Plan C</i>	<i>Plan F</i>	<i>Plan G</i>	<i>Plan N</i>		<i>Plan A</i>	<i>Plan C</i>	<i>Plan F</i>	<i>Plan G</i>	<i>Plan N</i>
N/A	N/A	N/A	N/A	N/A	<65	N/A	N/A	N/A	N/A	N/A
\$86.31	\$114.03	\$116.78	\$92.80	\$80.44	65	\$99.21	\$131.07	\$134.23	\$106.66	\$92.46
\$86.31	\$114.03	\$116.78	\$92.80	\$80.44	66	\$99.21	\$131.07	\$134.23	\$106.66	\$92.46
\$90.15	\$118.93	\$121.81	\$96.77	\$83.86	67	\$103.62	\$136.70	\$140.01	\$111.23	\$96.40
\$93.11	\$122.85	\$125.83	\$99.96	\$86.63	68	\$107.02	\$141.21	\$144.63	\$114.90	\$99.57
\$95.97	\$126.89	\$129.96	\$103.27	\$89.53	69	\$110.32	\$145.86	\$149.38	\$118.70	\$102.90
\$98.70	\$130.82	\$133.98	\$106.50	\$92.36	70	\$113.45	\$150.36	\$154.00	\$122.41	\$106.16
\$101.29	\$134.60	\$137.85	\$109.61	\$95.10	71	\$116.42	\$154.71	\$158.44	\$125.98	\$109.31
\$103.73	\$138.23	\$141.57	\$112.60	\$97.75	72	\$119.23	\$158.89	\$162.72	\$129.43	\$112.35
\$105.92	\$141.56	\$144.98	\$115.35	\$100.19	73	\$121.75	\$162.72	\$166.64	\$132.59	\$115.16
\$107.84	\$144.65	\$148.14	\$117.92	\$102.48	74	\$123.95	\$166.27	\$170.28	\$135.54	\$117.80
\$110.55	\$148.90	\$152.49	\$121.44	\$105.61	75	\$127.06	\$171.15	\$175.27	\$139.58	\$121.39
\$114.31	\$154.63	\$158.35	\$126.17	\$109.81	76	\$131.40	\$177.73	\$182.01	\$145.02	\$126.22
\$115.79	\$157.29	\$161.07	\$128.39	\$111.83	77	\$133.09	\$180.79	\$185.14	\$147.58	\$128.54
\$118.30	\$161.34	\$165.22	\$131.76	\$114.84	78	\$135.98	\$185.45	\$189.90	\$151.45	\$132.01
\$119.60	\$163.79	\$167.71	\$133.82	\$116.71	79	\$137.47	\$188.26	\$192.77	\$153.82	\$134.15
\$120.90	\$166.25	\$170.23	\$135.89	\$118.60	80	\$138.97	\$191.09	\$195.66	\$156.19	\$136.32
\$122.11	\$168.63	\$172.67	\$137.90	\$120.45	81	\$140.36	\$193.83	\$198.47	\$158.51	\$138.44
\$124.42	\$172.59	\$176.72	\$141.21	\$123.42	82	\$143.01	\$198.38	\$203.13	\$162.31	\$141.86
\$125.44	\$174.78	\$178.95	\$143.06	\$125.13	83	\$144.19	\$200.89	\$205.69	\$164.44	\$143.83
\$126.37	\$176.92	\$181.15	\$144.89	\$126.83	84	\$145.26	\$203.35	\$208.22	\$166.54	\$145.78
\$128.47	\$180.69	\$185.01	\$148.05	\$129.69	85	\$147.67	\$207.70	\$212.65	\$170.17	\$149.07
\$129.32	\$182.78	\$187.14	\$149.84	\$131.37	86	\$148.65	\$210.10	\$215.11	\$172.23	\$151.00
\$130.20	\$184.96	\$189.36	\$151.70	\$133.09	87	\$149.66	\$212.59	\$217.66	\$174.37	\$152.98
\$131.08	\$187.08	\$191.53	\$153.51	\$134.79	88	\$150.67	\$215.03	\$220.15	\$176.45	\$154.93
\$131.97	\$189.26	\$193.76	\$155.38	\$136.53	89	\$151.69	\$217.53	\$222.71	\$178.59	\$156.93
\$134.13	\$193.28	\$197.88	\$158.81	\$139.66	90	\$154.17	\$222.16	\$227.44	\$182.53	\$160.52
\$135.06	\$195.55	\$200.19	\$160.80	\$141.52	91	\$155.24	\$224.76	\$230.11	\$184.83	\$162.66
\$136.03	\$197.89	\$202.59	\$162.87	\$143.45	92	\$156.36	\$227.46	\$232.86	\$187.21	\$164.88
\$137.02	\$200.31	\$205.06	\$164.99	\$145.43	93	\$157.50	\$230.24	\$235.70	\$189.64	\$167.16
\$138.04	\$202.84	\$207.65	\$167.22	\$147.51	94	\$158.67	\$233.15	\$238.68	\$192.21	\$169.55
\$140.35	\$207.31	\$212.22	\$171.04	\$151.01	95	\$161.32	\$238.28	\$243.93	\$196.60	\$173.57
\$141.33	\$209.86	\$214.82	\$173.29	\$153.12	96	\$162.45	\$241.22	\$246.92	\$199.19	\$176.00
\$142.22	\$212.29	\$217.31	\$175.44	\$155.15	97	\$163.47	\$244.01	\$249.78	\$201.66	\$178.33
\$143.08	\$214.76	\$219.83	\$177.63	\$157.21	98	\$164.46	\$246.85	\$252.67	\$204.17	\$180.70
\$143.96	\$217.30	\$222.42	\$179.88	\$159.34	99	\$165.47	\$249.77	\$255.66	\$206.76	\$183.14

\* To obtain annual, semiannual, or quarterly premiums, multiply the Monthly Premium Amount by 12, 6, or 3, respectively

# FORETHOUGHT LIFE INSURANCE COMPANY - Monthly Premium Rates \*

These rates apply to ZIP codes starting with: 460, 461, 465 through 469, 472 through 479

## Standard Plans - Smoker

Female					Attained Age	Male				
Plan A	Plan C	Plan F	Plan G	Plan N		Plan A	Plan C	Plan F	Plan G	Plan N
N/A	N/A	N/A	N/A	N/A	<65	N/A	N/A	N/A	N/A	N/A
\$99.21	\$131.07	\$134.23	\$106.66	\$92.46	65	\$114.03	\$150.65	\$154.29	\$122.60	\$106.28
\$99.21	\$131.07	\$134.23	\$106.66	\$92.46	66	\$114.03	\$150.65	\$154.29	\$122.60	\$106.28
\$103.62	\$136.70	\$140.01	\$111.23	\$96.40	67	\$119.10	\$157.13	\$160.93	\$127.85	\$110.80
\$107.02	\$141.21	\$144.63	\$114.90	\$99.57	68	\$123.01	\$162.31	\$166.24	\$132.07	\$114.45
\$110.32	\$145.86	\$149.38	\$118.70	\$102.90	69	\$126.80	\$167.65	\$171.70	\$136.44	\$118.28
\$113.45	\$150.36	\$154.00	\$122.41	\$106.16	70	\$130.40	\$172.83	\$177.01	\$140.70	\$122.02
\$116.42	\$154.71	\$158.44	\$125.98	\$109.31	71	\$133.82	\$177.83	\$182.12	\$144.81	\$125.64
\$119.23	\$158.89	\$162.72	\$129.43	\$112.35	72	\$137.05	\$182.63	\$187.04	\$148.77	\$129.14
\$121.75	\$162.72	\$166.64	\$132.59	\$115.16	73	\$139.94	\$187.03	\$191.54	\$152.40	\$132.37
\$123.95	\$166.27	\$170.28	\$135.54	\$117.80	74	\$142.47	\$191.11	\$195.72	\$155.79	\$135.40
\$127.06	\$171.15	\$175.27	\$139.58	\$121.39	75	\$146.05	\$196.72	\$201.46	\$160.44	\$139.53
\$131.40	\$177.73	\$182.01	\$145.02	\$126.22	76	\$151.03	\$204.29	\$209.21	\$166.69	\$145.08
\$133.09	\$180.79	\$185.14	\$147.58	\$128.54	77	\$152.98	\$207.81	\$212.80	\$169.63	\$147.75
\$135.98	\$185.45	\$189.90	\$151.45	\$132.01	78	\$156.30	\$213.16	\$218.28	\$174.08	\$151.73
\$137.47	\$188.26	\$192.77	\$153.82	\$134.15	79	\$158.01	\$216.39	\$221.58	\$176.80	\$154.20
\$138.97	\$191.09	\$195.66	\$156.19	\$136.32	80	\$159.73	\$219.64	\$224.90	\$179.53	\$156.69
\$140.36	\$193.83	\$198.47	\$158.51	\$138.44	81	\$161.33	\$222.79	\$228.13	\$182.19	\$159.13
\$143.01	\$198.38	\$203.13	\$162.31	\$141.86	82	\$164.38	\$228.02	\$233.48	\$186.56	\$163.06
\$144.19	\$200.89	\$205.69	\$164.44	\$143.83	83	\$165.73	\$230.91	\$236.43	\$189.01	\$165.32
\$145.26	\$203.35	\$208.22	\$166.54	\$145.78	84	\$166.96	\$233.74	\$239.33	\$191.42	\$167.56
\$147.67	\$207.70	\$212.65	\$170.17	\$149.07	85	\$169.73	\$238.73	\$244.43	\$195.60	\$171.35
\$148.65	\$210.10	\$215.11	\$172.23	\$151.00	86	\$170.86	\$241.49	\$247.25	\$197.97	\$173.56
\$149.66	\$212.59	\$217.66	\$174.37	\$152.98	87	\$172.02	\$244.36	\$250.18	\$200.42	\$175.84
\$150.67	\$215.03	\$220.15	\$176.45	\$154.93	88	\$173.18	\$247.16	\$253.05	\$202.82	\$178.08
\$151.69	\$217.53	\$222.71	\$178.59	\$156.93	89	\$174.36	\$250.04	\$255.99	\$205.28	\$180.38
\$154.17	\$222.16	\$227.44	\$182.53	\$160.52	90	\$177.21	\$255.36	\$261.43	\$209.81	\$184.51
\$155.24	\$224.76	\$230.11	\$184.83	\$162.66	91	\$178.44	\$258.35	\$264.49	\$212.45	\$186.97
\$156.36	\$227.46	\$232.86	\$187.21	\$164.88	92	\$179.72	\$261.45	\$267.66	\$215.18	\$189.52
\$157.50	\$230.24	\$235.70	\$189.64	\$167.16	93	\$181.03	\$264.64	\$270.92	\$217.98	\$192.14
\$158.67	\$233.15	\$238.68	\$192.21	\$169.55	94	\$182.38	\$267.99	\$274.34	\$220.93	\$194.89
\$161.32	\$238.28	\$243.93	\$196.60	\$173.57	95	\$185.43	\$273.89	\$280.38	\$225.98	\$199.51
\$162.45	\$241.22	\$246.92	\$199.19	\$176.00	96	\$186.72	\$277.26	\$283.82	\$228.95	\$202.30
\$163.47	\$244.01	\$249.78	\$201.66	\$178.33	97	\$187.90	\$280.47	\$287.10	\$231.79	\$204.98
\$164.46	\$246.85	\$252.67	\$204.17	\$180.70	98	\$189.04	\$283.73	\$290.43	\$234.68	\$207.70
\$165.47	\$249.77	\$255.66	\$206.76	\$183.14	99	\$190.20	\$287.09	\$293.86	\$237.66	\$210.51

\* To obtain annual, semiannual, or quarterly premiums, multiply the Monthly Premium Amount by 12, 6, or 3, respectively

# FORETHOUGHT LIFE INSURANCE COMPANY - Monthly Premium Rates \*

These rates apply to ZIP codes starting with: 470, 471

## Standard Plans - Nonsmoker

Female					Attained Age	Male				
Plan A	Plan C	Plan F	Plan G	Plan N		Plan A	Plan C	Plan F	Plan G	Plan N
N/A	N/A	N/A	N/A	N/A	<65	N/A	N/A	N/A	N/A	N/A
\$91.49	\$120.87	\$123.79	\$98.37	\$85.27	65	\$105.16	\$138.93	\$142.28	\$113.06	\$98.01
\$91.49	\$120.87	\$123.79	\$98.37	\$85.27	66	\$105.16	\$138.93	\$142.28	\$113.06	\$98.01
\$95.56	\$126.07	\$129.12	\$102.58	\$88.89	67	\$109.84	\$144.90	\$148.41	\$117.90	\$102.18
\$98.70	\$130.22	\$133.38	\$105.96	\$91.83	68	\$113.44	\$149.68	\$153.31	\$121.79	\$105.54
\$101.73	\$134.50	\$137.76	\$109.47	\$94.90	69	\$116.94	\$154.61	\$158.34	\$125.82	\$109.07
\$104.62	\$138.67	\$142.02	\$112.89	\$97.90	70	\$120.26	\$159.38	\$163.24	\$129.75	\$112.53
\$107.37	\$142.68	\$146.12	\$116.19	\$100.81	71	\$123.41	\$163.99	\$167.95	\$133.54	\$115.87
\$109.95	\$146.52	\$150.06	\$119.36	\$103.62	72	\$126.38	\$168.42	\$172.48	\$137.20	\$119.09
\$112.28	\$150.05	\$153.68	\$122.27	\$106.20	73	\$129.06	\$172.48	\$176.64	\$140.55	\$122.07
\$114.31	\$153.33	\$157.03	\$125.00	\$108.63	74	\$131.39	\$176.25	\$180.50	\$143.67	\$124.87
\$117.18	\$157.83	\$161.64	\$128.73	\$111.95	75	\$134.68	\$181.42	\$185.79	\$147.95	\$128.67
\$121.17	\$163.91	\$167.85	\$133.74	\$116.40	76	\$139.28	\$188.39	\$192.93	\$153.72	\$133.79
\$122.74	\$166.73	\$170.73	\$136.09	\$118.54	77	\$141.08	\$191.64	\$196.25	\$156.43	\$136.25
\$125.40	\$171.02	\$175.13	\$139.67	\$121.73	78	\$144.14	\$196.58	\$201.29	\$160.54	\$139.93
\$126.78	\$173.62	\$177.77	\$141.85	\$123.71	79	\$145.72	\$199.56	\$204.34	\$163.05	\$142.20
\$128.15	\$176.23	\$180.44	\$144.04	\$125.72	80	\$147.31	\$202.56	\$207.40	\$165.56	\$144.50
\$129.44	\$178.75	\$183.03	\$146.17	\$127.68	81	\$148.78	\$205.46	\$210.38	\$168.02	\$146.75
\$131.89	\$182.95	\$187.32	\$149.68	\$130.83	82	\$151.59	\$210.28	\$215.32	\$172.05	\$150.37
\$132.97	\$185.27	\$189.69	\$151.64	\$132.64	83	\$152.84	\$212.94	\$218.03	\$174.31	\$152.46
\$133.95	\$187.54	\$192.02	\$153.58	\$134.44	84	\$153.98	\$215.55	\$220.71	\$176.53	\$154.53
\$136.18	\$191.53	\$196.11	\$156.93	\$137.47	85	\$156.53	\$220.16	\$225.41	\$180.38	\$158.01
\$137.08	\$193.75	\$198.37	\$158.83	\$139.25	86	\$157.57	\$222.71	\$228.02	\$182.56	\$160.06
\$138.01	\$196.06	\$200.72	\$160.80	\$141.08	87	\$158.64	\$225.35	\$230.72	\$184.83	\$162.16
\$138.94	\$198.30	\$203.02	\$162.72	\$142.88	88	\$159.71	\$227.93	\$233.36	\$187.04	\$164.23
\$139.89	\$200.62	\$205.39	\$164.70	\$144.72	89	\$160.79	\$230.58	\$236.07	\$189.31	\$166.35
\$142.18	\$204.88	\$209.75	\$168.34	\$148.04	90	\$163.42	\$235.49	\$241.09	\$193.48	\$170.15
\$143.16	\$207.28	\$212.20	\$170.45	\$150.01	91	\$164.55	\$238.25	\$243.92	\$195.92	\$172.42
\$144.19	\$209.76	\$214.75	\$172.64	\$152.06	92	\$165.74	\$241.11	\$246.83	\$198.44	\$174.77
\$145.24	\$212.33	\$217.36	\$174.89	\$154.16	93	\$166.95	\$244.05	\$249.84	\$201.02	\$177.19
\$146.32	\$215.01	\$220.11	\$177.25	\$156.36	94	\$168.19	\$247.14	\$253.00	\$203.74	\$179.72
\$148.77	\$219.75	\$224.95	\$181.30	\$160.07	95	\$171.00	\$252.58	\$258.57	\$208.40	\$183.98
\$149.81	\$222.45	\$227.71	\$183.69	\$162.31	96	\$172.20	\$255.69	\$261.74	\$211.14	\$186.56
\$150.75	\$225.03	\$230.35	\$185.97	\$164.46	97	\$173.28	\$258.65	\$264.77	\$213.76	\$189.03
\$151.66	\$227.65	\$233.02	\$188.29	\$166.64	98	\$174.33	\$261.66	\$267.83	\$216.42	\$191.54
\$152.60	\$230.34	\$235.77	\$190.67	\$168.90	99	\$175.40	\$264.76	\$271.00	\$219.17	\$194.13

\* To obtain annual, semiannual, or quarterly premiums, multiply the Monthly Premium Amount by 12, 6, or 3, respectively

# FORETHOUGHT LIFE INSURANCE COMPANY - Monthly Premium Rates \*

These rates apply to ZIP codes starting with: 470, 471

## Standard Plans - Smoker

Female					Attained Age	Male				
Plan A	Plan C	Plan F	Plan G	Plan N		Plan A	Plan C	Plan F	Plan G	Plan N
N/A	N/A	N/A	N/A	N/A	<65	N/A	N/A	N/A	N/A	N/A
\$105.16	\$138.93	\$142.28	\$113.06	\$98.01	65	\$120.87	\$159.69	\$163.55	\$129.96	\$112.66
\$105.16	\$138.93	\$142.28	\$113.06	\$98.01	66	\$120.87	\$159.69	\$163.55	\$129.96	\$112.66
\$109.84	\$144.90	\$148.41	\$117.90	\$102.18	67	\$126.25	\$166.56	\$170.59	\$135.52	\$117.45
\$113.44	\$149.68	\$153.31	\$121.79	\$105.54	68	\$130.39	\$172.05	\$176.21	\$139.99	\$121.32
\$116.94	\$154.61	\$158.34	\$125.82	\$109.07	69	\$134.41	\$177.71	\$182.00	\$144.63	\$125.38
\$120.26	\$159.38	\$163.24	\$129.75	\$112.53	70	\$138.22	\$183.20	\$187.63	\$149.14	\$129.34
\$123.41	\$163.99	\$167.95	\$133.54	\$115.87	71	\$141.85	\$188.50	\$193.05	\$153.50	\$133.18
\$126.38	\$168.42	\$172.48	\$137.20	\$119.09	72	\$145.27	\$193.59	\$198.26	\$157.70	\$136.89
\$129.06	\$172.48	\$176.64	\$140.55	\$122.07	73	\$148.34	\$198.25	\$203.03	\$161.54	\$140.31
\$131.39	\$176.25	\$180.50	\$143.67	\$124.87	74	\$151.02	\$202.58	\$207.46	\$165.14	\$143.52
\$134.68	\$181.42	\$185.79	\$147.95	\$128.67	75	\$154.81	\$208.52	\$213.55	\$170.07	\$147.90
\$139.28	\$188.39	\$192.93	\$153.72	\$133.79	76	\$160.09	\$216.55	\$221.76	\$176.69	\$153.78
\$141.08	\$191.64	\$196.25	\$156.43	\$136.25	77	\$162.16	\$220.28	\$225.57	\$179.81	\$156.62
\$144.14	\$196.58	\$201.29	\$160.54	\$139.93	78	\$165.68	\$225.95	\$231.38	\$184.52	\$160.83
\$145.72	\$199.56	\$204.34	\$163.05	\$142.20	79	\$167.49	\$229.37	\$234.87	\$187.41	\$163.45
\$147.31	\$202.56	\$207.40	\$165.56	\$144.50	80	\$169.31	\$232.82	\$238.39	\$190.30	\$166.09
\$148.78	\$205.46	\$210.38	\$168.02	\$146.75	81	\$171.01	\$236.16	\$241.82	\$193.12	\$168.68
\$151.59	\$210.28	\$215.32	\$172.05	\$150.37	82	\$174.24	\$241.70	\$247.49	\$197.75	\$172.84
\$152.84	\$212.94	\$218.03	\$174.31	\$152.46	83	\$175.67	\$244.76	\$250.62	\$200.35	\$175.24
\$153.98	\$215.55	\$220.71	\$176.53	\$154.53	84	\$176.98	\$247.76	\$253.69	\$202.91	\$177.61
\$156.53	\$220.16	\$225.41	\$180.38	\$158.01	85	\$179.91	\$253.05	\$259.10	\$207.34	\$181.63
\$157.57	\$222.71	\$228.02	\$182.56	\$160.06	86	\$181.11	\$255.98	\$262.09	\$209.85	\$183.97
\$158.64	\$225.35	\$230.72	\$184.83	\$162.16	87	\$182.34	\$259.02	\$265.19	\$212.45	\$186.39
\$159.71	\$227.93	\$233.36	\$187.04	\$164.23	88	\$183.57	\$261.99	\$268.23	\$214.99	\$188.76
\$160.79	\$230.58	\$236.07	\$189.31	\$166.35	89	\$184.82	\$265.04	\$271.35	\$217.60	\$191.20
\$163.42	\$235.49	\$241.09	\$193.48	\$170.15	90	\$187.84	\$270.68	\$277.12	\$222.40	\$195.58
\$164.55	\$238.25	\$243.92	\$195.92	\$172.42	91	\$189.15	\$273.85	\$280.36	\$225.20	\$198.19
\$165.74	\$241.11	\$246.83	\$198.44	\$174.77	92	\$190.50	\$277.14	\$283.72	\$228.09	\$200.89
\$166.95	\$244.05	\$249.84	\$201.02	\$177.19	93	\$191.89	\$280.52	\$287.18	\$231.06	\$203.67
\$168.19	\$247.14	\$253.00	\$203.74	\$179.72	94	\$193.32	\$284.07	\$290.80	\$234.19	\$206.58
\$171.00	\$252.58	\$258.57	\$208.40	\$183.98	95	\$196.56	\$290.32	\$297.20	\$239.54	\$211.48
\$172.20	\$255.69	\$261.74	\$211.14	\$186.56	96	\$197.92	\$293.90	\$300.85	\$242.69	\$214.44
\$173.28	\$258.65	\$264.77	\$213.76	\$189.03	97	\$199.17	\$297.30	\$304.33	\$245.70	\$217.28
\$174.33	\$261.66	\$267.83	\$216.42	\$191.54	98	\$200.38	\$300.75	\$307.86	\$248.76	\$220.16
\$175.40	\$264.76	\$271.00	\$219.17	\$194.13	99	\$201.61	\$304.32	\$311.49	\$251.92	\$223.14

\* To obtain annual, semiannual, or quarterly premiums, multiply the Monthly Premium Amount by 12, 6, or 3, respectively

# FORETHOUGHT LIFE INSURANCE COMPANY - Monthly Premium Rates \*

These rates apply to ZIP codes starting with: 462 through 464

## Standard Plans - Nonsmoker

<i>Female</i>					<i>Attained Age</i>	<i>Male</i>				
<i>Plan A</i>	<i>Plan C</i>	<i>Plan F</i>	<i>Plan G</i>	<i>Plan N</i>		<i>Plan A</i>	<i>Plan C</i>	<i>Plan F</i>	<i>Plan G</i>	<i>Plan N</i>
N/A	N/A	N/A	N/A	N/A	<65	N/A	N/A	N/A	N/A	N/A
\$100.98	\$133.42	\$136.63	\$108.58	\$94.11	65	\$116.08	\$153.35	\$157.05	\$124.79	\$108.18
\$100.98	\$133.42	\$136.63	\$108.58	\$94.11	66	\$116.08	\$153.35	\$157.05	\$124.79	\$108.18
\$105.48	\$139.15	\$142.52	\$113.22	\$98.12	67	\$121.24	\$159.94	\$163.81	\$130.14	\$112.79
\$108.94	\$143.73	\$147.22	\$116.95	\$101.36	68	\$125.21	\$165.22	\$169.22	\$134.43	\$116.50
\$112.28	\$148.46	\$152.05	\$120.83	\$104.75	69	\$129.07	\$170.66	\$174.77	\$138.88	\$120.39
\$115.48	\$153.06	\$156.76	\$124.61	\$108.06	70	\$132.74	\$175.92	\$180.18	\$143.22	\$124.21
\$118.51	\$157.48	\$161.28	\$128.24	\$111.27	71	\$136.21	\$181.01	\$185.37	\$147.40	\$127.89
\$121.36	\$161.73	\$165.64	\$131.74	\$114.37	72	\$139.50	\$185.90	\$190.38	\$151.43	\$131.45
\$123.93	\$165.63	\$169.63	\$134.96	\$117.22	73	\$142.45	\$190.38	\$194.97	\$155.13	\$134.74
\$126.17	\$169.24	\$173.32	\$137.97	\$119.90	74	\$145.02	\$194.54	\$199.23	\$158.58	\$137.83
\$129.34	\$174.21	\$178.41	\$142.08	\$123.56	75	\$148.66	\$200.25	\$205.07	\$163.31	\$142.03
\$133.74	\$180.92	\$185.27	\$147.62	\$128.48	76	\$153.74	\$207.94	\$212.95	\$169.67	\$147.68
\$135.47	\$184.03	\$188.45	\$150.22	\$130.84	77	\$155.72	\$211.52	\$216.61	\$172.67	\$150.39
\$138.41	\$188.77	\$193.31	\$154.16	\$134.36	78	\$159.10	\$216.98	\$222.18	\$177.20	\$154.45
\$139.93	\$191.63	\$196.22	\$156.57	\$136.55	79	\$160.84	\$220.26	\$225.54	\$179.97	\$156.96
\$141.45	\$194.51	\$199.17	\$158.99	\$138.76	80	\$162.59	\$223.58	\$228.92	\$182.74	\$159.49
\$142.87	\$197.30	\$202.02	\$161.34	\$140.93	81	\$164.22	\$226.78	\$232.21	\$185.46	\$161.97
\$145.57	\$201.93	\$206.76	\$165.22	\$144.40	82	\$167.32	\$232.10	\$237.66	\$189.90	\$165.98
\$146.76	\$204.49	\$209.37	\$167.38	\$146.40	83	\$168.70	\$235.04	\$240.66	\$192.39	\$168.28
\$147.85	\$207.00	\$211.95	\$169.52	\$148.39	84	\$169.95	\$237.92	\$243.62	\$194.85	\$170.56
\$150.31	\$211.41	\$216.46	\$173.22	\$151.74	85	\$172.77	\$243.01	\$248.80	\$199.10	\$174.41
\$151.30	\$213.85	\$218.95	\$175.31	\$153.70	86	\$173.92	\$245.82	\$251.68	\$201.51	\$176.67
\$152.33	\$216.40	\$221.55	\$177.49	\$155.72	87	\$175.10	\$248.73	\$254.66	\$204.01	\$178.99
\$153.36	\$218.88	\$224.09	\$179.61	\$157.70	88	\$176.28	\$251.59	\$257.58	\$206.45	\$181.27
\$154.40	\$221.43	\$226.70	\$181.79	\$159.74	89	\$177.48	\$254.51	\$260.57	\$208.95	\$183.61
\$156.93	\$226.14	\$231.52	\$185.81	\$163.40	90	\$180.38	\$259.93	\$266.10	\$213.56	\$187.81
\$158.02	\$228.79	\$234.22	\$188.14	\$165.58	91	\$181.63	\$262.97	\$269.23	\$216.25	\$190.31
\$159.16	\$231.53	\$237.03	\$190.56	\$167.84	92	\$182.94	\$266.13	\$272.45	\$219.04	\$192.91
\$160.31	\$234.36	\$239.92	\$193.04	\$170.15	93	\$184.28	\$269.38	\$275.77	\$221.88	\$195.58
\$161.51	\$237.32	\$242.95	\$195.65	\$172.59	94	\$185.64	\$272.79	\$279.26	\$224.89	\$198.37
\$164.21	\$242.55	\$248.30	\$200.12	\$176.68	95	\$188.74	\$278.79	\$285.40	\$230.02	\$203.08
\$165.36	\$245.54	\$251.34	\$202.75	\$179.15	96	\$190.07	\$282.23	\$288.90	\$233.05	\$205.92
\$166.40	\$248.38	\$254.25	\$205.26	\$181.53	97	\$191.26	\$285.49	\$292.24	\$235.94	\$208.65
\$167.40	\$251.27	\$257.20	\$207.83	\$183.94	98	\$192.42	\$288.81	\$295.62	\$238.88	\$211.42
\$168.43	\$254.24	\$260.23	\$210.46	\$186.43	99	\$193.60	\$292.23	\$299.12	\$241.91	\$214.27

\* To obtain annual, semiannual, or quarterly premiums, multiply the Monthly Premium Amount by 12, 6, or 3, respectively

# **FORETHOUGHT LIFE INSURANCE COMPANY - Monthly Premium Rates \***

These rates apply to ZIP codes starting with: 462 through 464

## Standard Plans - Smoker

<i>Female</i>					<i>Attained Age</i>	<i>Male</i>				
<i>Plan A</i>	<i>Plan C</i>	<i>Plan F</i>	<i>Plan G</i>	<i>Plan N</i>		<i>Plan A</i>	<i>Plan C</i>	<i>Plan F</i>	<i>Plan G</i>	<i>Plan N</i>
N/A	N/A	N/A	N/A	N/A	<65	N/A	N/A	N/A	N/A	N/A
\$116.08	\$153.35	\$157.05	\$124.79	\$108.18	65	\$133.42	\$176.26	\$180.52	\$143.44	\$124.35
\$116.08	\$153.35	\$157.05	\$124.79	\$108.18	66	\$133.42	\$176.26	\$180.52	\$143.44	\$124.35
\$121.24	\$159.94	\$163.81	\$130.14	\$112.79	67	\$139.35	\$183.84	\$188.29	\$149.58	\$129.64
\$125.21	\$165.22	\$169.22	\$134.43	\$116.50	68	\$143.92	\$189.90	\$194.50	\$154.52	\$133.91
\$129.07	\$170.66	\$174.77	\$138.88	\$120.39	69	\$148.36	\$196.15	\$200.89	\$159.63	\$138.39
\$132.74	\$175.92	\$180.18	\$143.22	\$124.21	70	\$152.57	\$202.21	\$207.10	\$164.62	\$142.76
\$136.21	\$181.01	\$185.37	\$147.40	\$127.89	71	\$156.57	\$208.06	\$213.08	\$169.43	\$147.00
\$139.50	\$185.90	\$190.38	\$151.43	\$131.45	72	\$160.35	\$213.68	\$218.84	\$174.06	\$151.09
\$142.45	\$190.38	\$194.97	\$155.13	\$134.74	73	\$163.73	\$218.83	\$224.10	\$178.31	\$154.87
\$145.02	\$194.54	\$199.23	\$158.58	\$137.83	74	\$166.69	\$223.60	\$228.99	\$182.27	\$158.42
\$148.66	\$200.25	\$205.07	\$163.31	\$142.03	75	\$170.88	\$230.16	\$235.71	\$187.71	\$163.25
\$153.74	\$207.94	\$212.95	\$169.67	\$147.68	76	\$176.71	\$239.02	\$244.78	\$195.03	\$169.74
\$155.72	\$211.52	\$216.61	\$172.67	\$150.39	77	\$178.99	\$243.14	\$248.98	\$198.47	\$172.87
\$159.10	\$216.98	\$222.18	\$177.20	\$154.45	78	\$182.87	\$249.40	\$255.39	\$203.67	\$177.52
\$160.84	\$220.26	\$225.54	\$179.97	\$156.96	79	\$184.87	\$253.18	\$259.25	\$206.86	\$180.41
\$162.59	\$223.58	\$228.92	\$182.74	\$159.49	80	\$186.88	\$256.98	\$263.13	\$210.05	\$183.33
\$164.22	\$226.78	\$232.21	\$185.46	\$161.97	81	\$188.76	\$260.66	\$266.91	\$213.16	\$186.18
\$167.32	\$232.10	\$237.66	\$189.90	\$165.98	82	\$192.32	\$266.78	\$273.17	\$218.28	\$190.78
\$168.70	\$235.04	\$240.66	\$192.39	\$168.28	83	\$193.90	\$270.16	\$276.62	\$221.14	\$193.42
\$169.95	\$237.92	\$243.62	\$194.85	\$170.56	84	\$195.34	\$273.48	\$280.02	\$223.96	\$196.05
\$172.77	\$243.01	\$248.80	\$199.10	\$174.41	85	\$198.58	\$279.31	\$285.98	\$228.85	\$200.48
\$173.92	\$245.82	\$251.68	\$201.51	\$176.67	86	\$199.91	\$282.54	\$289.28	\$231.62	\$203.07
\$175.10	\$248.73	\$254.66	\$204.01	\$178.99	87	\$201.26	\$285.90	\$292.71	\$234.49	\$205.73
\$176.28	\$251.59	\$257.58	\$206.45	\$181.27	88	\$202.62	\$289.18	\$296.07	\$237.30	\$208.35
\$177.48	\$254.51	\$260.57	\$208.95	\$183.61	89	\$204.00	\$292.55	\$299.51	\$240.18	\$211.04
\$180.38	\$259.93	\$266.10	\$213.56	\$187.81	90	\$207.34	\$298.77	\$305.87	\$245.48	\$215.88
\$181.63	\$262.97	\$269.23	\$216.25	\$190.31	91	\$208.77	\$302.27	\$309.45	\$248.57	\$218.75
\$182.94	\$266.13	\$272.45	\$219.04	\$192.91	92	\$210.27	\$305.90	\$313.16	\$251.76	\$221.74
\$184.28	\$269.38	\$275.77	\$221.88	\$195.58	93	\$211.81	\$309.63	\$316.98	\$255.04	\$224.80
\$185.64	\$272.79	\$279.26	\$224.89	\$198.37	94	\$213.38	\$313.55	\$320.98	\$258.49	\$228.02
\$188.74	\$278.79	\$285.40	\$230.02	\$203.08	95	\$216.95	\$320.45	\$328.04	\$264.40	\$233.43
\$190.07	\$282.23	\$288.90	\$233.05	\$205.92	96	\$218.46	\$324.39	\$332.07	\$267.87	\$236.69
\$191.26	\$285.49	\$292.24	\$235.94	\$208.65	97	\$219.84	\$328.15	\$335.91	\$271.19	\$239.83
\$192.42	\$288.81	\$295.62	\$238.88	\$211.42	98	\$221.18	\$331.96	\$339.80	\$274.58	\$243.01
\$193.60	\$292.23	\$299.12	\$241.91	\$214.27	99	\$222.53	\$335.90	\$343.82	\$278.06	\$246.30

\* To obtain annual, semiannual, or quarterly premiums, multiply the Monthly Premium Amount by 12, 6, or 3, respectively



**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
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after: <ul style="list-style-type: none"> <li>• While using 60 lifetime reserve days</li> <li>• Once lifetime reserve days are used:               <ul style="list-style-type: none"> <li>- Additional 365 days</li> <li>- Beyond the additional 365 days</li> </ul> </li> </ul>	All but \$1,156 All but \$289 a day  All but \$578 a day  \$0 \$0	\$0 \$289 a day  \$578 a day  100% of Medicare Eligible Expenses \$0	\$1,156 (Part A Deductible) \$0  \$0  \$0** All Costs
<b>SKILLED NURSING FACILITY CARE*</b> 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 21st thru 100th day 101st day and after	All approved amounts All but \$144.50 a day \$0	\$0 \$0 \$0	\$0 Up to \$144.50 a day All Costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> 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 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 \$140 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
<b>MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment. First \$140 of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 Generally 80%	\$0 Generally 20%	\$140 (Part B Deductible) \$0
<b>Part B Excess Charges</b> (Above Medicare-approved amounts)	\$0	\$0	All costs
<b>BLOOD</b> First 3 pints Next \$140 of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 \$0 80%	All Costs \$0 20%	\$0 \$140 (Part B Deductible) \$0
<b>CLINICAL LABORATORY SERVICES</b> – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

**PARTS A & B**

<b>HOME HEALTH CARE MEDICARE-APPROVED SERVICES</b> • Medically necessary skilled care services and medical supplies • Durable medical equipment - First \$140 of Medicare-approved amounts* - Remainder of Medicare-approved amounts	100%   \$0 80%	\$0   \$0 20%	\$0   \$140 (Part B Deductible) \$0
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**PLAN C**  
**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
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after: • While using 60 lifetime reserve days • Once lifetime reserve days are used: - Additional 365 days - Beyond the additional 365 days	All but \$1,156 All but \$289 a day All but \$578 a day \$0 \$0	\$1,156 (Part A Deductible) \$289 a day \$578 a day 100% of Medicare Eligible Expenses \$0	\$0 \$0 \$0 \$0** All Costs
<b>SKILLED NURSING FACILITY CARE*</b> 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 21st thru 100th day 101st day and after	All approved amounts All but \$144.50 a day \$0	\$0 Up to \$144.50 a day \$0	\$0 \$0 All Costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> 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 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 C**  
**MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR**

\* Once You have been billed \$140 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
<b>MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment. First \$140 of Medicare-approved amounts* Remainder of Medicare-approved amounts	 \$0 Generally 80%	 \$140 (Part B Deductible) Generally 20%	 \$0 \$0
<b>Part B Excess Charges</b> (Above Medicare-approved amounts)	\$0	\$0	All Costs
<b>BLOOD</b> First 3 pints Next \$140 of Medicare-approved amounts* Remainder of Medicare-approved amounts	 \$0 \$0 80%	 All Costs \$140 (Part B Deductible) 20%	 \$0 \$0 \$0
<b>CLINICAL LABORATORY SERVICES</b> – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

**PARTS A & B**

<b>HOME HEALTH CARE MEDICARE-APPROVED SERVICES</b> • Medically necessary skilled care services and medical supplies • Durable medical equipment First \$140 of Medicare-approved amounts* Remainder of Medicare-approved amounts	 100%  \$0 80%	 \$0  \$140 (Part B Deductible) 20%	 \$0  \$0 \$0
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**OTHER BENEFITS – NOT COVERED BY MEDICARE**

<b>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</b> Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of charges	 \$0 \$0	 \$0 80% to a lifetime maximum benefit of \$50,000	 \$250 20% and amounts over the \$50,000 lifetime maximum
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**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
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after: <ul style="list-style-type: none"> <li>• While using 60 lifetime reserve days</li> <li>• Once lifetime reserve days are used:               <ul style="list-style-type: none"> <li>- Additional 365 days</li> <li>- Beyond the additional 365 days</li> </ul> </li> </ul>	All but \$1,156 All but \$289 a day  All but \$578 a day  \$0 \$0	\$1,156 (Part A Deductible) \$289 a day  \$578 a day  100% of Medicare Eligible Expenses \$0	\$0 \$0  \$0 \$0** All Costs
<b>SKILLED NURSING FACILITY CARE*</b> 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 21st thru 100th day 101st day and after	All approved amounts All but \$144.50 a day \$0	\$0 Up to \$144.50 a day \$0	\$0 \$0 All Costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> 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 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 F**  
**MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR**

\* Once You have been billed \$140 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
<b>MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment. First \$140 of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 Generally 80%	\$140 (Part B Deductible) Generally 20%	\$0 \$0
<b>Part B Excess Charges</b> (Above Medicare-approved amounts)	\$0	100%	\$0
<b>BLOOD</b> First 3 pints Next \$140 of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 \$0 80%	All Costs \$140 (Part B Deductible) 20%	\$0 \$0 \$0
<b>CLINICAL LABORATORY SERVICES</b> – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

**PARTS A & B**

<b>HOME HEALTH CARE MEDICARE-APPROVED SERVICES</b> • Medically necessary skilled care services and medical supplies • Durable medical equipment	100%	\$0	\$0
- First \$140 of Medicare-approved amounts* - Remainder of Medicare-approved amounts	\$0 80%	\$140 (Part B Deductible) 20%	\$0 \$0

**OTHER BENEFITS – NOT COVERED BY MEDICARE**

<b>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</b> Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of charges	\$0 \$0	\$0 80% to a lifetime maximum benefit of \$50,000	\$250 20% and amounts over the \$50,000 lifetime maximum
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**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
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after: <ul style="list-style-type: none"> <li>• While using 60 lifetime reserve days</li> <li>• Once lifetime reserve days are used: <ul style="list-style-type: none"> <li>- Additional 365 days</li> <li>- Beyond the additional 365 days</li> </ul> </li> </ul>	All but \$1,156 All but \$289 a day  All but \$578 a day  \$0 \$0	\$1,156 (Part A Deductible) \$289 a day  \$578 a day  100% of Medicare Eligible Expenses \$0	\$0 \$0  \$0 \$0** All Costs
<b>SKILLED NURSING FACILITY CARE*</b> 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 21st thru 100th day 101st day and after	All approved amounts All but \$144.50 a day \$0	\$0 Up to \$144.50 a day \$0	\$0 \$0 All Costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> 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 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 G**  
**MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR**

\* Once You have been billed \$140 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
<b>MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment. First \$140 of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 Generally 80%	\$0 Generally 20%	\$140 (Part B Deductible) \$0
<b>Part B Excess Charges</b> (Above Medicare-approved amounts)	\$0	100%	\$0
<b>BLOOD</b> First 3 pints Next \$140 of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 \$0 80%	All Costs \$0 20%	\$0 \$140 (Part B Deductible) \$0
<b>CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

**PARTS A & B**

<b>HOME HEALTH CARE MEDICARE-APPROVED SERVICES</b> • Medically necessary skilled care services and medical supplies • Durable medical equipment First \$140 of Medicare-approved amounts* Remainder of Medicare-approved amounts	100%  \$0 80%	\$0  \$0 20%	\$0  \$140 (Part B Deductible) \$0
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**OTHER BENEFITS – NOT COVERED BY MEDICARE**

<b>FOREIGN TRAVEL - NOT COVERED BY MEDICARE</b> Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of charges	\$0 \$0	\$0 80% to a lifetime maximum benefit of \$50,000	\$250 20% and amounts over the \$50,000 lifetime maximum
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**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
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after: <ul style="list-style-type: none"> <li>• While using 60 lifetime reserve days</li> <li>• Once lifetime reserve days are used: <ul style="list-style-type: none"> <li>- Additional 365 days</li> <li>- Beyond the additional 365 days</li> </ul> </li> </ul>	All but \$1,156 All but \$289 a day  All but \$578 a day  \$0 \$0	\$1,156 (Part A Deductible) \$289 a day  \$578 a day  100% of Medicare Eligible Expenses \$0	\$0 \$0  \$0 \$0** All Costs
<b>SKILLED NURSING FACILITY CARE*</b> 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 21st thru 100th day 101st day and after	All approved amounts All but \$144.50 a day \$0	\$0 Up to \$144.50 a day \$0	\$0 \$0 All Costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> 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 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 N**  
**MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR**

\* Once You have been billed \$140 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
<b>MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUT-PATIENT HOSPITAL TREATMENT</b> , such as Physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment. First \$140 of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 Generally 80%	\$0 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.	\$140 (Part B Deductible) 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.
<b>Part B Excess Charges</b> (Above Medicare-approved amounts)	\$0	\$0	All Costs
<b>BLOOD</b> First 3 pints Next \$140 of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$140 (Part B Deductible) \$0
<b>CLINICAL LABORATORY SERVICES</b> – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

## PLAN N

### PARTS A & B

<b>HOME HEALTH CARE MEDICARE-APPROVED SERVICES</b>			
• Medically necessary skilled care services and medical supplies	100%	\$0	\$0
• Durable medical equipment			
- First \$140 of Medicare-approved amounts*	\$0	\$0	\$140 (Part B Deductible)
- Remainder of Medicare-approved amounts	80%	20%	\$0

### OTHER BENEFITS – NOT COVERED BY MEDICARE

<b>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</b>			
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