

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 co-insurance plus coverage for 365 additional days after Medicare benefits end.

Medical Expenses: Part B co-insurance (generally 20% of Medicare-approved expenses), or co-payment for hospital outpatient services. Plans K, L and N require insured to pay a portion of Part B co-insurance or co-payments.

Blood: First three pints of blood each year.

Hospice: Part A co-insurance.

A	B	C#	D	F#	F*	G#
Basic, including 100% Part B co-insurance	Basic, including 100% Part B co-insurance	Basic, including 100% Part B co-insurance	Basic, including 100% Part B co-insurance	Basic, including 100% Part B co-insurance		Basic, including 100% Part B co-insurance
		Skilled Nursing Facility co-insurance	Skilled Nursing Facility co-insurance	Skilled Nursing Facility co-insurance		Skilled Nursing Facility co-insurance
	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

K	L	M	N#
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 co-insurance	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 co-insurance	75% Skilled Nursing Facility co-insurance	Skilled Nursing Facility co-insurance	Skilled Nursing Facility co-insurance
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		

Plans C, F, G and N are also offered as Medicare Select Plans.

* 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.

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, PO 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.

LIMITATIONS AND EXCLUSIONS

Your Medicare Supplement Policy will not contain limitations and exclusions that are more restrictive than the limitations and exclusions contained in Medicare. The limitations and exclusions include:

- (a) expenses incurred while this policy is not in force, except as provided in the Extension of Benefits section;
- (b) Hospital or Skilled Nursing Facility confinement charges incurred prior to the effective date of coverage;
- (c) that portion of any expense incurred which is paid for by Medicare;
- (d) services for non-Medicare Eligible Expenses, including, but not limited to, routine exams, take-home drugs and eye refractions;
- (e) services for which a charge is not normally made in the absence of insurance; or
- (f) loss or expense that is payable under any other Medicare supplement insurance policy or certificate.

REFUND OF PREMIUM

This Policy contains a provision providing for a refund or partial refund of premium upon your death or the surrender of the Policy.

GRIEVANCE PROCEDURE

We have a customer service program which can provide information to you, handle your complaints, and help satisfy your concerns. This grievance procedure is intended to provide an opportunity for you and us to achieve mutual agreement for the settlement of disputes that have not been settled through our customer service program or your desire to have settled by means of a written grievance. The following procedures are aimed at achieving mutual agreement for the settlement of a dispute.

- (1) All Grievances may be presented to us either in writing or orally. Any written Grievance between you and us or between you and a Hospital must be dealt with through this Grievance procedure. Out-of-hospital Grievances will be addressed immediately and resolved as soon as possible. You should contact us within 60 days of the date you are notified of any adverse action with respect to an out-of-hospital Grievance. In-hospital Grievances relating to ongoing hospital treatment will be addressed immediately on receipt of any written or oral Grievance and will be resolved as quickly as possible in a manner which does not interfere with, obstruct or interrupt your continued medical treatment and care.
- (2) Any written Grievance must contain the words "THIS IS A GRIEVANCE" or other words that clearly state that the intention of the written communication is to serve as a written Grievance to be handled according to this procedure.
- (3) A Grievance must be filed by submitting the complete details in writing to Forethought Life Insurance Company, c/o Grievance Review, Post Office Box 14659, Clearwater, FL 33766-4659.
- (4) Each Grievance is processed within a maximum of 60 days after it is received by us. Each level of the Grievance process is handled by a person with problem-solving authority. A Physician, other than your treating physician, must be involved in reviewing any medically related Grievances.
- (5) If a Grievance is found to be valid, corrective action will be taken promptly.
- (6) All concerned parties are to be notified about the result of a Grievance.
- (7) You have the right to appeal to the Department of Insurance after first completing our grievance process.
- (8) Any meeting with you must be scheduled at a location or in a manner which is convenient and will not necessitate excessive travel or undue hardship.

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: 754-760, 762-769, 778-781, 783, 785-792, 795-799, 885

Nonsmoker

Standard Plan A	<i>Female</i>				Attained Age	<i>Male</i>				
	Select					Standard Plan A	Select			
	Plan C	Plan F	Plan G	Plan N			Plan C	Plan F	Plan G	Plan N
255.49	N/A	N/A	N/A	N/A	<65	293.67	N/A	N/A	N/A	N/A
96.26	101.93	104.45	82.24	70.55	65	110.65	117.16	120.06	94.53	81.09
96.26	101.93	104.45	82.24	70.55	66	110.65	117.16	120.06	94.53	81.09
100.55	106.31	108.95	85.77	73.56	67	115.57	122.20	125.23	98.59	84.55
103.84	109.83	112.54	88.60	75.99	68	119.36	126.24	129.36	101.84	87.34
107.04	113.44	116.24	91.53	78.52	69	123.04	130.39	133.61	105.21	90.25
110.08	116.94	119.84	94.39	81.01	70	126.53	134.42	137.75	108.49	93.12
112.97	120.32	123.29	97.14	83.41	71	129.85	138.30	141.71	111.66	95.87
115.69	123.57	126.63	99.80	85.73	72	132.98	142.04	145.55	114.71	98.54
118.14	126.55	129.68	102.24	87.88	73	135.79	145.46	149.06	117.52	101.01
120.27	129.31	132.50	104.51	89.89	74	138.24	148.63	152.30	120.13	103.32
123.30	133.11	136.39	107.63	92.64	75	141.72	153.00	156.77	123.71	106.48
127.49	138.23	141.64	111.82	96.32	76	146.54	158.88	162.80	128.53	110.71
129.14	140.60	144.07	113.80	98.09	77	148.44	161.61	165.60	130.80	112.74
131.94	144.23	147.78	116.78	100.73	78	151.66	165.78	169.86	134.23	115.78
133.39	146.41	150.02	118.60	102.37	79	153.32	168.29	172.43	136.32	117.67
134.84	148.61	152.27	120.44	104.02	80	154.99	170.82	175.02	138.43	119.56
136.20	150.74	154.45	122.22	105.64	81	156.55	173.27	177.53	140.49	121.43
138.76	154.29	158.07	125.15	108.24	82	159.50	177.34	181.69	143.85	124.42
139.91	156.23	160.06	126.80	109.75	83	160.81	179.58	183.98	145.74	126.15
140.94	158.15	162.02	128.41	111.24	84	162.00	181.78	186.23	147.60	127.86
143.28	161.52	165.49	131.22	113.75	85	164.69	185.66	190.22	150.83	130.75
144.24	163.40	167.40	132.81	115.22	86	165.80	187.82	192.41	152.65	132.44
145.22	165.33	169.38	134.45	116.74	87	166.92	190.03	194.69	154.54	134.18
146.20	167.23	171.32	136.05	118.22	88	168.04	192.22	196.92	156.38	135.89
147.19	169.18	173.31	137.71	119.75	89	169.18	194.46	199.21	158.29	137.64
149.60	172.79	177.00	140.75	122.50	90	171.96	198.60	203.45	161.79	140.80
150.64	174.81	179.06	142.52	124.12	91	173.15	200.93	205.82	163.82	142.67
151.71	176.90	181.21	144.35	125.81	92	174.38	203.34	208.29	165.92	144.61
152.83	179.05	183.42	146.23	127.55	93	175.66	205.81	210.83	168.08	146.61
153.96	181.32	185.74	148.20	129.38	94	176.97	208.42	213.49	170.35	148.72
156.54	185.32	189.82	151.60	132.45	95	179.93	213.01	218.19	174.25	152.24
157.62	187.59	192.15	153.58	134.30	96	181.18	215.62	220.86	176.53	154.36
158.62	189.77	194.37	155.50	136.08	97	182.32	218.13	223.42	178.73	156.42
159.58	191.97	196.63	157.44	137.88	98	183.43	220.66	226.01	180.96	158.49
160.56	194.25	198.95	159.43	139.75	99	184.55	223.28	228.68	183.25	160.64

* 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: 754-760, 762-769, 778-781, 783, 785-792, 795-799, 885

Smoker

Standard Plan A	Female				Attained Age	Male				
	Select					Standard Plan A	Select			
	Plan C	Plan F	Plan G	Plan N			Plan C	Plan F	Plan G	Plan N
293.67	N/A	N/A	N/A	N/A	<65	337.55	N/A	N/A	N/A	N/A
110.65	117.16	120.06	94.53	81.09	65	127.18	134.67	138.00	108.66	93.21
110.65	117.16	120.06	94.53	81.09	66	127.18	134.67	138.00	108.66	93.21
115.57	122.20	125.23	98.59	84.55	67	132.84	140.46	143.94	113.32	97.18
119.36	126.24	129.36	101.84	87.34	68	137.19	145.10	148.69	117.06	100.39
123.04	130.39	133.61	105.21	90.25	69	141.42	149.87	153.58	120.93	103.74
126.53	134.42	137.75	108.49	93.12	70	145.44	154.50	158.33	124.70	107.03
129.85	138.30	141.71	111.66	95.87	71	149.25	158.96	162.89	128.34	110.20
132.98	142.04	145.55	114.71	98.54	72	152.85	163.26	167.30	131.85	113.27
135.79	145.46	149.06	117.52	101.01	73	156.08	167.19	171.33	135.08	116.10
138.24	148.63	152.30	120.13	103.32	74	158.90	170.84	175.06	138.08	118.76
141.72	153.00	156.77	123.71	106.48	75	162.90	175.86	180.19	142.20	122.39
146.54	158.88	162.80	128.53	110.71	76	168.44	182.62	187.13	147.74	127.25
148.44	161.61	165.60	130.80	112.74	77	170.62	185.76	190.34	150.35	129.59
151.66	165.78	169.86	134.23	115.78	78	174.32	190.55	195.24	154.29	133.08
153.32	168.29	172.43	136.32	117.67	79	176.23	193.44	198.20	156.69	135.25
154.99	170.82	175.02	138.43	119.56	80	178.15	196.34	201.17	159.12	137.43
156.55	173.27	177.53	140.49	121.43	81	179.94	199.16	204.06	161.48	139.57
159.50	177.34	181.69	143.85	124.42	82	183.33	203.84	208.84	165.35	143.01
160.81	179.58	183.98	145.74	126.15	83	184.84	206.41	211.47	167.52	145.00
162.00	181.78	186.23	147.60	127.86	84	186.21	208.94	214.06	169.65	146.97
164.69	185.66	190.22	150.83	130.75	85	189.30	213.40	218.64	173.37	150.29
165.80	187.82	192.41	152.65	132.44	86	190.57	215.88	221.16	175.46	152.23
166.92	190.03	194.69	154.54	134.18	87	191.86	218.43	223.78	177.63	154.23
168.04	192.22	196.92	156.38	135.89	88	193.15	220.94	226.34	179.75	156.19
169.18	194.46	199.21	158.29	137.64	89	194.46	223.52	228.98	181.94	158.21
171.96	198.60	203.45	161.79	140.80	90	197.65	228.28	233.85	185.96	161.84
173.15	200.93	205.82	163.82	142.67	91	199.02	230.95	236.57	188.30	163.99
174.38	203.34	208.29	165.92	144.61	92	200.44	233.72	239.41	190.71	166.22
175.66	205.81	210.83	168.08	146.61	93	201.91	236.56	242.33	193.20	168.52
176.97	208.42	213.49	170.35	148.72	94	203.41	239.56	245.39	195.80	170.94
179.93	213.01	218.19	174.25	152.24	95	206.82	244.84	250.79	200.29	174.99
181.18	215.62	220.86	176.53	154.36	96	208.25	247.84	253.86	202.91	177.43
182.32	218.13	223.42	178.73	156.42	97	209.56	250.72	256.80	205.44	179.79
183.43	220.66	226.01	180.96	158.49	98	210.84	253.63	259.78	208.00	182.17
184.55	223.28	228.68	183.25	160.64	99	212.13	256.64	262.85	210.63	184.64

* 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: 733,750-753, 761, 782, 784, 793, 794

Nonsmoker

Standard Plan A	Female				Attained Age	Male				
	Select					Standard Plan A	Select			
	Plan C	Plan F	Plan G	Plan N			Plan C	Plan F	Plan G	Plan N
283.59	N/A	N/A	N/A	N/A	<65	325.97	N/A	N/A	N/A	N/A
106.85	113.14	115.94	91.29	78.31	65	122.82	130.05	133.27	104.93	90.01
106.85	113.14	115.94	91.29	78.31	66	122.82	130.05	133.27	104.93	90.01
111.61	118.00	120.93	95.20	81.65	67	128.28	135.64	139.01	109.43	93.85
115.26	121.91	124.92	98.35	84.35	68	132.49	140.13	143.59	113.04	96.95
118.81	125.92	129.03	101.60	87.16	69	136.57	144.73	148.31	116.78	100.18
122.19	129.80	133.02	104.77	89.92	70	140.45	149.21	152.90	120.42	103.36
125.40	133.56	136.85	107.83	92.59	71	144.13	153.51	157.30	123.94	106.42
128.42	137.16	140.56	110.78	95.16	72	147.61	157.66	161.56	127.33	109.38
131.14	140.47	143.94	113.49	97.55	73	150.73	161.46	165.46	130.45	112.12
133.50	143.53	147.08	116.01	99.78	74	153.45	164.98	169.05	133.34	114.69
136.86	147.75	151.39	119.47	102.83	75	157.31	169.83	174.01	137.32	118.19
141.51	153.44	157.22	124.12	106.92	76	162.66	176.36	180.71	142.67	122.89
143.35	156.07	159.92	126.32	108.88	77	164.77	179.39	183.82	145.19	125.14
146.45	160.10	164.04	129.63	111.81	78	168.34	184.02	188.54	149.00	128.52
148.06	162.52	166.52	131.65	113.63	79	170.19	186.80	191.40	151.32	130.61
149.67	164.96	169.02	133.69	115.46	80	172.04	189.61	194.27	153.66	132.71
151.18	167.32	171.44	135.66	117.26	81	173.77	192.33	197.06	155.94	134.79
154.02	171.26	175.46	138.92	120.15	82	177.05	196.85	201.68	159.67	138.11
155.30	173.42	177.67	140.75	121.82	83	178.50	199.33	204.22	161.77	140.03
156.44	175.55	179.84	142.54	123.48	84	179.82	201.78	206.72	163.84	141.92
159.04	179.29	183.69	145.65	126.26	85	182.81	206.08	211.14	167.42	145.13
160.11	181.37	185.81	147.42	127.89	86	184.04	208.48	213.58	169.44	147.01
161.19	183.52	188.01	149.24	129.58	87	185.28	210.93	216.11	171.54	148.94
162.28	185.63	190.17	151.02	131.22	88	186.52	213.36	218.58	173.58	150.84
163.38	187.79	192.37	152.86	132.92	89	187.79	215.85	221.12	175.70	152.78
166.06	191.80	196.47	156.23	135.98	90	190.88	220.45	225.83	179.59	156.29
167.21	194.04	198.76	158.20	137.77	91	192.20	223.03	228.46	181.84	158.36
168.40	196.36	201.14	160.23	139.65	92	193.56	225.71	231.20	184.17	160.52
169.64	198.75	203.60	162.32	141.58	93	194.98	228.45	234.02	186.57	162.74
170.90	201.27	206.17	164.50	143.61	94	196.44	231.35	236.97	189.09	165.08
173.76	205.71	210.70	168.28	147.02	95	199.72	236.44	242.19	193.42	168.99
174.96	208.22	213.29	170.47	149.07	96	201.11	239.34	245.15	195.95	171.34
176.07	210.64	215.75	172.61	151.05	97	202.38	242.12	248.00	198.39	173.63
177.13	213.09	218.26	174.76	153.05	98	203.61	244.93	250.87	200.87	175.92
178.22	215.62	220.83	176.97	155.12	99	204.85	247.84	253.83	203.41	178.31

* 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: 733,750-753, 761, 782, 784, 793, 794

Smoker

Standard Plan A	Female				Attained Age	Male				
	Select					Standard Plan A	Select			
	Plan C	Plan F	Plan G	Plan N			Plan C	Plan F	Plan G	Plan N
325.97	N/A	N/A	N/A	N/A	<65	374.68	N/A	N/A	N/A	N/A
122.82	130.05	133.27	104.93	90.01	65	141.17	149.48	153.18	120.61	103.46
122.82	130.05	133.27	104.93	90.01	66	141.17	149.48	153.18	120.61	103.46
128.28	135.64	139.01	109.43	93.85	67	147.45	155.91	159.77	125.79	107.87
132.49	140.13	143.59	113.04	96.95	68	152.28	161.06	165.05	129.94	111.43
136.57	144.73	148.31	116.78	100.18	69	156.98	166.36	170.47	134.23	115.15
140.45	149.21	152.90	120.42	103.36	70	161.44	171.50	175.75	138.42	118.80
144.13	153.51	157.30	123.94	106.42	71	165.67	176.45	180.81	142.46	122.32
147.61	157.66	161.56	127.33	109.38	72	169.66	181.22	185.70	146.35	125.73
150.73	161.46	165.46	130.45	112.12	73	173.25	185.58	190.18	149.94	128.87
153.45	164.98	169.05	133.34	114.69	74	176.38	189.63	194.32	153.27	131.82
157.31	169.83	174.01	137.32	118.19	75	180.82	195.20	200.01	157.84	135.85
162.66	176.36	180.71	142.67	122.89	76	186.97	202.71	207.71	163.99	141.25
164.77	179.39	183.82	145.19	125.14	77	189.39	206.19	211.28	166.89	143.84
168.34	184.02	188.54	149.00	128.52	78	193.50	211.51	216.72	171.26	147.72
170.19	186.80	191.40	151.32	130.61	79	195.62	214.72	220.00	173.93	150.13
172.04	189.61	194.27	153.66	132.71	80	197.75	217.94	223.30	176.62	152.55
173.77	192.33	197.06	155.94	134.79	81	199.73	221.07	226.51	179.24	154.92
177.05	196.85	201.68	159.67	138.11	82	203.50	226.26	231.81	183.54	158.74
178.50	199.33	204.22	161.77	140.03	83	205.17	229.12	234.73	185.95	160.95
179.82	201.78	206.72	163.84	141.92	84	206.69	231.92	237.61	188.31	163.14
182.81	206.08	211.14	167.42	145.13	85	210.12	236.87	242.69	192.44	166.82
184.04	208.48	213.58	169.44	147.01	86	211.53	239.63	245.49	194.76	168.98
185.28	210.93	216.11	171.54	148.94	87	212.96	242.46	248.40	197.17	171.20
186.52	213.36	218.58	173.58	150.84	88	214.40	245.24	251.24	199.52	173.37
187.79	215.85	221.12	175.70	152.78	89	215.85	248.11	254.17	201.95	175.61
190.88	220.45	225.83	179.59	156.29	90	219.39	253.39	259.57	206.42	179.64
192.20	223.03	228.46	181.84	158.36	91	220.91	256.35	262.59	209.01	182.03
193.56	225.71	231.20	184.17	160.52	92	222.49	259.43	265.75	211.69	184.50
194.98	228.45	234.02	186.57	162.74	93	224.12	262.58	268.99	214.45	187.06
196.44	231.35	236.97	189.09	165.08	94	225.79	265.91	272.38	217.34	189.74
199.72	236.44	242.19	193.42	168.99	95	229.57	271.77	278.38	222.32	194.24
201.11	239.34	245.15	195.95	171.34	96	231.16	275.10	281.78	225.23	196.95
202.38	242.12	248.00	198.39	173.63	97	232.61	278.30	285.05	228.04	199.57
203.61	244.93	250.87	200.87	175.92	98	234.03	281.53	288.36	230.88	202.21
204.85	247.84	253.83	203.41	178.31	99	235.46	284.87	291.76	233.80	204.95

* 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: 770 through 777

Nonsmoker

Standard Plan A	Female				Attained Age	Male				
	Select					Standard Plan A	Select			
	Plan C	Plan F	Plan G	Plan N			Plan C	Plan F	Plan G	Plan N
319.36	N/A	N/A	N/A	N/A	<65	367.09	N/A	N/A	N/A	N/A
120.33	127.41	130.56	102.80	88.19	65	138.31	146.45	150.08	118.16	101.36
120.33	127.41	130.56	102.80	88.19	66	138.31	146.45	150.08	118.16	101.36
125.69	132.89	136.19	107.21	91.95	67	144.46	152.75	156.54	123.24	105.69
129.80	137.29	140.68	110.75	94.99	68	149.20	157.80	161.70	127.30	109.18
133.80	141.80	145.30	114.41	98.15	69	153.80	162.99	167.01	131.51	112.81
137.60	146.18	149.80	117.99	101.26	70	158.16	168.03	172.19	135.61	116.40
141.21	150.40	154.11	121.43	104.26	71	162.31	172.88	177.14	139.58	119.84
144.61	154.46	158.29	124.75	107.16	72	166.23	177.55	181.94	143.39	123.18
147.68	158.19	162.10	127.80	109.85	73	169.74	181.83	186.33	146.90	126.26
150.34	161.64	165.63	130.64	112.36	74	172.80	185.79	190.38	150.16	129.15
154.13	166.39	170.49	134.54	115.80	75	177.15	191.25	195.96	154.64	133.10
159.36	172.79	177.05	139.78	120.40	76	183.18	198.60	203.50	160.66	138.39
161.43	175.75	180.09	142.25	122.61	77	185.55	202.01	207.00	163.50	140.93
164.93	180.29	184.73	145.98	125.91	78	189.58	207.23	212.33	167.79	144.73
166.74	183.01	187.53	148.25	127.96	79	191.65	210.36	215.54	170.40	147.09
168.55	185.76	190.34	150.55	130.03	80	193.74	213.53	218.78	173.04	149.45
170.25	188.43	193.06	152.78	132.05	81	195.69	216.59	221.91	175.61	151.79
173.45	192.86	197.59	156.44	135.30	82	199.38	221.68	227.11	179.81	155.53
174.89	195.29	200.08	158.50	137.19	83	201.01	224.48	229.98	182.18	157.69
176.18	197.69	202.53	160.51	139.05	84	202.50	227.23	232.79	184.50	159.83
179.10	201.90	206.86	164.03	142.19	85	205.86	232.08	237.78	188.54	163.44
180.30	204.25	209.25	166.01	144.03	86	207.25	234.78	240.51	190.81	165.55
181.53	206.66	211.73	168.06	145.93	87	208.65	237.54	243.36	193.18	167.73
182.75	209.04	214.15	170.06	147.78	88	210.05	240.28	246.15	195.48	169.86
183.99	211.48	216.64	172.14	149.69	89	211.48	243.08	249.01	197.86	172.05
187.00	215.99	221.25	175.94	153.13	90	214.95	248.25	254.31	202.24	176.00
188.30	218.51	223.83	178.15	155.15	91	216.44	251.16	257.28	204.78	178.34
189.64	221.13	226.51	180.44	157.26	92	217.98	254.18	260.36	207.40	180.76
191.04	223.81	229.28	182.79	159.44	93	219.58	257.26	263.54	210.10	183.26
192.45	226.65	232.18	185.25	161.73	94	221.21	260.53	266.86	212.94	185.90
195.68	231.65	237.28	189.50	165.56	95	224.91	266.26	272.74	217.81	190.30
197.03	234.49	240.19	191.98	167.88	96	226.48	269.53	276.08	220.66	192.95
198.28	237.21	242.96	194.38	170.10	97	227.90	272.66	279.28	223.41	195.53
199.48	239.96	245.79	196.80	172.35	98	229.29	275.83	282.51	226.20	198.11
200.70	242.81	248.69	199.29	174.69	99	230.69	279.10	285.85	229.06	200.80

* 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: 770 through 777

Smoker

Standard Plan A	Female				Attained Age	Male				
	Select					Standard Plan A	Select			
	Plan C	Plan F	Plan G	Plan N			Plan C	Plan F	Plan G	Plan N
367.09	N/A	N/A	N/A	N/A	<65	421.94	N/A	N/A	N/A	N/A
138.31	146.45	150.08	118.16	101.36	65	158.98	168.34	172.50	135.83	116.51
138.31	146.45	150.08	118.16	101.36	66	158.98	168.34	172.50	135.83	116.51
144.46	152.75	156.54	123.24	105.69	67	166.05	175.58	179.93	141.65	121.48
149.20	157.80	161.70	127.30	109.18	68	171.49	181.38	185.86	146.33	125.49
153.80	162.99	167.01	131.51	112.81	69	176.78	187.34	191.98	151.16	129.68
158.16	168.03	172.19	135.61	116.40	70	181.80	193.13	197.91	155.88	133.79
162.31	172.88	177.14	139.58	119.84	71	186.56	198.70	203.61	160.43	137.75
166.23	177.55	181.94	143.39	123.18	72	191.06	204.08	209.13	164.81	141.59
169.74	181.83	186.33	146.90	126.26	73	195.10	208.99	214.16	168.85	145.13
172.80	185.79	190.38	150.16	129.15	74	198.63	213.55	218.83	172.60	148.45
177.15	191.25	195.96	154.64	133.10	75	203.63	219.83	225.24	177.75	152.99
183.18	198.60	203.50	160.66	138.39	76	210.55	228.28	233.91	184.68	159.06
185.55	202.01	207.00	163.50	140.93	77	213.28	232.20	237.93	187.94	161.99
189.58	207.23	212.33	167.79	144.73	78	217.90	238.19	244.05	192.86	166.35
191.65	210.36	215.54	170.40	147.09	79	220.29	241.80	247.75	195.86	169.06
193.74	213.53	218.78	173.04	149.45	80	222.69	245.43	251.46	198.90	171.79
195.69	216.59	221.91	175.61	151.79	81	224.93	248.95	255.08	201.85	174.46
199.38	221.68	227.11	179.81	155.53	82	229.16	254.80	261.05	206.69	178.76
201.01	224.48	229.98	182.18	157.69	83	231.05	258.01	264.34	209.40	181.25
202.50	227.23	232.79	184.50	159.83	84	232.76	261.18	267.58	212.06	183.71
205.86	232.08	237.78	188.54	163.44	85	236.63	266.75	273.30	216.71	187.86
207.25	234.78	240.51	190.81	165.55	86	238.21	269.85	276.45	219.33	190.29
208.65	237.54	243.36	193.18	167.73	87	239.83	273.04	279.73	222.04	192.79
210.05	240.28	246.15	195.48	169.86	88	241.44	276.18	282.93	224.69	195.24
211.48	243.08	249.01	197.86	172.05	89	243.08	279.40	286.23	227.43	197.76
214.95	248.25	254.31	202.24	176.00	90	247.06	285.35	292.31	232.45	202.30
216.44	251.16	257.28	204.78	178.34	91	248.78	288.69	295.71	235.38	204.99
217.98	254.18	260.36	207.40	180.76	92	250.55	292.15	299.26	238.39	207.78
219.58	257.26	263.54	210.10	183.26	93	252.39	295.70	302.91	241.50	210.65
221.21	260.53	266.86	212.94	185.90	94	254.26	299.45	306.74	244.75	213.68
224.91	266.26	272.74	217.81	190.30	95	258.53	306.05	313.49	250.36	218.74
226.48	269.53	276.08	220.66	192.95	96	260.31	309.80	317.33	253.64	221.79
227.90	272.66	279.28	223.41	195.53	97	261.95	313.40	321.00	256.80	224.74
229.29	275.83	282.51	226.20	198.11	98	263.55	317.04	324.73	260.00	227.71
230.69	279.10	285.85	229.06	200.80	99	265.16	320.80	328.56	263.29	230.80

* 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
HOSPITALIZATION* 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"> • While using 60 lifetime reserve days • Once lifetime reserve days are used: <ul style="list-style-type: none"> - Additional 365 days - Beyond the additional 365 days 	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
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 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
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$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 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
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 \$140 of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 Generally 80%	\$0 Generally 20%	\$140 (Part B Deductible) \$0
Part B Excess Charges (Above Medicare-approved amounts)	\$0	\$0	All costs
BLOOD 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
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

HOME HEALTH CARE MEDICARE-APPROVED SERVICES • 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.

For Medicare Select Plans, if you do not utilize a network provider, you are responsible for all charges.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* 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
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 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
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$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 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
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 \$140 of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 Generally 80%	\$140 (Part B Deductible) Generally 20%	\$0 \$0
Part B Excess Charges (Above Medicare-approved amounts)	\$0	\$0	All costs
BLOOD 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
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

HOME HEALTH CARE MEDICARE-APPROVED SERVICES • 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

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 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.

For Medicare Select Plans, if you do not utilize a network provider, you are responsible for all charges.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* 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"> • While using 60 lifetime reserve days • Once lifetime reserve days are used: <ul style="list-style-type: none"> - 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
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 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
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$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 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
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 \$140 of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 Generally 80%	\$140 (Part B Deductible) Generally 20%	\$0 \$0
Part B Excess Charges (Above Medicare-approved amounts)	\$0	100%	\$0
BLOOD 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
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

HOME HEALTH CARE MEDICARE-APPROVED SERVICES <ul style="list-style-type: none"> • Medically necessary skilled care services and medical supplies • Durable medical equipment <ul style="list-style-type: none"> - 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

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 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.

For Medicare Select Plans, if you do not utilize a network provider, you are responsible for all charges.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* 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"> • While using 60 lifetime reserve days • Once lifetime reserve days are used: <ul style="list-style-type: none"> - 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
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 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
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$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 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
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 \$140 of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 Generally 80%	\$0 Generally 20%	\$140 (Part B Deductible) \$0
Part B Excess Charges (Above Medicare-approved amounts)	\$0	100%	\$0
BLOOD 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
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

HOME HEALTH CARE MEDICARE-APPROVED SERVICES • 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

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 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.

For Medicare Select Plans, if you do not utilize a network provider, you are responsible for all charges.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* 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"> • While using 60 lifetime reserve days • Once lifetime reserve days are used: <ul style="list-style-type: none"> - 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
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 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
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$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 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
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUT-PATIENT 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 \$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.
Part B Excess Charges (Above Medicare-approved amounts)	\$0	\$0	All costs
BLOOD 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
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PLAN N

PARTS A & B

HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
• 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

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