An Absolute Broker

FAX/MAIL COVER LETTER

**Please FAX or MAIL this cover letter with the completed application to:

An Absolute Broker (mailing address below)

FAX# 775.522.7777

Dear An Absolute Broker,

Please accept my completed application for submittal and contact me to confirm receipt of this application

Name _____

E-mail _____

Date _____

Time _____

☐ Please contact me at this phone number _____ after you have reviewed my application for completeness and accuracy.

☐ I will contact An Absolute Broker at 910.232.4964 to verify receipt of my application.

**I understand that An Absolute Broker will not review this application until the following business day if I faxed this application after 5:00PM or on a weekend

I understand that the original, signed application and premium payment must still be mailed to An Absolute Broker. :

An Absolute Broker
Attn: New Enrollment
1319 Millitary Cutoff Rd #188
Wilmington, NC 28405

I will send the original, signed application and premium payment, as soon as I have been contacted by An Absolute Broker with confirmation that my application has been received by fax and reviewed for completeness.

FAMILY LIFE INSURANCE COMPANY

Home Office: Houston, TX **Medicare Supplement Administrative Office: P. O. Box 924408, Houston, TX 77292-4408**

APPLICATION FOR MEDICARE SUPPLEMENT INSURANCE

APPLICATION #:

APPLICANT	**RESIDENCE ADDRESS**
	Street:
Check the Medicare Supplement Plan You Prefer: ☐ **Standardized Plan A** ☐ **Standardized Plan F** ☐ **Standardized Plan B** ☐ **Standardized Plan G** ☐ **Standardized Plan C** ☐ **Standardized Plan M** ☐ **Standardized Plan D** ☐ **Standardized Plan N**	*City:* *State:* *Zip Code:*

MEDICARE INFORMATION	**MAILING ADDRESS**
Date first enrolled in Medicare Part B:_____ **Medicare Claim Number:** _____ ***(Please include Alpha Character)***	*Street:* *City:* *State:* *Zip Code:*

AGE	**DATE OF BIRTH**	**SEX**

SOCIAL SECURITY NUMBER

AREA CODE	**TELEPHONE NUMBER**

HEIGHT	**WEIGHT**

Effective Date:	***Special Requests:***

SPOUSE	**Spouse's Medicare Claim Number:**

UNDERWRITING RISK CLASSIFICATION QUESTION

Have you used any form of tobacco in the past five years?

☐ Yes ☐ No

(You do not have to answer this question if you are applying during open enrollment or a guaranteed issue period.)

MODAL PREMIUM: **$** _____

SPOUSAL DISCOUNT: **$** _____
(IF APPLICABLE)

POLICY FEE: **$ 25.00**

TOTAL INITIAL PREMIUM: **$** _____

PLEASE SELECT THE METHOD OF PAYMENT YOU WANT

☐ Bank Draft ☐ Annual ☐ Semiannual ☐ Quarterly ☐ Monthly Bank Draft

PART I – HEALTH QUESTIONS

YOU ARE *NOT REQUIRED* TO ANSWER HEALTH QUESTIONS 1-14 IF YOU ARE IN OPEN ENROLLMENT OR A GUARANTEED ISSUE PERIOD. PLEASE SEE PAGE FOUR FOR AN EXPLANATION OF OPEN ENROLLMENT/GUARANTEED ISSUE PERIOD INFORMATION.

IF YOU ANSWER "YES" TO ANY OF THE HEALTH QUESTIONS 1-14, YOU MAY NOT BE ELIGIBLE FOR COVERAGE.

1.	Are you bedridden or confined to a wheelchair or require the assistance of a motorized mobility aid; or in the past two years have you suffered two or more falls within a six month period?	☐ Yes	☐ No
2.	Are you currently hospitalized or confined to a nursing facility; or have you been hospitalized two or more times within the past year?	☐ Yes	☐ No
3.	In the past two years, has surgery or tests been advised by a physician but not performed?	☐ Yes	☐ No
4.	Is surgery anticipated in the next twelve months?	☐ Yes	☐ No
5.	Within the past two years have you had an amputation caused by disease?	☐ Yes	☐ No

PART I – HEALTH QUESTIONS CONTINUED

6.	Do you have now, or during the past five years have you received medical treatment, or been advised to have treatment, surgery or medication for any of the following:		
	a. Parkinson's Disease, Myasthenia Gravis, Multiple or Amyotrophic Lateral Sclerosis, Muscular Dystrophy, Alzheimer's Disease, or any other cognitive disorder?	☐ Yes	☐ No
	b. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or Human immunodeficiency virus (HIV) infection?	☐ Yes	☐ No
	c. Diabetes that has required more than 50 units of insulin daily or more than two medications (insulin or oral), Chronic Kidney Disease or Insufficiency, or Renal Failure requiring dialysis?	☐ Yes	☐ No
	d. Emphysema, Chronic Obstructive Pulmonary Disease (COPD), or any Chronic Pulmonary condition?	☐ Yes	☐ No
	e. Internal Cancer, Leukemia, Malignant Melanoma, Hodgkin's Disease, or Lymphoma?	☐ Yes	☐ No
	f. Congestive Heart Failure (CHF), heart attack, Coronary or Carotid Artery Disease, Peripheral Vascular Disease, Stroke or Transient Ischemic Attack (TIA)?	☐ Yes	☐ No
7.	Within the past two years have you had atrial fibrillation, heart valve surgery, cardiac pacemaker replaced or implanted, or been treated with a heart defibrillating device?	☐ Yes	☐ No
8.	Within the past two years have you had, or been treated for, or has treatment been recommended by a physician for Cirrhosis of the Liver, Hepatitis, Alcohol or Drug Abuse, or Systemic Lupus?	☐ Yes	☐ No
9.	Have you had an organ transplant or been advised to have an organ transplant?	☐ Yes	☐ No
10.	Are you currently using the services of a home health care agency?	☐ Yes	☐ No
11.	Do you require or receive any assistance with any of your activities of daily living such as transferring, bathing, toileting, eating, dressing, or continence?	☐ Yes	☐ No
12.	Within the past two years have you had, or been treated for, or has treatment been recommended by a physician for Disabling Arthritis, Paget's Disease of the bone, or Rheumatoid Arthritis?	☐ Yes	☐ No
13.	Do you now, or during the past five years have you received medical treatment, or been advised to have treatment, surgery or medication for Osteoporosis with fracture?	☐ Yes	☐ No
14.	Are you diabetic, and if so do you have or have you been treated for any of the following conditions: diabetic retinopathy, peripheral vascular disease, kidney disease, kidney failure, neuropathy, stroke, congestive heart failure, heart condition, or high blood pressure treated with more than two medications?	☐ Yes	☐ No

Do you take prescription medications? If yes, please list below all the prescription medications you are currently taking. Attach an additional sheet if necessary. ☐ Yes ☐ No

Prescription Medication Name	Date Originally Prescribed	Frequency and Dosage	**Diagnosis/Onset Date

**** PLEASE DO NOT LIST WATER PILL, WATER RETENTION, FLUID RETENTION OR BLOOD THINNER AS THESE ARE NOT MEDICAL CONDITIONS AND WILL REQUIRE A TELEPHONE INTERVIEW.**

Primary Physician Information

Name:

Address:

CITY: **STATE:** **ZIP:**

Telephone:

Did you turn age 65 in the last 6 months? ☐ Yes ☐ No

Did you enroll in Medicare Part B in the last 6 months? ☐ Yes ☐ No If yes, what is the effective date? _____

PART II – MEDICAL COVERAGE REPLACEMENT (MUST BE COMPLETED)

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare Supplement policy, or that you had certain rights to buy such a policy you may be guaranteed acceptance in one or more of our Medicare Supplement plans. Please include a copy of the notice from your prior insurer with our application. PLEASE ANSWER ALL QUESTIONS. Please Mark Yes or No with an "X."

To the best of your knowledge:

1. Are you covered for medical assistance through the state Medicaid program? ☐ Yes ☐ No

   NOTE TO APPLICANT: If you are participating in a "Spend-Down" program and have not met your "Share of Cost," please answer NO to this question.

   IF YES,

   (a) Will Medicaid pay your premiums for this Medicare Supplement policy? ☐ Yes ☐ No

   (b) Do you receive any benefits from Medicaid OTHER THAN payment toward your Medicare Part B premium? ☐ Yes ☐ No

2. (a) If you had coverage from any Medicare plan other than original Medicare within the last 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO) fill in your start and end dates. START _____ END _____

   (b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy? ☐ Yes ☐ No

   (c) Was this your first time in this type of Medicare plan? ☐ Yes ☐ No

   (d) Did you drop a Medicare Supplement plan to enroll in the Medicare plan? ☐ Yes ☐ No

3. (a) Do you have another Medicare Supplement policy in force? ☐ Yes ☐ No

   (b) If so, with which company: _____

   with which plan: _____

   and what paid-to-date do you have? _____

   (c) If so, do you intend to replace your current Medicare Supplement policy with this policy? ☐ Yes ☐ No

4. Have you had coverage under any other health insurance within the past 63 days (for example, an employer, union, or individual plan)? ☐ Yes ☐ No

   (a) If yes, with what company, what kind of policy and reason for termination?

   _____

   (b) What are your dates of coverage under the other policy? START _____ END _____

IMPORTANT STATEMENTS TO BE READ AND SIGNED BY THE APPLICANT

(1) You do not need more than one Medicare Supplement Insurance Policy.

(2) If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

(3) You may be eligible for benefits under Medicaid and may not need a Medicare Supplement Insurance Policy.

(4) If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement Insurance Policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted, if requested, within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.

(5) If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available a substantially equivalent policy) will be reinstituted, if requested, within 90 days of losing your employer or union based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.

(6) Counseling services may be available in your state to provide advice concerning your purchase of a Medicare Supplement Insurance policy and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

OPEN ENROLLMENT/GUARANTEED ISSUE PERIOD INFORMATION

Open Enrollment: You are eligible for Open Enrollment and will not need to answer Health Questions 1-14 on Pages 1 and 2 of this application if (a) you are within six months of purchasing Medicare Part B coverage for the first time; or (b) you were eligible for early Medicare and you are within six months of turning age 65; or (c) you were retroactively enrolled in Medicare Part B due to a retroactive eligibility decision made by the Social Security Administration and you are applying within a six month period beginning with the month in which you received notification of the retroactive eligibility decision.

Guaranteed Issue For Eligible Persons Under the Balanced Budget Act of 1997: The following are definitions of the categories of individuals who are eligible for Guaranteed Issue under the Balanced Budget Act of 1997:

(a) Enrolled under an employee welfare benefit plan that either: (1) supplements Medicare, and the plan terminates, or the plan ceases to provide all such supplemental health benefits; or (2) is primary to Medicare and the plan terminates or the plan ceases to provide all health benefits to the individual because the individual leaves the plan; or

(b) Enrolled in a Medicare Advantage plan or Program of All-Inclusive Care for the Elderly (PACE) and the organization's certification or plan is terminated or specific circumstances permit discontinuance including, but not limited to, a change in residence of the individual, the plan is terminated within a residence area, the organization substantially violated a material policy provision, or a material misrepresentation was made to the individual; or

(c) Enrolled in a Medicare risk contract, health care prepayment plan, cost contract or Medicare Select plan, or similar organization, and the organization's certification or plan is terminated or specific circumstances permit discontinuance including, but not limited to, a change in residence of the individual, the plan is terminated within a residence area, the organization substantially violated a material policy provision, or a material misrepresentation was made to the individual; or

(d) Enrolled in a Medicare Supplement policy and coverage discontinues due to insolvency or other involuntary termination of coverage under the policy, substantial violation of a material policy provision, or material misrepresentation; or

(e) Enrolled under a Medicare Supplement policy, terminates and enrolls for the first time in a Medicare Advantage plan, a risk or cost contract, a Medicare Select plan, or a PACE provider, and then the insured person terminates coverage within 12 months of enrollment; or

(f) Upon *first* becoming eligible for benefits under Part A at age 65, you enrolled in a Medicare Advantage plan or PACE provider and then you disenroll within 12 months; or

(g) Lost eligibility for health benefits under Medicaid.

Documentation of these events must be submitted with the application. You must apply within 63 days of the date of termination of previous coverage in order to qualify as an eligible person.

AUTHORIZATION AND CERTIFICATION

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager or other medical facility, insurance or reinsurance company, Medical Information Bureau (MIB), consumer reporting agency, Division of Motor Vehicles, the Veterans Administration or other medical or medically-related facility, insurance company or other organization, institution or person including Medicare, that has any records or knowledge of me or my health or having any non-medical information concerning me to give Family Life Insurance Company, or its reinsurers, any such information. All information used or disclosed pursuant to authorization may be subject to redisclosure by the recipient and may no longer be protected. I understand that I am authorizing Family Life Insurance Company to receive my health information, prescription drug usage history and my non-medical information. I understand that prescription drug usage may be used to verify the presence of certain medical conditions and that such history will not be used to decline coverage. These medical conditions will be confirmed by a telephone interview prior to being used in the underwriting process. The released information received by Family Life Insurance Company will remain protected by federal and/or state regulations as long as it is maintained by the health plan. Medical information will not be used to decline coverage if you are applying during an open enrollment or guaranteed issue period.

I understand that the information requested is necessary for evaluation and underwriting of my application for the Medicare Supplement Insurance Policy for which I have applied; to determine eligibility for insurance, risk rating or policy issue determinations; obtain reinsurance; administer claims and determine or fulfill responsibility for coverage and provision of benefits; and to conduct other legally permissible activities that relate to any coverage I have, or have applied for, with Family Life Insurance Company. I understand that telephone interviews may be a part of the application process and that any information obtained from such telephone interviews may be used to decline my application for coverage. I understand that failure to provide the authorization to Family Life Insurance Company *will* result in the rejection of the Medicare Supplement Insurance Policy coverage. I understand that I may revoke this authorization at any time by notifying Family Life Insurance Company in writing at their Medicare Supplement Administrative Office: P.O. Box 924408, Houston, Texas 77292-4408. I understand that such revocation will not have any effect on actions Family Life Insurance Company took prior to their receiving the revocation notice. I understand that this authorization will be valid for thirty (30) months from the date signed. A photocopy of this authorization will be treated in the same manner as the original.

To the best of my knowledge and belief, all of the answers to the questions contained in this application are true and complete and I understand and agree that: (a) the insurance shall not take effect unless and until the application has been accepted and approved by the Company, the full first premium has been paid, and the policy has been delivered to the applicant; and (b) oral statements between the agent and myself are not binding on the Company unless accepted by the Company in writing. The undersigned applicant certifies that the applicant has read, or had read to him, the completed application and that he realizes that any false statements or misrepresentations therein material to the risk may result in loss of coverage under the policy to which this application is a part.

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application, or files a claim containing a false or deceptive statement, may be guilty of insurance fraud.

I acknowledge receiving: (a) an Outline of Coverage for the policy applied for, and (b) a "Guide to Health Insurance for People with Medicare."

Signed At: _____
(City /State)

Dated: _____ Applicant's Signature:_____
(Month/Day/Year) (Please Enter Mother's Maiden Name)

AGENT'S CERTIFICATION

The undersigned Agent certifies that the Applicant has read, or had read to the Applicant, the completed application and that the Applicant realizes that any false statement or misrepresentation in the application may result in loss of coverage under the policy.

TO BE COMPLETED BY AGENT (Attach separate sheet, if necessary)

1. List any other health insurance policy you have sold to the Applicant that is still in force.

_____
_____
_____
_____

2. List any other health insurance policy you have sold to the Applicant in the past five (5) years that is no longer in force.

_____
_____
_____
_____

I certify that:

1. I have truly and accurately recorded the information supplied by the Applicant on the application; and
2. I have given an outline of coverage for the policy applied for and a Guide To Health Insurance for People With Medicare to the Applicant.

Agent's Signature:	**Date:**
	AI01997
Agent's Printed Name:	**Agent No.:**

AUTHORIZATION

IN FAVOR OF: **Family Life Insurance Company**

Administrative office **P.O. Box 924408, Houston, Texas 77292-4408**

Name of Bank Customer: **Policy Numbers**

Insured's Name:

Account Number : **Routing Number:**

☐ **Checking**
☐ **Savings**

To (Name of Bank):

Address of Bank:

You are hereby authorized, as a convenience to me, to honor and charge my account for checks, drafts and other orders, including without limitation any order initiated by electronic means, drawn by The Company indicated above, (hereinafter referred to as THE COMPANY), on my account by and payable to the order of The Company for the payment of premiums provided there are sufficient collected funds in such account to pay the same upon presentation. I agree that your rights in respect to each such check or other order drawn by The Company shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice I agree that you shall be fully protected in honoring any such check or other orders drawn by The Company. I further agree that if any such checks or other orders drawn by The Company be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in forfeiture of insurance.

Date **Signature of Depositor**

(Please Enter Mother's Maiden Name)

Signature must be the same as on the signature card at bank, and if a company account the name of the account must be shown.

AUTHORIZATION

To: **The Bank above**

In consideration of your compliance with the individual authorization of your depositors to pay checks, drafts or orders, drawn and signed by us to our order, we agree:

- To indemnify you and hold you harmless from any loss you may suffer as a consequence of your actions resulting from or in connection with the execution and issuance of any check, draft or order, whether or not genuine, purporting to be executed and received by you in the regular course of business for the purpose of payment of such insurance premiums including any costs or expenses reasonably incurred in connection therewith.
- In the event that any such check, draft or order shall be dishonored, whether with or without cause, and whether intentionally or inadvertently, to indemnify you for such loss even though dishonor results in forfeiture of the insurance.
- To defend at our own cost and expense any action which might be brought by any depositor or any other persons because of your actions taken pursuant to said authorization and direction or in any manner arising by reason of your participation in this plan of premium collection.

(Attach Voided Check)

AUTHORITY TO HONOR PREMIUM CHECKS

NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE OR MEDICARE ADVANTAGE

FAMILY LIFE INSURANCE COMPANY

Home Office: Houston, Texas

Administrative Office: P. O. Box 924408 Houston, Texas 77292-4408

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE

According to your application, you intend to terminate existing Medicare supplement or Medicare Advantage insurance and replace it with a policy to be issued by Family Life Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the certificate.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision, you should terminate your present Medicare supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY AGENT:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason (check one):

☐ Additional benefits.

☐ No change in benefits, but lower premiums.

☐ Fewer benefits and lower premiums.

☐ Change in benefits. **(Gaining additional benefit(s) but losing some existing benefit(s)).**

☐ My plan has outpatient drug coverage and I am enrolling in Part D.

☐ Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment.

_____

☐ Other (please specify) _____

If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

AI01997

Signature of Agent, Broker or Other Representative

Mark Sheffield --- 1319 Military Cutoff Rd, #188 Wilmington, NC 28405

Typed Name and Address of Agent

The above “Notice to Applicant” was delivered to me on:

Applicant’s Signature (Please Enter Mother's Maiden Name) Date

MSREPL200810

10700 Northwest Freeway
Houston, Texas 77092

Application For:
Medicare Supplement Insurance Coverage
(print clearly in blue or black ink)

SSN:

Name: _____

UNDERWRITING AUTHORIZATION (Applicant)

I hereby authorize any licensed physician, medical practitioner, pharmacy, or pharmacy related facility, hospital, clinic, or other medical or medically related facility, insurance or reinsuring company, the Ingenix, or other organization, institution or person having any record of me available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me and any other non-medical information of me to give to Family Life Insurance Company, it's reinsurers or its legal representative, or any medical or pharmaceutical records retrieval service Family Life Insurance Company may engage, any and all such information as permitted by law and the rules of Ingenix. I also authorize any consumer reporting agency to prepare or procure an investigative consumer report on me. I understand the information obtained by use of the Authorization will be used by Family Life Insurance Company to determine eligibility for insurance and/or eligibility for benefits. I agree that a photographic copy or a facsimile of this Authorization shall be as valid as the original. I or my authorized representative is entitled to a copy of the authorization. This authorization will remain valid for twenty-four (24) months and may be revoked at any time. The revocation of the authorization must be submitted in writing.

This authorization includes any and all information you may have about me, including, but not limited to information regarding diagnosis, testing, treatment, and prognosis of my physical or mental condition as well as alcohol abuse treatment, drug abuse treatment, psychiatric treatment, pharmacy prescriptions, HIV testing and treatment, STD testing and treatment, sickle cell testing and treatment, lab data, and EKGs. This information may also be disclosed to any medical records company engaged by Family Life Insurance Company, including, but not limited to Ingenix and its agents. Although federal regulations require that we inform you of the potential that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by such regulation, all information received by Family Life Insurance Company pursuant to this authorization will be protected by federal and state privacy laws and regulations.

I understand that this authorization is required in order to enable Family Life Insurance Company to make eligibility, enrollment, benefit determinations, and underwriting and risk rating determinations relating to. If I refuse to sign or revoke this authorization, Family Life Insurance Company may refuse to consider my application for enrollment.

Signature: _____

Date: _____

Submit

PLEASE RETAIN A COPY FOR YOUR RECORDS

FAMILY LIFE INSURANCE COMPANY
Outline of Medicare Supplement Coverage-Cover Page
Benefit Plans A, B, C, D, F, G, M AND N

These charts show the benefits included in each of the standard Medicare supplement plans. Every company must make available Plan "A." Some plans may not be available in your state. Family Life Insurance Company offers six of the fourteen plans available.

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

A	B	C	D	F	F*	G	K	L	M	N
Basic Benefits, including 100% Part B coinsurance	Basic Benefits, including 100% Part B coinsurance	Basic Benefits, including 100% Part B coinsurance	Basic Benefits, including 100% Part B coinsurance	Basic Benefits, including 100% Part B coinsurance*		Basic Benefits, including 100% Part B coinsurance	Hospitalization and preventative care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventative care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance, except up to $20 copayment for office visit, and up to $50 copayment for ER
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance		Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible		Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Part B Deductible		Part B Deductible						
				Part B Excess (100%)		Part B Excess (100%)				
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency		Foreign Travel Emergency			Foreign Travel Emergency	Foreign Travel Emergency
							Out-of-pocket limit $[4620]; paid at 100% after limit reached	Out-of-pocket limit $[2310]; paid at 100% after limit reached		

***Plans F also have 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 $[2000] deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed $[2000]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare Deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.**

Family Life Insurance Company
Annual Preferred Premium Rates
FOR USE IN NORTH CAROLINA ZIP CODES
ALL OF STATE

Attained	Female								Male							
Age	Plan A	Plan B	Plan C	Plan D	Plan F	Plan G	Plan M	Plan N	Plan A	Plan B	Plan C	Plan D	Plan F	Plan G	Plan M	Plan N
0-64	1,527	N/A	2,170	N/A	N/A	N/A	N/A	N/A	1,756	N/A	2,496	N/A	N/A	N/A	N/A	N/A
65	875	1,064	1,221	1,116	1,272	1,121	1,005	890	1,006	1,224	1,404	1,283	1,463	1,290	1,155	1,024
66	875	1,064	1,221	1,116	1,272	1,121	1,005	890	1,006	1,224	1,404	1,283	1,463	1,290	1,155	1,024
67	918	1,116	1,283	1,170	1,328	1,177	1,054	930	1,055	1,283	1,475	1,346	1,528	1,354	1,211	1,070
68	960	1,167	1,340	1,223	1,381	1,230	1,100	967	1,103	1,342	1,541	1,407	1,589	1,415	1,266	1,112
69	1,000	1,217	1,398	1,275	1,436	1,283	1,148	1,005	1,150	1,399	1,607	1,467	1,653	1,474	1,321	1,157
70	1,040	1,266	1,456	1,328	1,494	1,335	1,195	1,046	1,197	1,456	1,675	1,527	1,718	1,535	1,374	1,203
71	1,080	1,314	1,516	1,378	1,554	1,385	1,240	1,088	1,243	1,511	1,744	1,586	1,787	1,593	1,427	1,251
72	1,120	1,362	1,577	1,429	1,615	1,436	1,286	1,131	1,288	1,568	1,814	1,644	1,857	1,652	1,479	1,301
73	1,159	1,410	1,638	1,478	1,678	1,487	1,330	1,174	1,333	1,621	1,884	1,701	1,929	1,709	1,530	1,351
74	1,198	1,457	1,696	1,528	1,734	1,536	1,375	1,214	1,378	1,676	1,949	1,757	1,993	1,767	1,581	1,396
75	1,236	1,503	1,752	1,576	1,788	1,585	1,418	1,251	1,421	1,729	2,015	1,813	2,057	1,822	1,631	1,440
76	1,272	1,549	1,805	1,624	1,840	1,631	1,461	1,288	1,464	1,780	2,075	1,867	2,116	1,876	1,681	1,481
77	1,308	1,591	1,855	1,669	1,888	1,678	1,502	1,321	1,505	1,831	2,134	1,920	2,172	1,929	1,728	1,520
78	1,343	1,634	1,905	1,714	1,934	1,722	1,543	1,354	1,545	1,880	2,190	1,970	2,224	1,981	1,774	1,557
79	1,375	1,672	1,949	1,754	1,979	1,762	1,578	1,385	1,581	1,923	2,242	2,016	2,276	2,026	1,815	1,593
80	1,405	1,708	1,991	1,792	2,020	1,800	1,612	1,414	1,615	1,965	2,290	2,061	2,322	2,072	1,854	1,625
81	1,433	1,743	2,032	1,827	2,058	1,837	1,644	1,440	1,647	2,004	2,336	2,101	2,366	2,113	1,891	1,657
82	1,459	1,775	2,070	1,860	2,094	1,871	1,674	1,466	1,678	2,041	2,381	2,139	2,408	2,152	1,926	1,686
83	1,484	1,804	2,105	1,892	2,127	1,902	1,703	1,489	1,705	2,075	2,421	2,176	2,446	2,188	1,958	1,713
84	1,505	1,832	2,138	1,920	2,158	1,929	1,728	1,511	1,731	2,106	2,460	2,208	2,481	2,220	1,987	1,737
85	1,527	1,857	2,170	1,948	2,188	1,958	1,753	1,531	1,756	2,137	2,496	2,239	2,516	2,252	2,015	1,761
86	1,548	1,882	2,197	1,973	2,214	1,985	1,776	1,549	1,779	2,164	2,527	2,270	2,546	2,282	2,043	1,782
87	1,565	1,903	2,222	1,996	2,239	2,005	1,796	1,568	1,799	2,189	2,556	2,295	2,575	2,308	2,065	1,802
88	1,581	1,924	2,246	2,016	2,264	2,027	1,815	1,585	1,818	2,212	2,584	2,319	2,603	2,331	2,087	1,822
89	1,595	1,941	2,267	2,035	2,283	2,046	1,832	1,598	1,835	2,233	2,607	2,340	2,626	2,352	2,106	1,838
90	1,610	1,958	2,285	2,052	2,300	2,063	1,847	1,610	1,851	2,252	2,627	2,360	2,645	2,373	2,124	1,852
91	1,622	1,973	2,301	2,068	2,314	2,080	1,861	1,620	1,865	2,269	2,646	2,378	2,662	2,391	2,140	1,863
92	1,633	1,987	2,314	2,082	2,328	2,094	1,874	1,630	1,878	2,285	2,662	2,396	2,678	2,409	2,157	1,874
93	1,644	2,000	2,328	2,098	2,341	2,108	1,888	1,639	1,891	2,300	2,677	2,411	2,692	2,424	2,170	1,885
94	1,655	2,013	2,339	2,111	2,352	2,121	1,900	1,646	1,903	2,314	2,690	2,427	2,705	2,440	2,185	1,893
95	1,664	2,025	2,348	2,123	2,361	2,134	1,911	1,653	1,914	2,329	2,702	2,441	2,715	2,454	2,196	1,901
96	1,673	2,036	2,358	2,134	2,369	2,145	1,920	1,659	1,925	2,340	2,711	2,454	2,726	2,467	2,209	1,908
97	1,681	2,043	2,364	2,142	2,378	2,155	1,929	1,664	1,932	2,350	2,719	2,464	2,734	2,478	2,218	1,914
98	1,685	2,051	2,370	2,151	2,385	2,162	1,936	1,669	1,939	2,359	2,727	2,473	2,742	2,486	2,226	1,919
99	1,690	2,055	2,374	2,155	2,388	2,167	1,939	1,672	1,944	2,364	2,730	2,478	2,746	2,492	2,230	1,923

Premium payable other than annual will be determined according to the following factors:

Semi Annual	Quarterly	Monthly
1/2	1/4	1/12

A discount factor of .93 is applied for married applicants.
There is a one time $25.00 policy fee.

Family Life Insurance Company
Annual Standard Premium Rates
FOR USE IN NORTH CAROLINA ZIP CODES
ALL OF STATE

Attained	Female								Male							
Age	Plan A	Plan B	Plan C	Plan D	Plan F	Plan G	Plan M	Plan N	Plan A	Plan B	Plan C	Plan D	Plan F	Plan G	Plan M	Plan N
0-64	1,697	N/A	2,411	N/A	N/A	N/A	N/A	N/A	1,951	N/A	2,772	N/A	N/A	N/A	N/A	N/A
65	973	1,183	1,357	1,240	1,414	1,246	1,116	990	1,118	1,360	1,560	1,426	1,625	1,434	1,283	1,138
66	973	1,183	1,357	1,240	1,414	1,246	1,116	990	1,118	1,360	1,560	1,426	1,625	1,434	1,283	1,138
67	1,020	1,241	1,426	1,300	1,475	1,307	1,169	1,033	1,172	1,426	1,639	1,495	1,698	1,503	1,346	1,188
68	1,066	1,297	1,489	1,359	1,535	1,367	1,224	1,074	1,226	1,491	1,712	1,564	1,765	1,572	1,407	1,236
69	1,112	1,351	1,553	1,416	1,597	1,425	1,275	1,118	1,279	1,554	1,785	1,629	1,836	1,639	1,467	1,285
70	1,156	1,407	1,619	1,475	1,660	1,483	1,328	1,162	1,330	1,618	1,861	1,696	1,910	1,705	1,527	1,337
71	1,201	1,461	1,684	1,530	1,726	1,540	1,378	1,208	1,381	1,680	1,937	1,760	1,986	1,771	1,585	1,391
72	1,245	1,514	1,752	1,587	1,795	1,596	1,429	1,256	1,432	1,741	2,015	1,825	2,063	1,835	1,643	1,444
73	1,287	1,567	1,820	1,643	1,864	1,652	1,478	1,304	1,482	1,801	2,094	1,889	2,143	1,899	1,700	1,500
74	1,331	1,619	1,885	1,698	1,926	1,706	1,528	1,348	1,530	1,862	2,167	1,952	2,215	1,963	1,758	1,550
75	1,373	1,670	1,947	1,752	1,987	1,760	1,577	1,391	1,579	1,921	2,239	2,014	2,286	2,024	1,813	1,600
76	1,414	1,720	2,005	1,804	2,044	1,813	1,624	1,431	1,626	1,978	2,306	2,074	2,350	2,085	1,867	1,645
77	1,454	1,769	2,062	1,854	2,098	1,864	1,669	1,469	1,672	2,034	2,371	2,132	2,413	2,144	1,919	1,689
78	1,492	1,816	2,116	1,903	2,150	1,914	1,713	1,505	1,717	2,088	2,434	2,190	2,472	2,201	1,971	1,730
79	1,528	1,858	2,166	1,948	2,199	1,959	1,753	1,540	1,757	2,137	2,492	2,240	2,529	2,252	2,016	1,770
80	1,561	1,898	2,213	1,990	2,244	2,001	1,792	1,570	1,795	2,183	2,544	2,289	2,580	2,301	2,060	1,806
81	1,592	1,936	2,257	2,030	2,287	2,041	1,827	1,601	1,831	2,227	2,596	2,335	2,630	2,347	2,101	1,841
82	1,621	1,972	2,300	2,067	2,327	2,079	1,860	1,628	1,864	2,268	2,645	2,377	2,676	2,390	2,139	1,873
83	1,647	2,005	2,339	2,101	2,363	2,113	1,891	1,654	1,895	2,306	2,690	2,417	2,717	2,429	2,176	1,902
84	1,672	2,035	2,377	2,133	2,397	2,144	1,920	1,678	1,924	2,340	2,733	2,453	2,757	2,466	2,208	1,929
85	1,697	2,063	2,411	2,164	2,430	2,176	1,948	1,701	1,951	2,373	2,772	2,488	2,795	2,501	2,239	1,956
86	1,720	2,091	2,442	2,193	2,460	2,204	1,973	1,721	1,977	2,405	2,807	2,521	2,829	2,536	2,270	1,981
87	1,739	2,115	2,470	2,217	2,487	2,230	1,996	1,741	2,000	2,432	2,841	2,550	2,860	2,564	2,295	2,003
88	1,757	2,138	2,497	2,241	2,516	2,253	2,017	1,761	2,021	2,458	2,870	2,576	2,892	2,591	2,319	2,024
89	1,773	2,157	2,518	2,261	2,537	2,273	2,035	1,777	2,039	2,480	2,897	2,600	2,918	2,614	2,340	2,043
90	1,788	2,176	2,538	2,281	2,556	2,293	2,053	1,789	2,056	2,501	2,919	2,622	2,938	2,637	2,360	2,057
91	1,801	2,193	2,556	2,298	2,573	2,310	2,068	1,801	2,073	2,521	2,940	2,643	2,957	2,657	2,379	2,070
92	1,815	2,208	2,573	2,314	2,587	2,327	2,082	1,811	2,087	2,539	2,957	2,662	2,975	2,677	2,396	2,082
93	1,827	2,222	2,587	2,330	2,601	2,343	2,098	1,821	2,101	2,556	2,974	2,679	2,992	2,694	2,411	2,094
94	1,838	2,236	2,599	2,346	2,613	2,358	2,111	1,830	2,115	2,573	2,990	2,696	3,005	2,711	2,426	2,103
95	1,850	2,250	2,610	2,359	2,623	2,371	2,123	1,836	2,127	2,588	3,001	2,713	3,016	2,727	2,442	2,112
96	1,859	2,261	2,619	2,371	2,633	2,384	2,134	1,843	2,138	2,601	3,012	2,727	3,028	2,742	2,455	2,119
97	1,867	2,271	2,627	2,381	2,642	2,394	2,142	1,850	2,146	2,612	3,022	2,737	3,037	2,753	2,463	2,126
98	1,873	2,279	2,634	2,388	2,650	2,402	2,150	1,854	2,155	2,620	3,029	2,747	3,048	2,762	2,473	2,134
99	1,877	2,284	2,638	2,395	2,654	2,407	2,156	1,858	2,158	2,627	3,034	2,754	3,051	2,768	2,479	2,136

Premium payable other than annual will be determined according to the following factors:

Semi Annual	Quarterly	Monthly
1/2	1/4	1/12

A discount factor of .93 is applied for married applicants.
There is a one time $25.00 policy fee.

PREMIUM INFORMATION

Family Life Insurance Company may change your premium if a new table of rates is applicable to the policy. The change in the table of rates will apply to all covered persons in the same class on the date of change. Class is defined as attained age, underwriting class, state and zip code of residence.

Premiums are based on your attained age and will change on Your Policy Anniversary Date.

Premiums are based on your attained age and will change on Your Policy Anniversary Date. The following illustration reflects the increase in premium due to age over a period of 10 years*. (This information is based on the annual rates in the outline for Plan B and the individual being a 65 year old Male Non Smoker at the time of issue. Rate increases can also be applied in the future).*

Age	**65**	**66**	**67**	**68**	**69**	**70**	**71**	**72**	**73**	**74**	**75**
Premium	$1,224	$1,224	$1,283	$1,342	$1399	$1,456	$1,511	$1,568	$1,621	$1,676	$1,729

Premiums for other Medicare supplement policies that are issue age or community rated do not increase due to changes in the policyholder's age.

You should compare other Medicare Supplement policies that are issue age bases to policies of attained age bases. While the cost of the policy at the covered individuals present age may be lower than the cost of a Medicare supplement policy based on issue age or community rating, it is important to compare the potential cost of these policies over the life of the policy.

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 Family Life Insurance Company.

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to our Medicare Supplement Administrative Office at P. O. Box 924408, Houston, Texas 77292-4408. 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 payments.

POLICY REPLACEMENT

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE

This policy may not fully cover all of your medical costs. Neither Family 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

This policy does not contain a pre-existing condition limitation and this policy does not pay benefits for (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 incurred during a Medicare Part A Benefit Period that begins while this policy is not in force; (c) That portion of any expense incurred which is paid for by Medicare; (d) Services for non-Medicare Eligible Expenses unless specifically covered in the policy, 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 PREMIUMS

The Policy does contain a Pro-Rata Refund provision which provides for the partial refund of premium upon death.The Policy does contain a Cancellation By Insured provision which provides for a refund of premium upon surrender of the Policy.

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.

Please refer to your policy for details.

PLAN A
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but $[1100]	$0	[$1100] (Part A deductible)
61st thru 90th day	All but $[275] a day	[$275] a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but [$550] a day	[$550] a day	$0
— Once lifetime reserve days are used:			
— Additional 365 days	$0	100% of Medicare eligible expenses	$0**
— Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$137.50] a day	$0	Up to [$137.50] a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/ coinsurance	$0

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to 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 [$155] 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 [$155] of Medicare Approved Amounts*	$0	$0	[$155] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next [$155] of Medicare Approved Amounts*	$0	$0	[$155] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE			
MEDICARE APPROVED SERVICES			
— Medically necessary skilled care services and medical supplies	100%	$0	$0
— Durable medical equipment			
First [$155] of Medicare Approved Amounts*	$0	$0	[$155] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

PLAN B

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but [$1100]	[$1100] (Part A deductible)	$0
61st thru 90th day	All but [$275] a day	[$275] a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but [$550] a day	[$550] a day	$0
— Once lifetime reserve days are used:			
— Additional 365 days	$0	100% of Medicare eligible expenses	$0**
— Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$137.50] a day	$0	Up to [$137.50] a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/ coinsurance	$0

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to 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 B

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

*Once you have been billed [$155] 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 [$155] of Medicare Approved Amounts*	$0	$0	[$155] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next [$155] of Medicare Approved Amounts*	$0	$0	[$155] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
— Medically necessary skilled care services and medical supplies	100%	$0	$0
— Durable medical equipment			
First [$155] of Medicare Approved Amounts*	$0	$0	[$155] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

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
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but [$1100]	[$1100] (Part A deductible)	$0
61st thru 90th day	All but [$275] a day	[$275] a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but [$550] a day	[$550] a day	$0
— Once lifetime reserve days are used:			
— Additional 365 days	$0	100% of Medicare eligible expenses	$0**
— Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$137.50] a day	Up to [$137.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/ coinsurance	$0

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to 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 [$155] 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 [$155] of Medicare Approved Amounts*	$0	[$155] (Part B deductible)	$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next [$155] of Medicare Approved Amounts*	$0	[$155] (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
— Medically necessary skilled care services and medical supplies	100%	$0	$0
— Durable medical equipment			
First [$155] of Medicare Approved Amounts*	$0	[$155] (Part B deductible)	$0
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.

PLAN D

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but [$1100]	[$1100] (Part A deductible)	$0
61st thru 90th day	All but [$275] a day	[$275] a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but [$550] a day	[$550] a day	$0
— Once lifetime reserve days are used:			
— Additional 365 days	$0	100% of Medicare eligible expenses	$0**
— Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$137.50] a day	Up to [$137.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/ coinsurance	$0

****NOTICE**: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to 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 D

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

*Once you have been billed [$155] 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 [$155] of Medicare Approved Amounts*	$0	$0	[$155] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next [$155] of Medicare Approved Amounts*	$0	$0	[$155] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
— Medically necessary skilled care services and medical supplies	100%	$0	$0
— Durable medical equipment			
First [$155] of Medicare Approved Amounts*	$0	$0	[$155] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

PLAN F

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but [$1100]	[$1100] (Part A deductible)	$0
61st thru 90th day	All but [$275] a day	[$275] a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but [$550] a day	[$550] a day	$0
— Once lifetime reserve days are used:			
— Additional 365 days	$0	100% of Medicare eligible expenses	$0**
— Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$137.50] a day	Up to [$137.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	Medicare co-payment/ coinsurance	$0

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to 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 [$155] 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 [$155] of Medicare Approved Amounts*	$0	[$155] (Part B deductible)	$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next [$155] of Medicare Approved amounts*	$0	[$155] (Part B deductible)	$0
Remainder of Medicare Approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
— Medically necessary skilled care services and medical supplies	100%	$0	$0
— Durable medical equipment			
First [$155] of Medicare Approved Amounts*	$0	[$155] (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER SERVICES – NOT COVERED BY MEDICARE

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

PLAN G

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but [$1100]	[$1100] (Part A deductible)	$0
61st thru 90th day	All but [$275] a day	[$275] a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but [$550] a day	[$550] a day	$0
— Once lifetime reserve days are used:			
— Additional 365 days	$0	100% of Medicare eligible expenses	$0**
— Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$137.50] a day	Up to [$137.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/ coinsurance	$0

****NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to 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 [$155] 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 [$155] of Medicare Approved Amounts*	$0	$0	[$155] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	100%	0%
BLOOD			
First 3 pints	$0	All costs	$0
Next [$155] of Medicare Approved Amounts*	$0	$0	[$155] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
— Medically necessary skilled care services and medical supplies	100%	$0	$0
— Durable medical equipment			
First [$155] of Medicare Approved Amounts*	$0	$0	[$155] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

PLAN M

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but [$1100]	[$550] (50% Part A deductible)	[$550] (50% Part A deductible)
61st thru 90th day	All but [$275] a day	[$275] a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but [$550] a day	[$550] a day	$0
— Once lifetime reserve days are used:			
— Additional 365 days	$0	100% of Medicare eligible expenses	$0**
— Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$137.50] a day	Up to [$137.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/ coinsurance	$0

****NOTICE**: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to 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 M

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

*Once you have been billed [$155] 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 [$155] of Medicare Approved Amounts*	$0	$0	[$155] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next [$155] of Medicare Approved Amounts*	$0	$0	[$155] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
— Medically necessary skilled care services and medical supplies	100%	$0	$0
— Durable medical equipment			
First [$155] of Medicare Approved Amounts*	$0	$0	[$155] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

PLAN N

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies:			
First 60 days	All but [$1100]	[$1100] (Part A deductible)	$0
61st thru 90th day	All but [$275] a day	[$275] a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but [$550] a day	[$550] a day	$0
— Once lifetime reserve days are used:			
— Additional 365 days	$0	100% of Medicare eligible expenses	$0**
— Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but [$137.50] a day	Up to [$137.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/ coinsurance	$0

****NOTICE**: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to 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 [$155] 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 [$155] of Medicare Approved Amounts*	$0	$0	[$155] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Balance, other than up to [$20] per office visit and up to [$50] per emergency room visit. The co-payment of up to [$50] is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Up to [$20] per office visit and up to [$50] per emergency room visit. The co-payment of up to [$50] is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
PART B EXCESS CHARGES (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next [$155] of Medicare Approved Amounts*	$0	$0	[$155] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES — Medically necessary skilled care services and medical supplies — Durable medical equipment First [$155] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 100% $0 80%	 $0 $0 20%	 $0 [$155] (Part B deductible) $0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First $250 each calendar year 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.

FAMILY LIFE INSURANCE COMPANY
ANNUAL PREFERRED ATTAINED AGE PREMIUMS
RATES EFFECTIVE 6/1/10 (M & N)

NORTH CAROLINA

FOR USE IN ALL NORTH CAROLINA ZIP CODES

Attained Age	Female							
	Plan A	Plan B	Plan C	Plan D	Plan F	Plan G	Plan M	Plan N
0-64	1,527	N/A	2,170	N/A	N/A	N/A	N/A	N/A
65	875	1,064	1,221	1,116	1,272	1,121	1,005	890
66	875	1,064	1,221	1,116	1,272	1,121	1,005	890
67	918	1,116	1,283	1,170	1,328	1,177	1,054	930
68	960	1,167	1,340	1,223	1,381	1,230	1,100	967
69	1,000	1,217	1,398	1,275	1,436	1,283	1,148	1,005
70	1,040	1,266	1,456	1,328	1,494	1,335	1,195	1,046
71	1,080	1,314	1,516	1,378	1,554	1,385	1,240	1,088
72	1,120	1,362	1,577	1,429	1,615	1,436	1,286	1,131
73	1,159	1,410	1,638	1,478	1,678	1,487	1,330	1,174
74	1,198	1,457	1,696	1,528	1,734	1,536	1,375	1,214
75	1,236	1,503	1,752	1,576	1,788	1,585	1,418	1,251
76	1,272	1,549	1,805	1,624	1,840	1,631	1,461	1,288
77	1,308	1,591	1,855	1,669	1,888	1,678	1,502	1,321
78	1,343	1,634	1,905	1,714	1,934	1,722	1,543	1,354
79	1,375	1,672	1,949	1,754	1,979	1,762	1,578	1,385
80	1,405	1,708	1,991	1,792	2,020	1,800	1,612	1,414
81	1,433	1,743	2,032	1,827	2,058	1,837	1,644	1,440
82	1,459	1,775	2,070	1,860	2,094	1,871	1,674	1,466
83	1,484	1,804	2,105	1,892	2,127	1,902	1,703	1,489
84	1,505	1,832	2,138	1,920	2,158	1,929	1,728	1,511
85	1,527	1,857	2,170	1,948	2,188	1,958	1,753	1,531
86	1,548	1,882	2,197	1,973	2,214	1,985	1,776	1,549
87	1,565	1,903	2,222	1,996	2,239	2,005	1,796	1,568
88	1,581	1,924	2,246	2,016	2,264	2,027	1,815	1,585
89	1,595	1,941	2,267	2,035	2,283	2,046	1,832	1,598
90	1,610	1,958	2,285	2,052	2,300	2,063	1,847	1,610
91	1,622	1,973	2,301	2,068	2,314	2,080	1,861	1,620
92	1,633	1,987	2,314	2,082	2,328	2,094	1,874	1,630
93	1,644	2,000	2,328	2,098	2,341	2,108	1,888	1,639
94	1,655	2,013	2,339	2,111	2,352	2,121	1,900	1,646
95	1,664	2,025	2,348	2,123	2,361	2,134	1,911	1,653
96	1,673	2,036	2,358	2,134	2,369	2,145	1,920	1,659
97	1,681	2,043	2,364	2,142	2,378	2,155	1,929	1,664
98	1,685	2,051	2,370	2,151	2,385	2,162	1,936	1,669
99	1,690	2,055	2,374	2,155	2,388	2,167	1,939	1,672

Attained Age	Male							
	Plan A	Plan B	Plan C	Plan D	Plan F	Plan G	Plan M	Plan N
0-64	1,756	N/A	2,496	N/A	N/A	N/A	N/A	N/A
65	1,006	1,224	1,404	1,283	1,463	1,290	1,155	1,024
66	1,006	1,224	1,404	1,283	1,463	1,290	1,155	1,024
67	1,055	1,283	1,475	1,346	1,528	1,354	1,211	1,070
68	1,103	1,342	1,541	1,407	1,589	1,415	1,266	1,112
69	1,150	1,399	1,607	1,467	1,653	1,474	1,321	1,157
70	1,197	1,456	1,675	1,527	1,718	1,535	1,374	1,203
71	1,243	1,511	1,744	1,586	1,787	1,593	1,427	1,251
72	1,288	1,568	1,814	1,644	1,857	1,652	1,479	1,301
73	1,333	1,621	1,884	1,701	1,929	1,709	1,530	1,351
74	1,378	1,676	1,949	1,757	1,993	1,767	1,581	1,396
75	1,421	1,729	2,015	1,813	2,057	1,822	1,631	1,440
76	1,464	1,780	2,075	1,867	2,116	1,876	1,681	1,481
77	1,505	1,831	2,134	1,920	2,172	1,929	1,728	1,520
78	1,545	1,880	2,190	1,970	2,224	1,981	1,774	1,557
79	1,581	1,923	2,242	2,016	2,276	2,026	1,815	1,593
80	1,615	1,965	2,290	2,061	2,322	2,072	1,854	1,625
81	1,647	2,004	2,336	2,101	2,366	2,113	1,891	1,657
82	1,678	2,041	2,381	2,139	2,408	2,152	1,926	1,686
83	1,705	2,075	2,421	2,176	2,446	2,188	1,958	1,713
84	1,731	2,106	2,460	2,208	2,481	2,220	1,987	1,737
85	1,756	2,137	2,496	2,239	2,516	2,252	2,015	1,761
86	1,779	2,164	2,527	2,270	2,546	2,282	2,043	1,782
87	1,799	2,189	2,556	2,295	2,575	2,308	2,065	1,802
88	1,818	2,212	2,584	2,319	2,603	2,331	2,087	1,822
89	1,835	2,233	2,607	2,340	2,626	2,352	2,106	1,838
90	1,851	2,252	2,627	2,360	2,645	2,373	2,124	1,852
91	1,865	2,269	2,646	2,378	2,662	2,391	2,140	1,863
92	1,878	2,285	2,662	2,396	2,678	2,409	2,157	1,874
93	1,891	2,300	2,677	2,411	2,692	2,424	2,170	1,885
94	1,903	2,314	2,690	2,427	2,705	2,440	2,185	1,893
95	1,914	2,329	2,702	2,441	2,715	2,454	2,196	1,901
96	1,925	2,340	2,711	2,454	2,726	2,467	2,209	1,908
97	1,932	2,350	2,719	2,464	2,734	2,478	2,218	1,914
98	1,939	2,359	2,727	2,473	2,742	2,486	2,226	1,919
99	1,944	2,364	2,730	2,478	2,746	2,492	2,230	1,923

There is a one time $25 policy fee

Spousal Discount Factor: .93

Modal Factors: Semi Annual: 1/2 Quarterly: 1/4 Monthly: 1/12

FAMILY LIFE INSURANCE COMPANY
ANNUAL STANDARD ATTAINED AGE PREMIUMS
RATES EFFECTIVE 6/1/10 (M & N)

NORTH CAROLINA

FOR USE IN ALL NORTH CAROLINA ZIP CODES

Attained Age	Female								Male							
	Plan A	Plan B	Plan C	Plan D	Plan F	Plan G	Plan M	Plan N	Plan A	Plan B	Plan C	Plan D	Plan F	Plan G	Plan M	Plan N
0-64	1,697	N/A	2,411	N/A	N/A	N/A	N/A	N/A	1,951	N/A	2,772	N/A	N/A	N/A	N/A	N/A
65	973	1,183	1,357	1,240	1,414	1,246	1,116	990	1,118	1,360	1,560	1,426	1,625	1,434	1,283	1,138
66	973	1,183	1,357	1,240	1,414	1,246	1,116	990	1,118	1,360	1,560	1,426	1,625	1,434	1,283	1,138
67	1,020	1,241	1,426	1,300	1,475	1,307	1,169	1,033	1,172	1,426	1,639	1,495	1,698	1,503	1,346	1,188
68	1,066	1,297	1,489	1,359	1,535	1,367	1,224	1,074	1,226	1,491	1,712	1,564	1,765	1,572	1,407	1,236
69	1,112	1,351	1,553	1,416	1,597	1,425	1,275	1,118	1,279	1,554	1,785	1,629	1,836	1,639	1,467	1,285
70	1,156	1,407	1,619	1,475	1,660	1,483	1,328	1,162	1,330	1,618	1,861	1,696	1,910	1,705	1,527	1,337
71	1,201	1,461	1,684	1,530	1,726	1,540	1,378	1,208	1,381	1,680	1,937	1,760	1,986	1,771	1,585	1,391
72	1,245	1,514	1,752	1,587	1,795	1,596	1,429	1,256	1,432	1,741	2,015	1,825	2,063	1,835	1,643	1,444
73	1,287	1,567	1,820	1,643	1,864	1,652	1,478	1,304	1,482	1,801	2,094	1,889	2,143	1,899	1,700	1,500
74	1,331	1,619	1,885	1,698	1,926	1,706	1,528	1,348	1,530	1,862	2,167	1,952	2,215	1,963	1,758	1,550
75	1,373	1,670	1,947	1,752	1,987	1,760	1,577	1,391	1,579	1,921	2,239	2,014	2,286	2,024	1,813	1,600
76	1,414	1,720	2,005	1,804	2,044	1,813	1,624	1,431	1,626	1,978	2,306	2,074	2,350	2,085	1,867	1,645
77	1,454	1,769	2,062	1,854	2,098	1,864	1,669	1,469	1,672	2,034	2,371	2,132	2,413	2,144	1,919	1,689
78	1,492	1,816	2,116	1,903	2,150	1,914	1,713	1,505	1,717	2,088	2,434	2,190	2,472	2,201	1,971	1,730
79	1,528	1,858	2,166	1,948	2,199	1,959	1,753	1,540	1,757	2,137	2,492	2,240	2,529	2,252	2,016	1,770
80	1,561	1,898	2,213	1,990	2,244	2,001	1,792	1,570	1,795	2,183	2,544	2,289	2,580	2,301	2,060	1,806
81	1,592	1,936	2,257	2,030	2,287	2,041	1,827	1,601	1,831	2,227	2,596	2,335	2,630	2,347	2,101	1,841
82	1,621	1,972	2,300	2,067	2,327	2,079	1,860	1,628	1,864	2,268	2,645	2,377	2,676	2,390	2,139	1,873
83	1,647	2,005	2,339	2,101	2,363	2,113	1,891	1,654	1,895	2,306	2,690	2,417	2,717	2,429	2,176	1,902
84	1,672	2,035	2,377	2,133	2,397	2,144	1,920	1,678	1,924	2,340	2,733	2,453	2,757	2,466	2,208	1,929
85	1,697	2,063	2,411	2,164	2,430	2,176	1,948	1,701	1,951	2,373	2,772	2,488	2,795	2,501	2,239	1,956
86	1,720	2,091	2,442	2,193	2,460	2,204	1,973	1,721	1,977	2,405	2,807	2,521	2,829	2,536	2,270	1,981
87	1,739	2,115	2,470	2,217	2,487	2,230	1,996	1,741	2,000	2,432	2,841	2,550	2,860	2,564	2,295	2,003
88	1,757	2,138	2,497	2,241	2,516	2,253	2,017	1,761	2,021	2,458	2,870	2,576	2,892	2,591	2,319	2,024
89	1,773	2,157	2,518	2,261	2,537	2,273	2,035	1,777	2,039	2,480	2,897	2,600	2,918	2,614	2,340	2,043
90	1,788	2,176	2,538	2,281	2,556	2,293	2,053	1,789	2,056	2,501	2,919	2,622	2,938	2,637	2,360	2,057
91	1,801	2,193	2,556	2,298	2,573	2,310	2,068	1,801	2,073	2,521	2,940	2,643	2,957	2,657	2,379	2,070
92	1,815	2,208	2,573	2,314	2,587	2,327	2,082	1,811	2,087	2,539	2,957	2,662	2,975	2,677	2,396	2,082
93	1,827	2,222	2,587	2,330	2,601	2,343	2,098	1,821	2,101	2,556	2,974	2,679	2,992	2,694	2,411	2,094
94	1,838	2,236	2,599	2,346	2,613	2,358	2,111	1,830	2,115	2,573	2,990	2,696	3,005	2,711	2,426	2,103
95	1,850	2,250	2,610	2,359	2,623	2,371	2,123	1,836	2,127	2,588	3,001	2,713	3,016	2,727	2,442	2,112
96	1,859	2,261	2,619	2,371	2,633	2,384	2,134	1,843	2,138	2,601	3,012	2,727	3,028	2,742	2,455	2,119
97	1,867	2,271	2,627	2,381	2,642	2,394	2,142	1,850	2,146	2,612	3,022	2,737	3,037	2,753	2,463	2,126
98	1,873	2,279	2,634	2,388	2,650	2,402	2,150	1,854	2,155	2,620	3,029	2,747	3,048	2,762	2,473	2,134
99	1,877	2,284	2,638	2,395	2,654	2,407	2,156	1,858	2,158	2,627	3,034	2,754	3,051	2,768	2,479	2,136

There is a one time $25 policy fee

Spousal Discount Factor: .93

Modal Factors: Semi Annual: 1/2 Quarterly: 1/4 Monthly: 1/12

FAMILY LIFE INSURANCE COMPANY
MONTHLY PREFERRED ATTAINED AGE PREMIUMS
RATES EFFECTIVE 6/1/10 (M & N)

NORTH CAROLINA

FOR USE IN ALL NORTH CAROLINA ZIP CODES

Attained Age	Female							
	Plan A	Plan B	Plan C	Plan D	Plan F	Plan G	Plan M	Plan N
0-64	127.25	N/A	180.83	N/A	N/A	N/A	N/A	N/A
65	72.92	88.67	101.75	93.00	106.00	93.42	83.75	74.17
66	72.92	88.67	101.75	93.00	106.00	93.42	83.75	74.17
67	76.50	93.00	106.92	97.50	110.67	98.08	87.83	77.50
68	80.00	97.25	111.67	101.92	115.08	102.50	91.67	80.58
69	83.33	101.42	116.50	106.25	119.67	106.92	95.67	83.75
70	86.67	105.50	121.33	110.67	124.50	111.25	99.58	87.17
71	90.00	109.50	126.33	114.83	129.50	115.42	103.33	90.67
72	93.33	113.50	131.42	119.08	134.58	119.67	107.17	94.25
73	96.58	117.50	136.50	123.17	139.83	123.92	110.83	97.83
74	99.83	121.42	141.33	127.33	144.50	128.00	114.58	101.17
75	103.00	125.25	146.00	131.33	149.00	132.08	118.17	104.25
76	106.00	129.08	150.42	135.33	153.33	135.92	121.75	107.33
77	109.00	132.58	154.58	139.08	157.33	139.83	125.17	110.08
78	111.92	136.17	158.75	142.83	161.17	143.50	128.58	112.83
79	114.58	139.33	162.42	146.17	164.92	146.83	131.50	115.42
80	117.08	142.33	165.92	149.33	168.33	150.00	134.33	117.83
81	119.42	145.25	169.33	152.25	171.50	153.08	137.00	120.00
82	121.58	147.92	172.50	155.00	174.50	155.92	139.50	122.17
83	123.67	150.33	175.42	157.67	177.25	158.50	141.92	124.08
84	125.42	152.67	178.17	160.00	179.83	160.75	144.00	125.92
85	127.25	154.75	180.83	162.33	182.33	163.17	146.08	127.58
86	129.00	156.83	183.08	164.42	184.50	165.42	148.00	129.08
87	130.42	158.58	185.17	166.33	186.58	167.08	149.67	130.67
88	131.75	160.33	187.17	168.00	188.67	168.92	151.25	132.08
89	132.92	161.75	188.92	169.58	190.25	170.50	152.67	133.17
90	134.17	163.17	190.42	171.00	191.67	171.92	153.92	134.17
91	135.17	164.42	191.75	172.33	192.83	173.33	155.08	135.00
92	136.08	165.58	192.83	173.50	194.00	174.50	156.17	135.83
93	137.00	166.67	194.00	174.83	195.08	175.67	157.33	136.58
94	137.92	167.75	194.92	175.92	196.00	176.75	158.33	137.17
95	138.67	168.75	195.67	176.92	196.75	177.83	159.25	137.75
96	139.42	169.67	196.50	177.83	197.42	178.75	160.00	138.25
97	140.08	170.25	197.00	178.50	198.17	179.58	160.75	138.67
98	140.42	170.92	197.50	179.25	198.75	180.17	161.33	139.08
99	140.83	171.25	197.83	179.58	199.00	180.58	161.58	139.33

Attained Age	Male							
	Plan A	Plan B	Plan C	Plan D	Plan F	Plan G	Plan M	Plan N
0-64	146.33	N/A	208.00	N/A	N/A	N/A	N/A	N/A
65	83.83	102.00	117.00	106.92	121.92	107.50	96.25	85.33
66	83.83	102.00	117.00	106.92	121.92	107.50	96.25	85.33
67	87.92	106.92	122.92	112.17	127.33	112.83	100.92	89.17
68	91.92	111.83	128.42	117.25	132.42	117.92	105.50	92.67
69	95.83	116.58	133.92	122.25	137.75	122.83	110.08	96.42
70	99.75	121.33	139.58	127.25	143.17	127.92	114.50	100.25
71	103.58	125.92	145.33	132.17	148.92	132.75	118.92	104.25
72	107.33	130.67	151.17	137.00	154.75	137.67	123.25	108.42
73	111.08	135.08	157.00	141.75	160.75	142.42	127.50	112.58
74	114.83	139.67	162.42	146.42	166.08	147.25	131.75	116.33
75	118.42	144.08	167.92	151.08	171.42	151.83	135.92	120.00
76	122.00	148.33	172.92	155.58	176.33	156.33	140.08	123.42
77	125.42	152.58	177.83	160.00	181.00	160.75	144.00	126.67
78	128.75	156.67	182.50	164.17	185.33	165.08	147.83	129.75
79	131.75	160.25	186.83	168.00	189.67	168.83	151.25	132.75
80	134.58	163.75	190.83	171.75	193.50	172.67	154.50	135.42
81	137.25	167.00	194.67	175.08	197.17	176.08	157.58	138.08
82	139.83	170.08	198.42	178.25	200.67	179.33	160.50	140.50
83	142.08	172.92	201.75	181.33	203.83	182.33	163.17	142.75
84	144.25	175.50	205.00	184.00	206.75	185.00	165.58	144.75
85	146.33	178.08	208.00	186.58	209.67	187.67	167.92	146.75
86	148.25	180.33	210.58	189.17	212.17	190.17	170.25	148.50
87	149.92	182.42	213.00	191.25	214.58	192.33	172.08	150.17
88	151.50	184.33	215.33	193.25	216.92	194.25	173.92	151.83
89	152.92	186.08	217.25	195.00	218.83	196.00	175.50	153.17
90	154.25	187.67	218.92	196.67	220.42	197.75	177.00	154.33
91	155.42	189.08	220.50	198.17	221.83	199.25	178.33	155.25
92	156.50	190.42	221.83	199.67	223.17	200.75	179.75	156.17
93	157.58	191.67	223.08	200.92	224.33	202.00	180.83	157.08
94	158.58	192.83	224.17	202.25	225.42	203.33	182.08	157.75
95	159.50	194.08	225.17	203.42	226.25	204.50	183.00	158.42
96	160.42	195.00	225.92	204.50	227.17	205.58	184.08	159.00
97	161.00	195.83	226.58	205.33	227.83	206.50	184.83	159.50
98	161.58	196.58	227.25	206.08	228.50	207.17	185.50	159.92
99	162.00	197.00	227.50	206.50	228.83	207.67	185.83	160.25

There is a one time $25 policy fee

Spousal Discount Factor: .93

FAMILY LIFE INSURANCE COMPANY
MONTHLY STANDARD ATTAINED AGE PREMIUMS
RATES EFFECTIVE 6/1/10 (M & N)

NORTH CAROLINA

FOR USE IN ALL NORTH CAROLINA ZIP CODES

Attained Age	Female							
	Plan A	Plan B	Plan C	Plan D	Plan F	Plan G	Plan M	Plan N
0-64	141.42	N/A	200.92	N/A	N/A	N/A	N/A	N/A
65	81.08	98.58	113.08	103.33	117.83	103.83	93.00	82.50
66	81.08	98.58	113.08	103.33	117.83	103.83	93.00	82.50
67	85.00	103.42	118.83	108.33	122.92	108.92	97.42	86.08
68	88.83	108.08	124.08	113.25	127.92	113.92	102.00	89.50
69	92.67	112.58	129.42	118.00	133.08	118.75	106.25	93.17
70	96.33	117.25	134.92	122.92	138.33	123.58	110.67	96.83
71	100.08	121.75	140.33	127.50	143.83	128.33	114.83	100.67
72	103.75	126.17	146.00	132.25	149.58	133.00	119.08	104.67
73	107.25	130.58	151.67	136.92	155.33	137.67	123.17	108.67
74	110.92	134.92	157.08	141.50	160.50	142.17	127.33	112.33
75	114.42	139.17	162.25	146.00	165.58	146.67	131.42	115.92
76	117.83	143.33	167.08	150.33	170.33	151.08	135.33	119.25
77	121.17	147.42	171.83	154.50	174.83	155.33	139.08	122.42
78	124.33	151.33	176.33	158.58	179.17	159.50	142.75	125.42
79	127.33	154.83	180.50	162.33	183.25	163.25	146.08	128.33
80	130.08	158.17	184.42	165.83	187.00	166.75	149.33	130.83
81	132.67	161.33	188.08	169.17	190.58	170.08	152.25	133.42
82	135.08	164.33	191.67	172.25	193.92	173.25	155.00	135.67
83	137.25	167.08	194.92	175.08	196.92	176.08	157.58	137.83
84	139.33	169.58	198.08	177.75	199.75	178.67	160.00	139.83
85	141.42	171.92	200.92	180.33	202.50	181.33	162.33	141.75
86	143.33	174.25	203.50	182.75	205.00	183.67	164.42	143.42
87	144.92	176.25	205.83	184.75	207.25	185.83	166.33	145.08
88	146.42	178.17	208.08	186.75	209.67	187.75	168.08	146.75
89	147.75	179.75	209.83	188.42	211.42	189.42	169.58	148.08
90	149.00	181.33	211.50	190.08	213.00	191.08	171.08	149.08
91	150.08	182.75	213.00	191.50	214.42	192.50	172.33	150.08
92	151.25	184.00	214.42	192.83	215.58	193.92	173.50	150.92
93	152.25	185.17	215.58	194.17	216.75	195.25	174.83	151.75
94	153.17	186.33	216.58	195.50	217.75	196.50	175.92	152.50
95	154.17	187.50	217.50	196.58	218.58	197.58	176.92	153.00
96	154.92	188.42	218.25	197.58	219.42	198.67	177.83	153.58
97	155.58	189.25	218.92	198.42	220.17	199.50	178.50	154.17
98	156.08	189.92	219.50	199.00	220.83	200.17	179.17	154.50
99	156.42	190.33	219.83	199.58	221.17	200.58	179.67	154.83

Attained Age	Male							
	Plan A	Plan B	Plan C	Plan D	Plan F	Plan G	Plan M	Plan N
0-64	162.58	N/A	231.00	N/A	N/A	N/A	N/A	N/A
65	93.17	113.33	130.00	118.83	135.42	119.50	106.92	94.83
66	93.17	113.33	130.00	118.83	135.42	119.50	106.92	94.83
67	97.67	118.83	136.58	124.58	141.50	125.25	112.17	99.00
68	102.17	124.25	142.67	130.33	147.08	131.00	117.25	103.00
69	106.58	129.50	148.75	135.75	153.00	136.58	122.25	107.08
70	110.83	134.83	155.08	141.33	159.17	142.08	127.25	111.42
71	115.08	140.00	161.42	146.67	165.50	147.58	132.08	115.92
72	119.33	145.08	167.92	152.08	171.92	152.92	136.92	120.33
73	123.50	150.08	174.50	157.42	178.58	158.25	141.67	125.00
74	127.50	155.17	180.58	162.67	184.58	163.58	146.50	129.17
75	131.58	160.08	186.58	167.83	190.50	168.67	151.08	133.33
76	135.50	164.83	192.17	172.83	195.83	173.75	155.58	137.08
77	139.33	169.50	197.58	177.67	201.08	178.67	159.92	140.75
78	143.08	174.00	202.83	182.50	206.00	183.42	164.25	144.17
79	146.42	178.08	207.67	186.67	210.75	187.67	168.00	147.50
80	149.58	181.92	212.00	190.75	215.00	191.75	171.67	150.50
81	152.58	185.58	216.33	194.58	219.17	195.58	175.08	153.42
82	155.33	189.00	220.42	198.08	223.00	199.17	178.25	156.08
83	157.92	192.17	224.17	201.42	226.42	202.42	181.33	158.50
84	160.33	195.00	227.75	204.42	229.75	205.50	184.00	160.75
85	162.58	197.75	231.00	207.33	232.92	208.42	186.58	163.00
86	164.75	200.42	233.92	210.08	235.75	211.33	189.17	165.08
87	166.67	202.67	236.75	212.50	238.33	213.67	191.25	166.92
88	168.42	204.83	239.17	214.67	241.00	215.92	193.25	168.67
89	169.92	206.67	241.42	216.67	243.17	217.83	195.00	170.25
90	171.33	208.42	243.25	218.50	244.83	219.75	196.67	171.42
91	172.75	210.08	245.00	220.25	246.42	221.42	198.25	172.50
92	173.92	211.58	246.42	221.83	247.92	223.08	199.67	173.50
93	175.08	213.00	247.83	223.25	249.33	224.50	200.92	174.50
94	176.25	214.42	249.17	224.67	250.42	225.92	202.17	175.25
95	177.25	215.67	250.08	226.08	251.33	227.25	203.50	176.00
96	178.17	216.75	251.00	227.25	252.33	228.50	204.58	176.58
97	178.83	217.67	251.83	228.08	253.08	229.42	205.25	177.17
98	179.58	218.33	252.42	228.92	254.00	230.17	206.08	177.83
99	179.83	218.92	252.83	229.50	254.25	230.67	206.58	178.00

There is a one time $25 policy fee

Spousal Discount Factor: .93