Renaissance®
Life & Health Insurance Company of America
Health Administrative Office - P.O. Box 27248 Salt Lake City, Utah 84127-0248 - Phone: 1-844-202-4150

# Benefit Plans A, F, G and N

Outline of Medicare Supplement Coverage – Cover Page

**Benefit Chart of Medicare Supplement Plans Sold on or after January 1, 2020**

This chart shows the benefits included in each of the standard Medicare supplement plans. Some plans may not be available. Only applicants **FIRST** eligible for Medicare before 2020 may purchase Plans C, F, and high deductible F.

Note: A ✔ means 100% of the benefit is paid.

| | Plans Available to All Applicants | | | | | | | | Medicare first eligible before 2020 only | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Benefits** | **A** | **B** | **D** | **G[1]** | **K** | **L** | **M** | **N** | **C** | **F[1]** |
| Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up) | ✔ | ✔ | ✔ | ✔ | ✔ | ✔ | ✔ | ✔ | ✔ | ✔ |
| Medicare Part B Coinsurance or Copayment | ✔ | ✔ | ✔ | ✔ | 50% | 75% | ✔ | ✔ copays apply[3] | ✔ | ✔ |
| Blood (first three pints) | ✔ | ✔ | ✔ | ✔ | 50% | 75% | ✔ | ✔ | ✔ | ✔ |
| Part A hospice care coinsurance or copayment | ✔ | ✔ | ✔ | ✔ | 50% | 75% | ✔ | ✔ | ✔ | ✔ |
| Skilled nursing facility coinsurance | | | ✔ | ✔ | 50% | 75% | ✔ | ✔ | ✔ | ✔ |
| Medicare Part A deductible | | ✔ | ✔ | ✔ | 50% | 75% | 50% | ✔ | ✔ | ✔ |
| Medicare Part B deductible | | | | | | | | | ✔ | ✔ |
| Medicare Part B excess charges | | | | ✔ | | | | | | ✔ |
| Foreign travel emergency (up to plan limits) | | | ✔ | ✔ | | | ✔ | ✔ | ✔ | ✔ |
| Out-of pocket limit in 2019[2] | | | | | **$5,880[2]** | **$2,940[2]** | | | | |

[1]Plans F and G also have a high deductible option which require first paying a plan deductible of $2,340 before the plan begins to pay. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High deductible plan G does not cover the Medicare Part B deductible. However, high deductible plans F and G count your payment of the Medicare Part B deductible toward meeting the plan deductible.

[2]Plans K and L pay 100% of covered services for the rest of the calendar year once you meet the out-of-pocket yearly limit.

[3]Plan N pays 100% of the Part B coinsurance, except for a co-payment of up to $20 for some office visits and up to a $50 co-payment for emergency room visits that do not result in an inpatient admission.

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**NON-TOBACCO**

***ZIP CODES:*** *855-857, 859-860, 863-865*

# HOUSEHOLD DISCOUNT MONTHLY RATES*

(Refer to page 2 of this Outline of Coverage for Household Discount rules)

| Female | | | | | Male | | | |
|---|---|---|---|---|---|---|---|---|
| Std. Plan A RENA10ST-AZ | Std. Plan F RENF10ST-AZ | Std. Plan G RENG10ST-AZ | Std. Plan N RENN10ST-AZ | Issue Age | Std. Plan A RENA10ST-AZ | Std. Plan F RENF10ST-AZ | Std. Plan G RENG10ST-AZ | Std. Plan N RENN10ST-AZ |
| $103.40 | $130.99 | $105.65 | $87.94 | 65 | $118.85 | $150.56 | $121.43 | $101.08 |
| $103.40 | $130.99 | $105.65 | $87.94 | 66 | $118.85 | $150.56 | $121.43 | $101.08 |
| $103.40 | $130.99 | $105.65 | $87.94 | 67 | $118.85 | $150.56 | $121.43 | $101.08 |
| $107.14 | $136.92 | $110.43 | $91.93 | 68 | $123.15 | $157.38 | $126.93 | $105.67 |
| $110.99 | $142.82 | $115.22 | $95.89 | 69 | $127.58 | $164.16 | $132.43 | $110.22 |
| $114.50 | $148.71 | $120.00 | $99.84 | 70 | $131.61 | $170.94 | $137.93 | $114.76 |
| $116.18 | $155.34 | $125.39 | $104.29 | 71 | $133.54 | $178.55 | $144.13 | $119.87 |
| $117.87 | $162.02 | $130.84 | $108.78 | 72 | $135.48 | $186.22 | $150.39 | $125.03 |
| $118.98 | $168.11 | $135.81 | $112.87 | 73 | $136.76 | $193.23 | $156.10 | $129.74 |
| $120.57 | $174.24 | $140.83 | $116.98 | 74 | $138.59 | $200.27 | $161.87 | $134.46 |
| $122.24 | $180.30 | $145.88 | $121.05 | 75 | $140.51 | $207.24 | $167.68 | $139.14 |
| $126.44 | $186.32 | $150.99 | $125.09 | 76 | $145.33 | $214.16 | $173.55 | $143.79 |
| $130.24 | $192.41 | $156.12 | $129.18 | 77 | $149.71 | $221.16 | $179.45 | $148.49 |
| $132.72 | $196.38 | $159.54 | $131.85 | 78 | $152.55 | $225.72 | $183.38 | $151.55 |
| $135.29 | $200.53 | $163.11 | $134.63 | 79 | $155.50 | $230.49 | $187.48 | $154.74 |
| $137.24 | $204.84 | $166.80 | $137.53 | 80 | $157.75 | $235.45 | $191.73 | $158.08 |
| $138.84 | $209.35 | $170.65 | $140.55 | 81 | $159.58 | $240.63 | $196.15 | $161.55 |
| $140.53 | $214.04 | $174.67 | $143.71 | 82 | $161.53 | $246.03 | $200.77 | $165.18 |
| $142.70 | $219.51 | $179.29 | $147.38 | 83 | $164.02 | $252.31 | $206.08 | $169.40 |
| $145.01 | $225.19 | $184.09 | $151.19 | 84 | $166.68 | $258.84 | $211.60 | $173.78 |
| $148.11 | $231.11 | $189.09 | $155.17 | 85 | $170.25 | $265.64 | $217.35 | $178.35 |
| $150.95 | $237.26 | $194.29 | $159.30 | 86 | $173.50 | $272.71 | $223.32 | $183.11 |
| $154.70 | $243.67 | $199.69 | $163.61 | 87 | $177.82 | $280.08 | $229.53 | $188.05 |
| $158.61 | $250.26 | $205.26 | $168.03 | 88 | $182.31 | $287.66 | $235.93 | $193.14 |
| $163.07 | $257.21 | $211.12 | $172.69 | 89 | $187.44 | $295.64 | $242.66 | $198.50 |
| $167.82 | $264.56 | $217.33 | $177.63 | 90 | $192.89 | $304.09 | $249.80 | $204.17 |
| $173.08 | $272.24 | $223.80 | $182.78 | 91 | $198.94 | $312.92 | $257.24 | $210.09 |
| $178.81 | $280.31 | $230.61 | $188.20 | 92 | $205.53 | $322.20 | $265.07 | $216.32 |
| $185.19 | $288.76 | $237.75 | $193.87 | 93 | $212.86 | $331.91 | $273.28 | $222.84 |
| $192.06 | $297.74 | $245.35 | $199.91 | 94 | $220.76 | $342.23 | $282.01 | $229.79 |
| $199.54 | $307.15 | $253.29 | $206.23 | 95 | $229.36 | $353.05 | $291.14 | $237.05 |
| $207.48 | $317.06 | $261.67 | $212.88 | 96 | $238.48 | $364.43 | $300.77 | $244.69 |
| $215.70 | $327.41 | $270.42 | $219.82 | 97 | $247.93 | $376.34 | $310.83 | $252.67 |
| $224.59 | $338.39 | $279.69 | $227.18 | 98 | $258.15 | $388.96 | $321.48 | $261.13 |
| $234.50 | $349.95 | $289.47 | $234.96 | 99 | $269.54 | $402.24 | $332.73 | $270.07 |

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

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**TOBACCO**

***ZIP CODES:*** *855-857, 859-860, 863-865*

# *HOUSEHOLD DISCOUNT MONTHLY RATES**

(Refer to page 2 of this Outline of Coverage for Household Discount rules)

| Female | | | | | Male | | | |
|---|---|---|---|---|---|---|---|---|
| Std. Plan A RENA10ST-AZ | Std. Plan F RENF10ST-AZ | Std. Plan G RENG10ST-AZ | Std. Plan N RENN10ST-AZ | Issue Age | Std. Plan A RENA10ST-AZ | Std. Plan F RENF10ST-AZ | Std. Plan G RENG10ST-AZ | Std. Plan N RENN10ST-AZ |
| $118.85 | $150.56 | $121.43 | $101.08 | 65 | $136.61 | $173.06 | $139.58 | $116.19 |
| $118.85 | $150.56 | $121.43 | $101.08 | 66 | $136.61 | $173.06 | $139.58 | $116.19 |
| $118.85 | $150.56 | $121.43 | $101.08 | 67 | $136.61 | $173.06 | $139.58 | $116.19 |
| $123.15 | $157.38 | $126.93 | $105.67 | 68 | $141.56 | $180.90 | $145.90 | $121.46 |
| $127.58 | $164.16 | $132.43 | $110.22 | 69 | $146.64 | $188.69 | $152.22 | $126.68 |
| $131.61 | $170.94 | $137.93 | $114.76 | 70 | $151.28 | $196.48 | $158.54 | $131.91 |
| $133.54 | $178.55 | $144.13 | $119.87 | 71 | $153.49 | $205.23 | $165.67 | $137.78 |
| $135.48 | $186.22 | $150.39 | $125.03 | 72 | $155.72 | $214.05 | $172.86 | $143.71 |
| $136.76 | $193.23 | $156.10 | $129.74 | 73 | $157.19 | $222.10 | $179.42 | $149.12 |
| $138.59 | $200.27 | $161.87 | $134.46 | 74 | $159.30 | $230.20 | $186.06 | $154.55 |
| $140.51 | $207.24 | $167.68 | $139.14 | 75 | $161.51 | $238.21 | $192.74 | $159.93 |
| $145.33 | $214.16 | $173.55 | $143.79 | 76 | $167.05 | $246.16 | $199.48 | $165.27 |
| $149.71 | $221.16 | $179.45 | $148.49 | 77 | $172.08 | $254.21 | $206.26 | $170.68 |
| $152.55 | $225.72 | $183.38 | $151.55 | 78 | $175.35 | $259.45 | $210.79 | $174.20 |
| $155.50 | $230.49 | $187.48 | $154.74 | 79 | $178.74 | $264.93 | $215.49 | $177.87 |
| $157.75 | $235.45 | $191.73 | $158.08 | 80 | $181.32 | $270.64 | $220.38 | $181.70 |
| $159.58 | $240.63 | $196.15 | $161.55 | 81 | $183.43 | $276.58 | $225.46 | $185.69 |
| $161.53 | $246.03 | $200.77 | $165.18 | 82 | $185.67 | $282.79 | $230.77 | $189.86 |
| $164.02 | $252.31 | $206.08 | $169.40 | 83 | $188.53 | $290.01 | $236.87 | $194.72 |
| $166.68 | $258.84 | $211.60 | $173.78 | 84 | $191.58 | $297.52 | $243.21 | $199.75 |
| $170.25 | $265.64 | $217.35 | $178.35 | 85 | $195.69 | $305.33 | $249.82 | $205.00 |
| $173.50 | $272.71 | $223.32 | $183.11 | 86 | $199.43 | $313.46 | $256.69 | $210.47 |
| $177.82 | $280.08 | $229.53 | $188.05 | 87 | $204.39 | $321.93 | $263.82 | $216.15 |
| $182.31 | $287.66 | $235.93 | $193.14 | 88 | $209.55 | $330.64 | $271.18 | $222.00 |
| $187.44 | $295.64 | $242.66 | $198.50 | 89 | $215.45 | $339.82 | $278.92 | $228.16 |
| $192.89 | $304.09 | $249.80 | $204.17 | 90 | $221.72 | $349.53 | $287.13 | $234.68 |
| $198.94 | $312.92 | $257.24 | $210.09 | 91 | $228.67 | $359.67 | $295.68 | $241.48 |
| $205.53 | $322.20 | $265.07 | $216.32 | 92 | $236.24 | $370.34 | $304.68 | $248.64 |
| $212.86 | $331.91 | $273.28 | $222.84 | 93 | $244.67 | $381.51 | $314.12 | $256.14 |
| $220.76 | $342.23 | $282.01 | $229.79 | 94 | $253.75 | $393.37 | $324.15 | $264.12 |
| $229.36 | $353.05 | $291.14 | $237.05 | 95 | $263.63 | $405.80 | $334.65 | $272.47 |
| $238.48 | $364.43 | $300.77 | $244.69 | 96 | $274.12 | $418.89 | $345.71 | $281.25 |
| $247.93 | $376.34 | $310.83 | $252.67 | 97 | $284.98 | $432.57 | $357.27 | $290.43 |
| $258.15 | $388.96 | $321.48 | $261.13 | 98 | $296.73 | $447.08 | $369.52 | $300.15 |
| $269.54 | $402.24 | $332.73 | $270.07 | 99 | $309.82 | $462.34 | $382.45 | $310.42 |

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

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## MONTHLY RATES*

## NON-TOBACCO

**ZIP CODES:** *855-857, 859-860, 863-865*

| Female | | | | | Male | | | |
|---|---|---|---|---|---|---|---|---|
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| $117.50 | $148.85 | $120.05 | $99.93 | 65 | $135.06 | $171.09 | $137.99 | $114.87 |
| $117.50 | $148.85 | $120.05 | $99.93 | 66 | $135.06 | $171.09 | $137.99 | $114.87 |
| $117.50 | $148.85 | $120.05 | $99.93 | 67 | $135.06 | $171.09 | $137.99 | $114.87 |
| $121.75 | $155.60 | $125.49 | $104.47 | 68 | $139.95 | $178.85 | $144.24 | $120.08 |
| $126.13 | $162.29 | $130.93 | $108.96 | 69 | $144.98 | $186.55 | $150.49 | $125.25 |
| $130.12 | $168.99 | $136.36 | $113.46 | 70 | $149.56 | $194.24 | $156.74 | $130.41 |
| $132.02 | $176.52 | $142.49 | $118.51 | 71 | $151.75 | $202.90 | $163.79 | $136.22 |
| $133.94 | $184.11 | $148.68 | $123.61 | 72 | $153.96 | $211.62 | $170.89 | $142.08 |
| $135.21 | $191.03 | $154.32 | $128.26 | 73 | $155.41 | $219.58 | $177.38 | $147.43 |
| $137.01 | $198.00 | $160.03 | $132.93 | 74 | $157.49 | $227.58 | $183.94 | $152.80 |
| $138.91 | $204.89 | $165.78 | $137.56 | 75 | $159.67 | $235.50 | $190.55 | $158.11 |
| $143.68 | $211.73 | $171.57 | $142.15 | 76 | $165.15 | $243.37 | $197.21 | $163.39 |
| $148.00 | $218.65 | $177.41 | $146.80 | 77 | $170.12 | $251.32 | $203.92 | $168.74 |
| $150.82 | $223.16 | $181.30 | $149.83 | 78 | $173.36 | $256.50 | $208.39 | $172.22 |
| $153.73 | $227.87 | $185.35 | $152.98 | 79 | $176.71 | $261.92 | $213.05 | $175.84 |
| $155.96 | $232.78 | $189.55 | $156.28 | 80 | $179.26 | $267.56 | $217.87 | $179.64 |
| $157.77 | $237.89 | $193.93 | $159.71 | 81 | $181.34 | $273.44 | $222.90 | $183.58 |
| $159.70 | $243.23 | $198.49 | $163.30 | 82 | $183.56 | $279.57 | $228.15 | $187.70 |
| $162.16 | $249.44 | $203.73 | $167.48 | 83 | $186.39 | $286.72 | $234.18 | $192.50 |
| $164.78 | $255.90 | $209.19 | $171.81 | 84 | $189.41 | $294.14 | $240.45 | $197.48 |
| $168.31 | $262.62 | $214.88 | $176.33 | 85 | $193.46 | $301.86 | $246.98 | $202.68 |
| $171.53 | $269.62 | $220.78 | $181.03 | 86 | $197.16 | $309.90 | $253.77 | $208.08 |
| $175.80 | $276.90 | $226.92 | $185.92 | 87 | $202.07 | $318.27 | $260.83 | $213.70 |
| $180.24 | $284.39 | $233.25 | $190.94 | 88 | $207.17 | $326.89 | $268.10 | $219.47 |
| $185.31 | $292.28 | $239.91 | $196.24 | 89 | $213.00 | $335.96 | $275.76 | $225.56 |
| $190.70 | $300.63 | $246.96 | $201.85 | 90 | $219.20 | $345.56 | $283.86 | $232.01 |
| $196.68 | $309.36 | $254.32 | $207.70 | 91 | $226.07 | $355.59 | $292.32 | $238.74 |
| $203.19 | $318.53 | $262.06 | $213.86 | 92 | $233.55 | $366.13 | $301.22 | $245.82 |
| $210.44 | $328.14 | $270.18 | $220.31 | 93 | $241.89 | $377.17 | $310.55 | $253.23 |
| $218.25 | $338.34 | $278.80 | $227.18 | 94 | $250.86 | $388.90 | $320.46 | $261.12 |
| $226.75 | $349.04 | $287.83 | $234.35 | 95 | $260.63 | $401.19 | $330.84 | $269.37 |
| $235.77 | $360.29 | $297.35 | $241.91 | 96 | $271.00 | $414.13 | $341.78 | $278.05 |
| $245.11 | $372.06 | $307.29 | $249.80 | 97 | $281.74 | $427.66 | $353.21 | $287.13 |
| $255.22 | $384.54 | $317.83 | $258.16 | 98 | $293.36 | $441.99 | $365.32 | $296.74 |
| $266.48 | $397.67 | $328.95 | $267.00 | 99 | $306.30 | $457.09 | $378.10 | $306.89 |

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

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## MONTHLY RATES*

## TOBACCO

**ZIP CODES:** *855-857, 859-860, 863-865*

| Female | | | | | Male | | | |
|---|---|---|---|---|---|---|---|---|
| Std. Plan A RENA10ST-AZ | Std. Plan F RENF10ST-AZ | Std. Plan G RENG10ST-AZ | Std. Plan N RENN10ST-AZ | Issue Age | Std. Plan A RENA10ST-AZ | Std. Plan F RENF10ST-AZ | Std. Plan G RENG10ST-AZ | Std. Plan N RENN10ST-AZ |
| $135.06 | $171.09 | $137.99 | $114.87 | 65 | $155.24 | $196.66 | $158.61 | $132.03 |
| $135.06 | $171.09 | $137.99 | $114.87 | 66 | $155.24 | $196.66 | $158.61 | $132.03 |
| $135.06 | $171.09 | $137.99 | $114.87 | 67 | $155.24 | $196.66 | $158.61 | $132.03 |
| $139.95 | $178.85 | $144.24 | $120.08 | 68 | $160.86 | $205.57 | $165.79 | $138.02 |
| $144.98 | $186.55 | $150.49 | $125.25 | 69 | $166.64 | $214.42 | $172.98 | $143.96 |
| $149.56 | $194.24 | $156.74 | $130.41 | 70 | $171.91 | $223.27 | $180.16 | $149.90 |
| $151.75 | $202.90 | $163.79 | $136.22 | 71 | $174.42 | $233.22 | $188.26 | $156.57 |
| $153.96 | $211.62 | $170.89 | $142.08 | 72 | $176.96 | $243.24 | $196.43 | $163.31 |
| $155.41 | $219.58 | $177.38 | $147.43 | 73 | $178.63 | $252.39 | $203.89 | $169.46 |
| $157.49 | $227.58 | $183.94 | $152.80 | 74 | $181.02 | $261.59 | $211.43 | $175.63 |
| $159.67 | $235.50 | $190.55 | $158.11 | 75 | $183.53 | $270.69 | $219.02 | $181.74 |
| $165.15 | $243.37 | $197.21 | $163.39 | 76 | $189.83 | $279.73 | $226.68 | $187.81 |
| $170.12 | $251.32 | $203.92 | $168.74 | 77 | $195.54 | $288.87 | $234.39 | $193.95 |
| $173.36 | $256.50 | $208.39 | $172.22 | 78 | $199.26 | $294.83 | $239.53 | $197.95 |
| $176.71 | $261.92 | $213.05 | $175.84 | 79 | $203.11 | $301.06 | $244.88 | $202.12 |
| $179.26 | $267.56 | $217.87 | $179.64 | 80 | $206.05 | $307.54 | $250.43 | $206.48 |
| $181.34 | $273.44 | $222.90 | $183.58 | 81 | $208.44 | $314.30 | $256.21 | $211.01 |
| $183.56 | $279.57 | $228.15 | $187.70 | 82 | $210.99 | $321.35 | $262.24 | $215.75 |
| $186.39 | $286.72 | $234.18 | $192.50 | 83 | $214.24 | $329.56 | $269.17 | $221.27 |
| $189.41 | $294.14 | $240.45 | $197.48 | 84 | $217.71 | $338.09 | $276.38 | $226.99 |
| $193.46 | $301.86 | $246.98 | $202.68 | 85 | $222.37 | $346.97 | $283.89 | $232.96 |
| $197.16 | $309.90 | $253.77 | $208.08 | 86 | $226.62 | $356.21 | $291.69 | $239.17 |
| $202.07 | $318.27 | $260.83 | $213.70 | 87 | $232.26 | $365.83 | $299.80 | $245.63 |
| $207.17 | $326.89 | $268.10 | $219.47 | 88 | $238.13 | $375.73 | $308.16 | $252.27 |
| $213.00 | $335.96 | $275.76 | $225.56 | 89 | $244.83 | $386.16 | $316.96 | $259.27 |
| $219.20 | $345.56 | $283.86 | $232.01 | 90 | $251.95 | $397.19 | $326.28 | $266.68 |
| $226.07 | $355.59 | $292.32 | $238.74 | 91 | $259.85 | $408.72 | $336.00 | $274.41 |
| $233.55 | $366.13 | $301.22 | $245.82 | 92 | $268.45 | $420.84 | $346.23 | $282.55 |
| $241.89 | $377.17 | $310.55 | $253.23 | 93 | $278.03 | $433.53 | $356.95 | $291.07 |
| $250.86 | $388.90 | $320.46 | $261.12 | 94 | $288.35 | $447.01 | $368.35 | $300.14 |
| $260.63 | $401.19 | $330.84 | $269.37 | 95 | $299.58 | $461.14 | $380.28 | $309.62 |
| $271.00 | $414.13 | $341.78 | $278.05 | 96 | $311.50 | $476.01 | $392.85 | $319.60 |
| $281.74 | $427.66 | $353.21 | $287.13 | 97 | $323.84 | $491.56 | $405.99 | $330.03 |
| $293.36 | $441.99 | $365.32 | $296.74 | 98 | $337.19 | $508.04 | $419.91 | $341.08 |
| $306.30 | $457.09 | $378.10 | $306.89 | 99 | $352.07 | $525.39 | $434.60 | $352.75 |

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**NON-TOBACCO**
**ZIP CODES:** *850-853*

# HOUSEHOLD DISCOUNT MONTHLY RATES*

(Refer to page 2 of this Outline of Coverage for Household Discount rules)

| Female | | | | | Male | | | |
|---|---|---|---|---|---|---|---|---|
| Std. Plan A RENA10ST-AZ | Std. Plan F RENF10ST-AZ | Std. Plan G RENG10ST-AZ | Std. Plan N RENN10ST-AZ | Issue Age | Std. Plan A RENA10ST-AZ | Std. Plan F RENF10ST-AZ | Std. Plan G RENG10ST-AZ | Std. Plan N RENN10ST-AZ |
| $113.74 | $144.09 | $116.21 | $96.74 | 65 | $130.74 | $165.62 | $133.57 | $111.19 |
| $113.74 | $144.09 | $116.21 | $96.74 | 66 | $130.74 | $165.62 | $133.57 | $111.19 |
| $113.74 | $144.09 | $116.21 | $96.74 | 67 | $130.74 | $165.62 | $133.57 | $111.19 |
| $117.86 | $150.62 | $121.47 | $101.12 | 68 | $135.47 | $173.12 | $139.62 | $116.23 |
| $122.09 | $157.10 | $126.74 | $105.48 | 69 | $140.34 | $180.58 | $145.68 | $121.24 |
| $125.95 | $163.59 | $132.00 | $109.83 | 70 | $144.78 | $188.03 | $151.72 | $126.24 |
| $127.79 | $170.88 | $137.93 | $114.72 | 71 | $146.89 | $196.41 | $158.55 | $131.86 |
| $129.65 | $178.22 | $143.92 | $119.65 | 72 | $149.03 | $204.85 | $165.43 | $137.53 |
| $130.88 | $184.92 | $149.39 | $124.16 | 73 | $150.44 | $212.55 | $171.71 | $142.71 |
| $132.63 | $191.66 | $154.91 | $128.68 | 74 | $152.45 | $220.30 | $178.06 | $147.91 |
| $134.47 | $198.33 | $160.47 | $133.16 | 75 | $154.56 | $227.96 | $184.45 | $153.05 |
| $139.08 | $204.95 | $166.08 | $137.60 | 76 | $159.87 | $235.58 | $190.90 | $158.17 |
| $143.27 | $211.65 | $171.73 | $142.10 | 77 | $164.68 | $243.27 | $197.39 | $163.34 |
| $145.99 | $216.02 | $175.50 | $145.03 | 78 | $167.81 | $248.29 | $201.72 | $166.71 |
| $148.81 | $220.58 | $179.42 | $148.09 | 79 | $171.05 | $253.54 | $206.23 | $170.22 |
| $150.97 | $225.33 | $183.48 | $151.28 | 80 | $173.53 | $259.00 | $210.90 | $173.89 |
| $152.72 | $230.28 | $187.72 | $154.60 | 81 | $175.54 | $264.69 | $215.77 | $177.70 |
| $154.59 | $235.45 | $192.14 | $158.08 | 82 | $177.69 | $270.63 | $220.85 | $181.70 |
| $156.97 | $241.46 | $197.22 | $162.12 | 83 | $180.42 | $277.54 | $226.68 | $186.34 |
| $159.51 | $247.71 | $202.50 | $166.31 | 84 | $183.35 | $284.73 | $232.76 | $191.16 |
| $162.93 | $254.22 | $208.00 | $170.68 | 85 | $187.27 | $292.20 | $239.08 | $196.19 |
| $166.04 | $260.99 | $213.72 | $175.23 | 86 | $190.85 | $299.99 | $245.65 | $201.42 |
| $170.17 | $268.04 | $219.66 | $179.97 | 87 | $195.60 | $308.09 | $252.48 | $206.86 |
| $174.47 | $275.29 | $225.78 | $184.83 | 88 | $200.54 | $316.42 | $259.52 | $212.45 |
| $179.38 | $282.93 | $232.23 | $189.96 | 89 | $206.19 | $325.21 | $266.93 | $218.35 |
| $184.60 | $291.01 | $239.06 | $195.39 | 90 | $212.18 | $334.50 | $274.78 | $224.59 |
| $190.39 | $299.46 | $246.18 | $201.05 | 91 | $218.84 | $344.21 | $282.97 | $231.10 |
| $196.69 | $308.34 | $253.68 | $207.02 | 92 | $226.08 | $354.41 | $291.58 | $237.95 |
| $203.71 | $317.64 | $261.53 | $213.26 | 93 | $234.15 | $365.10 | $300.61 | $245.13 |
| $211.27 | $327.51 | $269.88 | $219.91 | 94 | $242.84 | $376.45 | $310.21 | $252.77 |
| $219.50 | $337.87 | $278.62 | $226.85 | 95 | $252.29 | $388.35 | $320.26 | $260.75 |
| $228.23 | $348.76 | $287.83 | $234.16 | 96 | $262.33 | $400.88 | $330.84 | $269.15 |
| $237.27 | $360.16 | $297.46 | $241.81 | 97 | $272.73 | $413.97 | $341.91 | $277.94 |
| $247.05 | $372.23 | $307.66 | $249.90 | 98 | $283.97 | $427.85 | $353.63 | $287.24 |
| $257.95 | $384.94 | $318.42 | $258.45 | 99 | $296.50 | $442.46 | $366.00 | $297.07 |

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

Renaissance
Life & Health Insurance Company of America

# HOUSEHOLD DISCOUNT MONTHLY RATES*

(Refer to page 2 of this Outline of Coverage for Household Discount rules)

**TOBACCO**

**ZIP CODES:** *850-853*

| Female | | | | | Male | | | |
|---|---|---|---|---|---|---|---|---|
| Std. Plan A RENA10ST-AZ | Std. Plan F RENF10ST-AZ | Std. Plan G RENG10ST-AZ | Std. Plan N RENN10ST-AZ | Issue Age | Std. Plan A RENA10ST-AZ | Std. Plan F RENF10ST-AZ | Std. Plan G RENG10ST-AZ | Std. Plan N RENN10ST-AZ |
| $130.74 | $165.62 | $133.57 | $111.19 | 65 | $150.27 | $190.37 | $153.53 | $127.81 |
| $130.74 | $165.62 | $133.57 | $111.19 | 66 | $150.27 | $190.37 | $153.53 | $127.81 |
| $130.74 | $165.62 | $133.57 | $111.19 | 67 | $150.27 | $190.37 | $153.53 | $127.81 |
| $135.47 | $173.12 | $139.62 | $116.23 | 68 | $155.71 | $198.99 | $160.48 | $133.60 |
| $140.34 | $180.58 | $145.68 | $121.24 | 69 | $161.31 | $207.56 | $167.44 | $139.35 |
| $144.78 | $188.03 | $151.72 | $126.24 | 70 | $166.41 | $216.13 | $174.39 | $145.10 |
| $146.89 | $196.41 | $158.55 | $131.86 | 71 | $168.84 | $225.76 | $182.24 | $151.56 |
| $149.03 | $204.85 | $165.43 | $137.53 | 72 | $171.30 | $235.46 | $190.14 | $158.08 |
| $150.44 | $212.55 | $171.71 | $142.71 | 73 | $172.91 | $244.31 | $197.37 | $164.04 |
| $152.45 | $220.30 | $178.06 | $147.91 | 74 | $175.23 | $253.22 | $204.66 | $170.01 |
| $154.56 | $227.96 | $184.45 | $153.05 | 75 | $177.66 | $262.03 | $212.01 | $175.92 |
| $159.87 | $235.58 | $190.90 | $158.17 | 76 | $183.76 | $270.78 | $219.43 | $181.80 |
| $164.68 | $243.27 | $197.39 | $163.34 | 77 | $189.28 | $279.63 | $226.89 | $187.74 |
| $167.81 | $248.29 | $201.72 | $166.71 | 78 | $192.88 | $285.40 | $231.87 | $191.62 |
| $171.05 | $253.54 | $206.23 | $170.22 | 79 | $196.61 | $291.43 | $237.04 | $195.65 |
| $173.53 | $259.00 | $210.90 | $173.89 | 80 | $199.46 | $297.70 | $242.42 | $199.87 |
| $175.54 | $264.69 | $215.77 | $177.70 | 81 | $201.77 | $304.24 | $248.01 | $204.26 |
| $177.69 | $270.63 | $220.85 | $181.70 | 82 | $204.24 | $311.07 | $253.85 | $208.85 |
| $180.42 | $277.54 | $226.68 | $186.34 | 83 | $207.38 | $319.01 | $260.56 | $214.19 |
| $183.35 | $284.73 | $232.76 | $191.16 | 84 | $210.74 | $327.27 | $267.54 | $219.73 |
| $187.27 | $292.20 | $239.08 | $196.19 | 85 | $215.25 | $335.87 | $274.81 | $225.51 |
| $190.85 | $299.99 | $245.65 | $201.42 | 86 | $219.37 | $344.81 | $282.36 | $231.52 |
| $195.60 | $308.09 | $252.48 | $206.86 | 87 | $224.83 | $354.12 | $290.21 | $237.77 |
| $200.54 | $316.42 | $259.52 | $212.45 | 88 | $230.51 | $363.71 | $298.30 | $244.20 |
| $206.19 | $325.21 | $266.93 | $218.35 | 89 | $237.00 | $373.80 | $306.82 | $250.97 |
| $212.18 | $334.50 | $274.78 | $224.59 | 90 | $243.89 | $384.48 | $315.84 | $258.15 |
| $218.84 | $344.21 | $282.97 | $231.10 | 91 | $251.53 | $395.64 | $325.25 | $265.63 |
| $226.08 | $354.41 | $291.58 | $237.95 | 92 | $259.86 | $407.37 | $335.15 | $273.51 |
| $234.15 | $365.10 | $300.61 | $245.13 | 93 | $269.13 | $419.66 | $345.53 | $281.76 |
| $242.84 | $376.45 | $310.21 | $252.77 | 94 | $279.12 | $432.71 | $356.56 | $290.54 |
| $252.29 | $388.35 | $320.26 | $260.75 | 95 | $289.99 | $446.38 | $368.11 | $299.71 |
| $262.33 | $400.88 | $330.84 | $269.15 | 96 | $301.53 | $460.78 | $380.28 | $309.37 |
| $272.73 | $413.97 | $341.91 | $277.94 | 97 | $313.48 | $475.83 | $393.00 | $319.47 |
| $283.97 | $427.85 | $353.63 | $287.24 | 98 | $326.40 | $491.78 | $406.47 | $330.17 |
| $296.50 | $442.46 | $366.00 | $297.07 | 99 | $340.80 | $508.58 | $420.69 | $341.46 |

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

Renaissance®
Life & Health Insurance Company of America

## MONTHLY RATES*

## NON-TOBACCO

**ZIP CODES:** *850-853*

| Female | | | | | Male | | | |
|---|---|---|---|---|---|---|---|---|
| Std. Plan A RENA10ST-AZ | Std. Plan F RENF10ST-AZ | Std. Plan G RENG10ST-AZ | Std. Plan N RENN10ST-AZ | Issue Age | Std. Plan A RENA10ST-AZ | Std. Plan F RENF10ST-AZ | Std. Plan G RENG10ST-AZ | Std. Plan N RENN10ST-AZ |
| $129.25 | $163.74 | $132.06 | $109.93 | 65 | $148.56 | $188.20 | $151.79 | $126.35 |
| $129.25 | $163.74 | $132.06 | $109.93 | 66 | $148.56 | $188.20 | $151.79 | $126.35 |
| $129.25 | $163.74 | $132.06 | $109.93 | 67 | $148.56 | $188.20 | $151.79 | $126.35 |
| $133.93 | $171.16 | $138.04 | $114.91 | 68 | $153.94 | $196.73 | $158.66 | $132.09 |
| $138.74 | $178.52 | $144.02 | $119.86 | 69 | $159.47 | $205.20 | $165.54 | $137.77 |
| $143.13 | $185.89 | $150.00 | $124.81 | 70 | $164.52 | $213.67 | $172.41 | $143.45 |
| $145.22 | $194.18 | $156.74 | $130.36 | 71 | $166.92 | $223.19 | $180.16 | $149.84 |
| $147.34 | $202.52 | $163.55 | $135.97 | 72 | $169.35 | $232.78 | $187.98 | $156.29 |
| $148.73 | $210.14 | $169.76 | $141.09 | 73 | $170.95 | $241.54 | $195.12 | $162.17 |
| $150.72 | $217.80 | $176.03 | $146.23 | 74 | $173.24 | $250.34 | $202.34 | $168.08 |
| $152.81 | $225.37 | $182.35 | $151.31 | 75 | $175.64 | $259.05 | $209.60 | $173.93 |
| $158.05 | $232.90 | $188.73 | $156.37 | 76 | $181.67 | $267.70 | $216.93 | $179.73 |
| $162.80 | $240.51 | $195.15 | $161.48 | 77 | $187.13 | $276.45 | $224.31 | $185.61 |
| $165.90 | $245.47 | $199.43 | $164.81 | 78 | $190.69 | $282.15 | $229.23 | $189.44 |
| $169.11 | $250.66 | $203.88 | $168.28 | 79 | $194.38 | $288.11 | $234.35 | $193.43 |
| $171.56 | $256.05 | $208.51 | $171.91 | 80 | $197.19 | $294.32 | $239.66 | $197.60 |
| $173.55 | $261.68 | $213.32 | $175.68 | 81 | $199.48 | $300.79 | $245.19 | $201.94 |
| $175.67 | $267.55 | $218.34 | $179.63 | 82 | $201.92 | $307.53 | $250.96 | $206.47 |
| $178.37 | $274.39 | $224.11 | $184.23 | 83 | $205.03 | $315.39 | $257.60 | $211.76 |
| $181.26 | $281.49 | $230.11 | $188.99 | 84 | $208.35 | $323.55 | $264.50 | $217.23 |
| $185.14 | $288.88 | $236.36 | $193.96 | 85 | $212.81 | $332.05 | $271.68 | $222.94 |
| $188.68 | $296.58 | $242.86 | $199.13 | 86 | $216.88 | $340.89 | $279.15 | $228.89 |
| $193.38 | $304.59 | $249.61 | $204.51 | 87 | $222.27 | $350.10 | $286.91 | $235.07 |
| $198.26 | $312.83 | $256.57 | $210.04 | 88 | $227.89 | $359.57 | $294.91 | $241.42 |
| $203.84 | $321.51 | $263.90 | $215.87 | 89 | $234.30 | $369.56 | $303.33 | $248.12 |
| $209.77 | $330.70 | $271.66 | $222.04 | 90 | $241.12 | $380.11 | $312.25 | $255.21 |
| $216.35 | $340.30 | $279.75 | $228.47 | 91 | $248.68 | $391.15 | $321.55 | $262.61 |
| $223.51 | $350.39 | $288.27 | $235.25 | 92 | $256.91 | $402.74 | $331.34 | $270.40 |
| $231.48 | $360.95 | $297.19 | $242.34 | 93 | $266.07 | $414.89 | $341.60 | $278.55 |
| $240.08 | $372.18 | $306.68 | $249.89 | 94 | $275.95 | $427.79 | $352.51 | $287.23 |
| $249.43 | $383.94 | $316.62 | $257.79 | 95 | $286.70 | $441.31 | $363.93 | $296.31 |
| $259.35 | $396.32 | $327.08 | $266.10 | 96 | $298.11 | $455.54 | $375.96 | $305.86 |
| $269.63 | $409.27 | $338.02 | $274.78 | 97 | $309.91 | $470.42 | $388.53 | $315.84 |
| $280.74 | $422.99 | $349.61 | $283.98 | 98 | $322.69 | $486.19 | $401.85 | $326.41 |
| $293.13 | $437.43 | $361.84 | $293.70 | 99 | $336.93 | $502.80 | $415.91 | $337.58 |

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

Renaissance®
Life & Health Insurance Company of America

## MONTHLY RATES*

## TOBACCO

**ZIP CODES:** 850-853

| Female | | | | | Male | | | |
|---|---|---|---|---|---|---|---|---|
| Std. Plan A RENA10ST-AZ | Std. Plan F RENF10ST-AZ | Std. Plan G RENG10ST-AZ | Std. Plan N RENN10ST-AZ | Issue Age | Std. Plan A RENA10ST-AZ | Std. Plan F RENF10ST-AZ | Std. Plan G RENG10ST-AZ | Std. Plan N RENN10ST-AZ |
| $148.56 | $188.20 | $151.79 | $126.35 | 65 | $170.76 | $216.33 | $174.47 | $145.23 |
| $148.56 | $188.20 | $151.79 | $126.35 | 66 | $170.76 | $216.33 | $174.47 | $145.23 |
| $148.56 | $188.20 | $151.79 | $126.35 | 67 | $170.76 | $216.33 | $174.47 | $145.23 |
| $153.94 | $196.73 | $158.66 | $132.09 | 68 | $176.95 | $226.13 | $182.37 | $151.82 |
| $159.47 | $205.20 | $165.54 | $137.77 | 69 | $183.30 | $235.86 | $190.28 | $158.36 |
| $164.52 | $213.67 | $172.41 | $143.45 | 70 | $189.10 | $245.60 | $198.18 | $164.89 |
| $166.92 | $223.19 | $180.16 | $149.84 | 71 | $191.86 | $256.54 | $207.09 | $172.23 |
| $169.35 | $232.78 | $187.98 | $156.29 | 72 | $194.66 | $267.56 | $216.07 | $179.64 |
| $170.95 | $241.54 | $195.12 | $162.17 | 73 | $196.49 | $277.63 | $224.28 | $186.41 |
| $173.24 | $250.34 | $202.34 | $168.08 | 74 | $199.12 | $287.75 | $232.57 | $193.19 |
| $175.64 | $259.05 | $209.60 | $173.93 | 75 | $201.88 | $297.76 | $240.92 | $199.91 |
| $181.67 | $267.70 | $216.93 | $179.73 | 76 | $208.81 | $307.70 | $249.35 | $206.59 |
| $187.13 | $276.45 | $224.31 | $185.61 | 77 | $215.09 | $317.76 | $257.83 | $213.34 |
| $190.69 | $282.15 | $229.23 | $189.44 | 78 | $219.19 | $324.31 | $263.48 | $217.74 |
| $194.38 | $288.11 | $234.35 | $193.43 | 79 | $223.42 | $331.17 | $269.37 | $222.33 |
| $197.19 | $294.32 | $239.66 | $197.60 | 80 | $226.66 | $338.29 | $275.47 | $227.13 |
| $199.48 | $300.79 | $245.19 | $201.94 | 81 | $229.28 | $345.73 | $281.83 | $232.11 |
| $201.92 | $307.53 | $250.96 | $206.47 | 82 | $232.09 | $353.49 | $288.46 | $237.32 |
| $205.03 | $315.39 | $257.60 | $211.76 | 83 | $235.66 | $362.52 | $296.09 | $243.40 |
| $208.35 | $323.55 | $264.50 | $217.23 | 84 | $239.48 | $371.90 | $304.02 | $249.69 |
| $212.81 | $332.05 | $271.68 | $222.94 | 85 | $244.61 | $381.67 | $312.28 | $256.26 |
| $216.88 | $340.89 | $279.15 | $228.89 | 86 | $249.28 | $391.83 | $320.86 | $263.09 |
| $222.27 | $350.10 | $286.91 | $235.07 | 87 | $255.49 | $402.41 | $329.78 | $270.19 |
| $227.89 | $359.57 | $294.91 | $241.42 | 88 | $261.94 | $413.30 | $338.98 | $277.50 |
| $234.30 | $369.56 | $303.33 | $248.12 | 89 | $269.31 | $424.78 | $348.66 | $285.20 |
| $241.12 | $380.11 | $312.25 | $255.21 | 90 | $277.14 | $436.91 | $358.91 | $293.35 |
| $248.68 | $391.15 | $321.55 | $262.61 | 91 | $285.84 | $449.59 | $369.60 | $301.85 |
| $256.91 | $402.74 | $331.34 | $270.40 | 92 | $295.30 | $462.92 | $380.85 | $310.81 |
| $266.07 | $414.89 | $341.60 | $278.55 | 93 | $305.83 | $476.88 | $392.65 | $320.18 |
| $275.95 | $427.79 | $352.51 | $287.23 | 94 | $317.19 | $491.71 | $405.19 | $330.15 |
| $286.70 | $441.31 | $363.93 | $296.31 | 95 | $329.54 | $507.25 | $418.31 | $340.58 |
| $298.11 | $455.54 | $375.96 | $305.86 | 96 | $342.65 | $523.61 | $432.14 | $351.56 |
| $309.91 | $470.42 | $388.53 | $315.84 | 97 | $356.22 | $540.72 | $446.59 | $363.03 |
| $322.69 | $486.19 | $401.85 | $326.41 | 98 | $370.91 | $558.84 | $461.90 | $375.19 |
| $336.93 | $502.80 | $415.91 | $337.58 | 99 | $387.28 | $577.93 | $478.06 | $388.02 |

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

**PREMIUM INFORMATION**
We, Renaissance Life & Health Insurance Company of America, can only raise your premium if (a) we change the premium rates which apply to all policies of this form issued by us and inforce in your state; (b) coverage under Medicare changes; or (c) you move to a different Zip Code. We will send you the advance written notice required by your state when we change the premium rates for all policies of this form issued by us and inforce in your state.

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

**HOUSEHOLD DISCOUNT**
If you are applying for a Renaissance Life & Health Insurance Company of America Standard Plan, you may be eligible for a Household Premium Discount. The discount is available if you currently have a household resident (at least one, no more than 3) who is age 50 or older:

- with whom you have continuously resided for the past 12 months or to whom you are either married or with whom you are in a civil union partnership; or

- who has an existing Medicare Supplement policy, or is applying for a policy, with Renaissance Life & Health Insurance Company of America.

**DISCLOSURES**
Use this Outline of Coverage to compare benefits and premiums among policies.

**READ YOUR POLICY VERY CAREFULLY**
This is only an Outline of Coverage, describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

**30-DAY RIGHT TO RETURN POLICY**
If you are not satisfied with your policy, you may return it to Renaissance Life & Health Insurance Company of America, Health Administrative Office, P.O. Box 27248, Salt Lake City, UT 84127-0248. 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 Renaissance Life & Health Insurance Company of America 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 the Medicare Buyers Guide for more details.

**COMPLETE ANSWERS ARE VERY IMPORTANT**
When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. Renaissance Life & Health Insurance Company of America 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.

**RENEWABILITY**
This policy is guaranteed renewable for life, as long as premiums are paid on time and the information on your application is correct.

# *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 A PAYS | YOU PAY |
|---|---|---|---|
| HOSPITALIZATION*<br>Semi-private room and board, general nursing and miscellaneous services and supplies | | | |
| First 60 days | All but $1,408 | $0 | $1,408 (Part A Deductible) |
| 61st thru 90th day | All but $352 a day | $352 a day | $0 |
| 91st day and after: | | | |
| • While using 60 lifetime reserve days | All but $704 a day | $704 a day | $0 |
| • Once lifetime reserve days are used:<br>- Additional 365 days<br>- Beyond the additional 365 days | <br>$0<br>$0 | <br>100% of Medicare Eligible Expenses<br>$0 | <br>$0**<br>All Costs |
| SKILLED NURSING FACILITY CARE*<br>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 $176 a day | $0 | Up to $176 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<br>You must meet Medicare's requirements, including a doctor's certification of terminal illness. | All but very limited co-payment / co-insurance for outpatient drugs and inpatient respite care | Medicare co-payment / co-insurance | $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 $198 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<br>Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment. | | | |
| First $198 of Medicare-approved amounts* | $0 | $0 | $198 (Part B Deductible) |
| Remainder of Medicare-approved amounts | Generally 80% | Generally 20% | $0 |
| Part B Excess Charges<br>(Above Medicare-approved amounts) | $0 | $0 | All costs |
| BLOOD | | | |
| First 3 pints | $0 | All costs | $0 |
| Next $198 of Medicare-approved amounts* | $0 | $0 | $198 (Part B Deductible) |
| Remainder of Medicare-approved amounts | 80% | 20% | $0 |
| CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES | 100% | $0 | $0 |

**PARTS A & B**

| | | | |
|---|---|---|---|
| HOME HEALTHCARE MEDICARE-APPROVED SERVICES | | | |
| • Medically necessary skilled care services and medical supplies | 100% | $0 | $0 |
| • Durable medical equipment | | | |
| - First $198 of Medicare-approved amounts* | $0 | $0 | $198 (Part B Deductible) |
| - Remainder of Medicare-approved amounts | 80% | 20% | $0 |

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

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

| SERVICES | MEDICARE PAYS | PLAN PAYS | YOU PAY |
|---|---|---|---|
| HOSPITALIZATION*<br>Semi-private room and board, general nursing and miscellaneous services and supplies | | | |
| First 60 days | All but $1,408 | $1,408 (Part A Deductible) | $0 |
| 61st thru 90th day | All but $352 a day | $352 a day | $0 |
| 91st day and after: | | | |
| • While using 60 lifetime reserve days | All but $704 a day | $704 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*<br>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 $176 a day | Up to $176 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<br>You must meet Medicare's requirements, including a doctor's certification of terminal illness. | All but very limited co-payment / co-insurance for outpatient drugs and inpatient respite care | Medicare co-payment/co-insurance | $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 $198 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<br>Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment. | | | |
| First $198 of Medicare-approved amounts* | $0 | $198 (Part B Deductible) | $0 |
| Remainder of Medicare-approved amounts | Generally 80% | Generally 20% | $0 |
| Part B Excess Charges<br>(Above Medicare-approved amounts) | $0 | 100% | $0 |
| BLOOD | | | |
| First 3 pints | $0 | All costs | $0 |
| Next $198 of Medicare-approved amounts* | $0 | $198 (Part B Deductible) | $0 |
| Remainder of Medicare-approved amounts | 80% | 20% | $0 |
| CLINICAL LABORATORY SERVICES –<br>TESTS FOR DIAGNOSTIC SERVICES | 100% | $0 | $0 |

**PARTS A & B**

| | | | |
|---|---|---|---|
| HOME HEALTHCARE MEDICARE-APPROVED SERVICES | | | |
| • Medically necessary skilled care services and medical supplies | 100% | $0 | $0 |
| • Durable medical equipment | | | |
| - First $198 of Medicare-approved amounts* | $0 | $198 (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 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*<br>Semi-private room and board, general nursing and miscellaneous services and supplies | | | |
| First 60 days | All but $1,408 | $1,408 (Part A Deductible) | $0 |
| 61st thru 90th day | All but $352 a day | $352 a day | $0 |
| 91st day and after: | | | |
| • While using 60 lifetime reserve days | All but $704 a day | $704 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*<br>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 $176 a day | Up to $176 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<br>You must meet Medicare's requirements, including a doctor's certification of terminal illness. | All but very limited co-payment / co-insurance for outpatient drugs and inpatient respite care | Medicare co-payment/co-insurance | $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 $198 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<br>Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment. | | | |
| First $198 of Medicare-approved amounts* | $0 | $0 | $198 (Unless Part B Deductible has been met) |
| Remainder of Medicare-approved amounts | Generally 80% | Generally 20% | $0 |
| Part B Excess Charges<br>(Above Medicare-approved amounts) | $0 | 100% | $0 |
| BLOOD | | | |
| First 3 pints | $0 | All costs | $0 |
| Next $198 of Medicare-approved amounts* | $0 | $0 | $198 (Unless Part B Deductible has been met) |
| Remainder of Medicare-approved amounts | 80% | 20% | $0 |
| CLINICAL LABORATORY SERVICES –<br>TESTS FOR DIAGNOSTIC SERVICES | 100% | $0 | $0 |

**PARTS A & B**

| | | | |
|---|---|---|---|
| HOME HEALTHCARE MEDICARE-APPROVED SERVICES | | | |
| • Medically necessary skilled care services and medical supplies | 100% | $0 | $0 |
| • Durable medical equipment | | | |
| - First $198 of Medicare-approved amounts* | $0 | $0 | $198 (Unless Part B Deductible has been met) |
| - 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 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*<br>Semi-private room and board, general nursing and miscellaneous services and supplies | | | |
| First 60 days | All but $1,408 | $1,408 (Part A Deductible) | $0 |
| 61st thru 90th day | All but $352 a day | $352 a day | $0 |
| 91st day and after: | | | |
| • While using 60 lifetime reserve days | All but $704 a day | $704 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*<br>You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-Sapproved facility within 30 days after leaving the hospital. | | | |
| First 20 days | All approved amounts | $0 | $0 |
| 21st thru 100th day | All but $176 a day | Up to $176 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<br>You must meet Medicare's requirements, including a doctor's certification of terminal illness. | All but very limited co-payment /<br>co-insurance for outpatient drugs and inpatient respite care | Medicare co-payment/co-insurance | $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 $198 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.

| | | | |
|---|---|---|---|
| MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as<br>Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment. | | | |
| First $198 of Medicare-approved amounts* | $0 | $0 | $198 (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<br>(Above Medicare-approved amounts) | $0 | $0 | All Costs |
| BLOOD | | | |
| First 3 pints | $0 | All costs | $0 |
| Next $198 of Medicare-approved amounts* | $0 | $0 | $198 (Part B Deductible) |
| Remainder of Medicare-approved amounts | 80% | 20% | $0 |
| CLINICAL LABORATORY SERVICES -<br>TESTS FOR DIAGNOSTIC SERVICES - | 100% | $0 | $0 |

# *PLAN N MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR*

* Once you have been billed $198 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.

**PARTS A & B**

| | | | |
|---|---|---|---|
| HOME HEALTHCARE MEDICARE-APPROVED SERVICES | | | |
| • Medically necessary skilled care services and medical supplies | 100% | $0 | $0 |
| • Durable medical equipment | | | |
| - First $198 of Medicare-approved amounts* | $0 | $0 | $198 (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 |