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

Outline of Medicare Supplement Coverage – Cover Page
Extended Basic Plan

The Commissioner of Insurance of the State of Minnesota has established two categories of Medicare Supplements and minimum standards for each, with the extended basic Medicare Supplement being the most comprehensive and the basic Medicare Supplement being the least comprehensive. This chart shows the benefits in each plan.

Basic - **Policy Form RENBAS10ST-MN Rev 070119**	**Extended Basic -** **Policy Form RENEXT10ST-MN Rev 070119**	**$20 AND $50 Copayment -** **Policy Form RENCOP10ST-MN Rev 070119**
Hospitalization: Part A Coinsurance	Hospitalization: Part A Coinsurance	Hospitalization: Part A Coinsurance
Medical Expenses: Part B Coinsurance	Medical Expenses: Part B Coinsurance	Medical Expenses: Part B Coinsurance except up to $20 copayment or office visit, up to $50 copayment for ER
Blood: First 3 pints of blood each year	Blood: First 3 pints of blood each year	Blood: First 3 pints of blood each year
Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance for the 21st through 100th day
Optional riders:	Part A Deductible	Part A Deductible
Part A Deductible Rider	Part B Deductible***	
Part B Deductible Rider	Part B Excess (100%)	
Preventive Medical Care Benefits Rider	Foreign Travel	Foreign Travel
Part B Excess Charges Rider	Hospice Care	Hospice Care
Foreign Travel	Preventive Care	
Hospice Care		

Premium Information

We, Renaissance Life & Health Insurance Company of America, will renew the policy each time You pay Us the premium. It must be paid by the date it is due or during the 31 days that follow. Your policy stays in force during this 31-day period. We can only change Your Premiums upon approval by the Department of Insurance and if a change is made for all policies bearing this form number in the state where You reside. Benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible amount and co-payment percentage factors. Premiums may be modified to correspond with the changes.

"Persons in your classification" means all persons having the same benefits.

* Optional Riders available for Part A Deductible, Part B Excess, Part B Deductible and Preventive Health Services

*** Coverage of the Part B deductible is only available for clients eligible for Medicare prior to 1/1/2020

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MONTHLY PREMIUMS

ZIP CODES: 550, 555-567

NON-TOBACCO-MONTHLY RATES	
Extended Basic - Policy Form RENEXT10ST-MN Rev 070119	
ALL AGES	$310.50

TOBACCO-MONTHLY RATES	
Extended Basic - Policy Form RENEXT10ST-MN Rev 070119	
ALL AGES	$356.90

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

The policy provides an anticipated loss ratio of 74.6%. This means that, on the average, Policyholders may expect that $74.60 of every $100.00 in premium will be returned as benefits to Policyholders over the life of the contract.

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MONTHLY PREMIUMS

ZIP CODES: 551, 553, 554

NON-TOBACCO-MONTHLY RATES	
Extended Basic - Policy Form RENEXT10ST-MN Rev 070119	
ALL AGES	$344.66

TOBACCO-MONTHLY RATES	
Extended Basic - Policy Form RENEXT10ST-MN Rev 070119	
ALL AGES	$396.16

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

The policy provides an anticipated loss ratio of 74.6%. This means that, on the average, Policyholders may expect that $74.60 of every $100.00 in premium will be returned as benefits to Policyholders over the life of the contract.

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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.

ANTICIPATED LOSS RATIOS
This policy or certificate is expected to return on average 74.6 percent of your premium dollar for health care. The lowest percentage permitted by state law for this policy or certificate is 65 percent.

This policy provides a minimum loss ratio of 74.6% . This means that, on the average, Policyholders may expect that $74.60 of every $100.00 in premium will be returned as benefits to Policyholders over the life of the contract.

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. Medical and health history information is not required during open enrollment and guaranteed issue when underwriting is prohibited. 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. This means you have the right to continue your policy in force for as long as you live. Unless there has been a Material Misrepresentation, we cannot cancel your coverage as long as you pay the required premium payment when it is due. Your coverage may not be canceled due to the deterioration in Your health.

THE POLICY DOES NOT COVER ALL MEDICAL EXPENSES BEYOND THOSE COVERED BY MEDICARE. THE POLICY DOES NOT COVER ALL SKILLED NURSING HOME CARE EXPENSES AND DOES NOT COVER CUSTODIAL OR RESIDENTIAL NURSING CARE. READ YOUR POLICY CAREFULLY TO DETERMINE WHICH NURSING HOME FACILITIES AND EXPENSES ARE COVERED BY YOUR POLICY.

We will not pay for services for which a charge is normally not made when there is no insurance. In addition, no benefits are payable for expense incurred before the coverage effective date.

LIMITATION ON OUT-OF-POCKET EXPENSE

When Your out-of-pocket expense equals $1,000.00 in a calendar year, We will pay 100% of additional covered expense You incur during the remainder of such calendar year **(EXTENDED BASIC POLICY FORM RENEXT10ST-MN** only).

EXTENDED BASIC PLAN - RENEXT10ST-MN Rev 070119
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	EXTENDED BASIC PLAN PAYS	YOU PAY
HOSPITALIZATION 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 Beyond the additional 365 days	 $0 $0	 100% of Medicare Eligible Expenses $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 $176 a day	Up to $176 a day	$0
101st day and after	$0	$0	Expenses not paid by Medicare or the policy
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/co-insurance for outpatient drugs and inpatient respite care	Medicare copayment / co-insurance	$0

EXTENDED BASIC PLAN - RENEXT10ST-MN Rev 070119
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

SERVICES	MEDICARE PAYS	EXTENDED BASIC 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 $198 of Medicare-approved amounts*	$0	$198 (Part B Deductible***)	$198 (Part B Deductible***)
Remainder of Medicare-approved amounts	80%	20% **	$0
Part B Excess Charges (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***)	$198 (Part B Deductible***)
Remainder of Medicare-approved amounts	80%	20% **	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

** Part B coinsurance (generally 20% of Medicare approved expenses), or in the case of hospital outpatient department services under a prospective payment system, applicable copayments.

*** Coverage of the Part B deductible is only available for clients eligible for Medicare prior to 1/1/2020.

EXTENDED BASIC PLAN - RENEXT10ST-MN Rev 070119
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR (continued)

PARTS A & B

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

OTHER BENEFITS - NOT COVERED BY MEDICARE

FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary care services beginning during travel outside the USA (hospital, medical expense and supplies)	$0	80% of covered expenses	Expenses not paid by Medicare or the policy
PREVENTIVE MEDICAL CARE BENEFIT – NOT COVERED BY MEDICARE Annual physical and preventive tests such as: fecal occult blood test, digital rectal exam, mammogram, hearing screening, dipstick urinalysis, diabetes screening, thyroid function test, influenza shot, tetanus and diphtheria booster and education, administered or ordered by Your doctor when not covered by Medicare.			
First $120 each calendar year	$0	$120	$0
Additional Charges	$0	$0	All Costs

** Part B coinsurance (generally 20% of Medicare approved expenses), or in the case of hospital outpatient department services under a prospective payment system, applicable copayments.

*** Coverage of the Part B deductible is only available for clients eligible for Medicare prior to 1/1/2020.

ADDITIONAL BENEFITS

1. Alcoholism and Chemical Dependency Treatment Benefit. We will pay the Usual and Customary Charge for the treatment of alcoholism and chemical dependency on the same basis as any other Sickness or Injury and as if Medicare paid benefits when treatment is provided in: (a) outpa tient alcoholism and chemical dependency services that must not place a greater financial burden on you or be more restrictive than those require ments and limitations for outpatient medical services; and (b) inpatient alcoholism and chemical dependency services that must not place a greater financial burden on you or be more restrictive than those requirements and limitations for inpatient medical services. Benefits are not payable for that portion of expense that is paid by Medicare or under any other part of this policy.
2. Scalp Hair Prosthesis. We will pay the expense incurred on the same basis as any other Sickness or Injury and as if Medicare paid benefits for a scalp hair prosthesis needed because of hair loss suffered as a result of alopecia areata. We will pay the Usual and Customary Charge for a scalp hair prosthesis procedure as a result of alopecia areata, limited to one prosthesis per benefit year. Benefits are not payable for that portion of expense that is paid by Medicare or under any other part of this policy.
3. Routine Screening Procedures for Cancer Benefit We will pay the Usual and Customary Charge for the expense incurred routine screening procedures for cancer and the office or facility visit, including mammograms, surveillance tests for ovarian cancer for women who are at risk for ovarian cancer, pap smears, and colorectal screening tests for men and women, when ordered or provided by a physician in accordance with the standard practice of medicine. mammograms and Pap smears. Benefits are not payable for that portion of expense that is paid by Medicare or under any other part of this policy.
4. Temporomandibular Joint Disorder and Craniomandibular Disorder. We will pay the Usual and Customary Charge for the surgical and nonsurgical treatment of temporomandibular joint disorder and craniomandibular disorder on the same basis as that for treatment to any other joint in the body. Such treatment must be administered or prescribed by a physician or dentist. Benefits are not payable under this part of your policy for any expense payable under another part of this policy.
5. Reconstructive Surgery. We will pay the Usual and Customary Charge for reconstructive surgery on the same basis as that for any other surgery if the reconstructive surgery is incidental to or follows surgery resulting from Injury, Sickness or other disease of the involved part. Benefits are not pay able under this part of your policy for any expense payable under another part of this policy. Reconstructive surgery benefits include all stages of reconstruction of the breast on which the mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prosthesis and physical complications at all stages of a mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and patient. Coverage may be subject to annual deductible, co-payment, and coinsurance provisions as may be deemed appropriate and as are consistent with those established for other benefits under the plan or coverage. Coverage may not: (1) deny to a patient eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the plan, solely for the purpose of avoiding the requirements of this section; and (2) penalize or otherwise reduce or limit the reimbursement of an attending provider, or provide monetary or other incentives to an attending provider to induce the provider to provide care to an individual participant or beneficiary in a manner inconsistent with this section. Written notice of the availability of the coverage must be delivered to the participant upon enrollment and annually thereafter.
6. Surgical Center Services. We will pay the Usual and Customary Charge for surgical center services for health care treatment or service rendered by a freestanding ambulatory surgical center or facilities offering ambulatory medical service but have been r on the same basis as coverage provided for the same health care treatment or service rendered by a Hospital. Benefits are not payable under this part of your policy for an expense payable under another part of this policy.
7. Immunization Benefits. We will pay the Usual and Customary Charge, not otherwise covered under Part D of the Medicare Program, for expense incurred for an immunization received by you. Benefits are not payable for that portion of expense for which benefits were paid by Medicare or under any other part of this policy.
8. Phenylketonuria Treatment. We will pay the Usual and Customary Charge for expenses incurred for the dietary treatment of phenylketonuria received by you when recommended by a Physician. Benefits are not payable for that portion of expense that is paid by Medicare or under any other part of this policy.

ADDITIONAL BENEFITS

9. Routine Prostate Cancer Screening. We will pay the expense incurred for prostate cancer screening. Benefits are limited to: (a) one screening per year at 50 years of age and older; and (b) at least one screening per year at 40 years of age or older if it is determined by your Physician that you are symptomatic or at a high risk of developing prostate cancer. Prostate cancer screening shall consist (at a minimum) of: (a) prostate-specific antigen blood test; and (b) a digital rectal examination.
10. Mammograms. Coverage will be provided, for the Usual and Customary Charge, for preventative mammogram screening (1) includes digital breast tomosynthesis for enrollees at risk for breast cancer, and (2) is covered as a preventative item or service.
11. Treatment of Lyme Disease. We will pay benefits for diagnosed Lyme disease as any other medical service. Benefits are not payable for that portion of expense that is paid by Medicare or under any other part of this policy.
12. Diabetes Equipment and Supplies Benefit. We will pay the Usual and Customary Charge for expenses incurred for all Physician prescribed medically appropriate and necessary equipment and supplies used in the management and treatment of diabetes, not otherwise covered under Medicare or Part D of the Medicare Program and diabetes outpatient self-management training and education, including medical nutrition therapy that is provided by a certified, registered, or licensed health care professional working in a program consistent with the national standards of diabetes self-management education as established by the American Diabetes Association. Coverage must include persons with gestational, type I or type II diabetes. Benefits will be limited to 80% of the Usual and Customary Charge not covered by Medicare or Part D of the Medicare Program.
13. Mental Health Services Benefit. We will pay the Usual and Customary Charge for the Medically Necessary treatment of mental health on the same basis as any other Sickness or Injury and as if Medicare paid benefits when treatment is provided in: (a) outpatient mental health services that must not place a greater financial burden on you or be more restrictive than those requirements and limitations for outpatient medical services; and (b) inpatient mental health services that must not place a greater financial burden on you or be more restrictive than those requirements and limitations for inpatient
medical services. Benefits are not payable for that portion of expense that is paid by Medicare or under any other part of this policy.
14. Ventilator-Dependent Persons Benefit. We will provide coverage for up to 120 hours of services provided by a home care nurse or personal care assistant to the ventilator-dependent person during the time the ventilator-dependent person is in a hospital licensed under chapter 144. The personal care assistant or home care nurse shall perform only the services of communicator or interpreter for the ventilator-dependent person during a transition period of up to 120 hours to assure adequate training of the hospital staff to communicate with the ventilator-dependent person and to understand the unique comfort, safety, and personal care needs of the ventilator-dependent person. Benefits are not payable for that portion of expense that is paid by Medicare or under any other part of this policy.

ADDITIONAL BENEFITS UNDER EXTENDED BASIC PLAN – RENEXT10ST-MN Rev 070119

We will pay 80% of the Usual and Customary Charges for the following articles and services prescribed by a physician which are not paid by Medicare or payable under any other provision of Your policy.

1. Hospital services.
2. Professional services for the diagnosis or treatment of Injuries, Sickness or conditions when such services are given by a physician or are under a physician's direction.
3. Services of a nursing home for not more than 120 days each year. Such services must qualify as reimbursable under Medicare.
4. Services of a home health agency. Such services must qualify as reimbursable under Medicare.
5. Use of radium or other radioactive materials.
6. Oxygen.
7. Anesthetics.
8. Prosthetic devises other than dental.
9. Rental or purchase, as appropriate, of durable medical equipment other than eyeglasses and hearing aids.
10. Diagnostic X-rays and lab tests.
11. Oral surgery for: (a) partially or completely unerupted impacted teeth, (b) a tooth root without the extraction of the entire root, or (c) the gums or tissues of the mouth when not performed in connection with the extraction or repair of teeth.
12. Services of a physical therapist.
13. Professional ambulance for service to the nearest facility qualified to treat the condition, or a reasonable mileage rate for transportation to a kidney dialysis center for treatment.
14. Well-baby care.
15. Up to $500.00 for a second surgical opinion. Not included is the repetition of diagnostic tests.
16. Services of an occupational therapist.

The above Additional Benefits are not payable for: (a) cosmetic surgery, except for repair of an Injury or a birth defect, (b) care which is primarily for custodial or for domiciliary purposes which would not qualify as eligible services under Medicare, (c) any charge for confinement in a private room to the extent it is in excess of the institution's charge for its most common semiprivate room unless the private room is prescribed as medically necessary by a physician, or (d) any charges for services or articles the provision of which is not within the scope of authorized practice of the institution or individual rendering the services or articles.