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

This chart shows the benefits included in each of the standard Medicare Supplement plans. Every company must make Plan "A" available. Some plans may not be available in your state.

Basic Benefits

Hospitalization: Part A co-insurance plus coverage for 365 additional days after Medicare benefits end.

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

Blood: First three pints of blood each year.

Hospice: Part A co-insurance.

Plans Available to All Applicants								Medicare first eligible before 2020 only		
A	**B**	**D**	**G[1]**	**K**	**L**	**M**	**N**	**C**	**F[1]**	**FHD[1]**
Basic, including 100% Part B co-insurance	Basic, including 100% Part B co-insurance	Basic, including 100% Part B co-insurance	Basic, including 100% Part B co-insurance	Basic, including 100% Part B co-insurance; other basic benefits paid at 50%	Basic, including 100% Part B co-insurance; other basic benefits paid at 75%	Basic, including 100% Part B co-insurance	Basic, including 100% Part B co-insurance, except up to $20 co-payment for office visits, and up to $50 co-payment for ER	Basic, including 100% Part B co-insurance	Basic, including 100% Part B co-insurance	
		Skilled Nursing Facility co-insurance	Skilled Nursing Facility co-insurance	50% Skilled Nursing Facility co-insurance	75% Skilled Nursing Facility co-insurance	Skilled Nursing Facility co-insurance	Skilled Nursing Facility co-insurance	Skilled Nursing Facility co-insurance	Skilled Nursing Facility co-insurance	
	Part A Deductible	Part A Deductible	Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	
								Part B Deductible	Part B Deductible	
			Part B Excess (100%)						Part B Excess (100%)	
		Foreign Travel Emergency	Foreign Travel Emergency			Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	
				Out-of-Pocket Limit $5,880; paid at 100% after limit reached	Out-of-Pocket Limit $2,940; paid at 100% after limit reached					

[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.

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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.

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HOUSEHOLD DISCOUNT MONTHLY RATES*

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

NON-TOBACCO

ZIP CODES: *ALL ZIP CODES*

Female					Male			
Std. Plan A RENA10ST-WY	Std. Plan F RENF10ST-WY	Std. Plan G RENG10ST-WY	Std. Plan N RENN10ST-WY	Attained Age	Std. Plan A RENA10ST-WY	Std. Plan F RENF10ST-WY	Std. Plan G RENG10ST-WY	Std. Plan N RENN10ST-WY
$89.75	$122.57	$91.81	$78.17	65	$103.16	$140.89	$105.53	$89.85
$89.75	$122.57	$91.81	$78.17	66	$103.16	$140.89	$105.53	$89.85
$89.75	$122.57	$91.81	$78.17	67	$103.16	$140.89	$105.53	$89.85
$93.01	$128.11	$95.97	$81.71	68	$106.91	$147.26	$110.32	$93.92
$96.34	$133.64	$100.12	$85.23	69	$110.74	$153.61	$115.08	$97.97
$99.38	$139.15	$104.29	$88.75	70	$114.24	$159.94	$119.87	$102.01
$100.84	$145.35	$108.98	$92.71	71	$115.90	$167.07	$125.26	$106.56
$102.31	$151.60	$113.70	$96.69	72	$117.60	$174.26	$130.69	$111.14
$103.27	$157.31	$118.02	$100.32	73	$118.70	$180.81	$135.66	$115.31
$104.65	$163.03	$122.38	$103.99	74	$120.29	$187.40	$140.67	$119.53
$106.11	$168.71	$126.78	$107.60	75	$121.96	$193.92	$145.72	$123.68
$109.75	$174.34	$131.22	$111.19	76	$126.15	$200.40	$150.82	$127.81
$113.06	$180.03	$135.69	$114.82	77	$129.95	$206.93	$155.96	$131.98
$115.20	$183.76	$138.66	$117.20	78	$132.41	$211.21	$159.38	$134.71
$117.42	$187.63	$141.75	$119.67	79	$134.97	$215.67	$162.93	$137.55
$119.13	$191.68	$144.97	$122.25	80	$136.93	$220.32	$166.63	$140.52
$120.51	$195.89	$148.31	$124.94	81	$138.51	$225.16	$170.48	$143.61
$121.98	$200.28	$151.80	$127.75	82	$140.21	$230.21	$174.48	$146.83
$123.87	$205.39	$155.81	$131.00	83	$142.38	$236.08	$179.10	$150.58
$125.87	$210.72	$159.98	$134.39	84	$144.68	$242.21	$183.89	$154.48
$128.57	$216.25	$164.33	$137.92	85	$147.78	$248.57	$188.89	$158.53
$131.02	$222.02	$168.84	$141.60	86	$150.59	$255.20	$194.07	$162.76
$134.28	$228.00	$173.55	$145.42	87	$154.34	$262.07	$199.48	$167.15
$137.67	$234.18	$178.37	$149.36	88	$158.24	$269.17	$205.03	$171.68
$141.54	$240.67	$183.47	$153.50	89	$162.69	$276.63	$210.88	$176.44
$145.68	$247.55	$188.86	$157.89	90	$167.44	$284.54	$217.09	$181.48
$150.24	$254.74	$194.49	$162.47	91	$172.69	$292.80	$223.56	$186.75
$155.20	$262.29	$200.43	$167.29	92	$178.39	$301.49	$230.38	$192.29
$160.75	$270.21	$206.62	$172.34	93	$184.77	$310.58	$237.50	$198.09
$166.71	$278.60	$213.22	$177.69	94	$191.62	$320.24	$245.08	$204.25
$173.20	$287.41	$220.12	$183.30	95	$199.08	$330.36	$253.02	$210.69
$180.09	$296.68	$227.41	$189.22	96	$207.00	$341.01	$261.39	$217.50
$187.23	$306.37	$235.01	$195.40	97	$215.20	$352.15	$270.13	$224.60
$194.95	$316.63	$243.07	$201.94	98	$224.08	$363.94	$279.39	$232.11
$203.54	$327.46	$251.58	$208.85	99	$233.96	$376.39	$289.17	$240.06

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

Renaissance®
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HOUSEHOLD DISCOUNT MONTHLY RATES*

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

TOBACCO

ZIP CODES: *ALL ZIP CODES*

Female					Male			
Std. Plan A RENA10ST-WY	Std. Plan F RENF10ST-WY	Std. Plan G RENG10ST-WY	Std. Plan N RENN10ST-WY	Attained Age	Std. Plan A RENA10ST-WY	Std. Plan F RENF10ST-WY	Std. Plan G RENG10ST-WY	Std. Plan N RENN10ST-WY
$103.16	$140.89	$105.53	$89.85	65	$118.58	$161.94	$121.30	$103.28
$103.16	$140.89	$105.53	$89.85	66	$118.58	$161.94	$121.30	$103.28
$103.16	$140.89	$105.53	$89.85	67	$118.58	$161.94	$121.30	$103.28
$106.91	$147.26	$110.32	$93.92	68	$122.88	$169.26	$126.80	$107.96
$110.74	$153.61	$115.08	$97.97	69	$127.28	$176.56	$132.28	$112.60
$114.24	$159.94	$119.87	$102.01	70	$131.30	$183.84	$137.78	$117.25
$115.90	$167.07	$125.26	$106.56	71	$133.22	$192.03	$143.98	$122.49
$117.60	$174.26	$130.69	$111.14	72	$135.17	$200.30	$150.22	$127.75
$118.70	$180.81	$135.66	$115.31	73	$136.44	$207.83	$155.93	$132.55
$120.29	$187.40	$140.67	$119.53	74	$138.27	$215.40	$161.69	$137.39
$121.96	$193.92	$145.72	$123.68	75	$140.18	$222.90	$167.50	$142.16
$126.15	$200.40	$150.82	$127.81	76	$145.00	$230.34	$173.36	$146.91
$129.95	$206.93	$155.96	$131.98	77	$149.37	$237.86	$179.26	$151.70
$132.41	$211.21	$159.38	$134.71	78	$152.20	$242.77	$183.20	$154.84
$134.97	$215.67	$162.93	$137.55	79	$155.14	$247.90	$187.28	$158.10
$136.93	$220.32	$166.63	$140.52	80	$157.39	$253.24	$191.53	$161.52
$138.51	$225.16	$170.48	$143.61	81	$159.21	$258.81	$195.95	$165.07
$140.21	$230.21	$174.48	$146.83	82	$161.16	$264.61	$200.55	$168.78
$142.38	$236.08	$179.10	$150.58	83	$163.65	$271.36	$205.86	$173.08
$144.68	$242.21	$183.89	$154.48	84	$166.29	$278.40	$211.37	$177.56
$147.78	$248.57	$188.89	$158.53	85	$169.86	$285.71	$217.11	$182.22
$150.59	$255.20	$194.07	$162.76	86	$173.10	$293.33	$223.07	$187.08
$154.34	$262.07	$199.48	$167.15	87	$177.41	$301.23	$229.29	$192.13
$158.24	$269.17	$205.03	$171.68	88	$181.89	$309.39	$235.66	$197.33
$162.69	$276.63	$210.88	$176.44	89	$187.00	$317.97	$242.40	$202.80
$167.44	$284.54	$217.09	$181.48	90	$192.46	$327.06	$249.52	$208.60
$172.69	$292.80	$223.56	$186.75	91	$198.49	$336.56	$256.96	$214.66
$178.39	$301.49	$230.38	$192.29	92	$205.05	$346.54	$264.80	$221.02
$184.77	$310.58	$237.50	$198.09	93	$212.38	$356.99	$272.98	$227.69
$191.62	$320.24	$245.08	$204.25	94	$220.26	$368.09	$281.70	$234.77
$199.08	$330.36	$253.02	$210.69	95	$228.83	$379.72	$290.82	$242.18
$207.00	$341.01	$261.39	$217.50	96	$237.93	$391.97	$300.45	$250.00
$215.20	$352.15	$270.13	$224.60	97	$247.36	$404.77	$310.49	$258.16
$224.08	$363.94	$279.39	$232.11	98	$257.56	$418.33	$321.14	$266.80
$233.96	$376.39	$289.17	$240.06	99	$268.92	$432.63	$332.38	$275.93

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

Renaissance®
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MONTHLY RATES*

NON-TOBACCO

ZIP CODES: *ALL ZIP CODES*

Female					Male			
Std. Plan A RENA10ST-WY	Std. Plan F RENF10ST-WY	Std. Plan G RENG10ST-WY	Std. Plan N RENN10ST-WY	Attained Age	Std. Plan A RENA10ST-WY	Std. Plan F RENF10ST-WY	Std. Plan G RENG10ST-WY	Std. Plan N RENN10ST-WY
$101.99	$139.28	$104.33	$88.83	65	$117.23	$160.10	$119.92	$102.10
$101.99	$139.28	$104.33	$88.83	66	$117.23	$160.10	$119.92	$102.10
$101.99	$139.28	$104.33	$88.83	67	$117.23	$160.10	$119.92	$102.10
$105.69	$145.58	$109.06	$92.86	68	$121.49	$167.34	$125.36	$106.73
$109.48	$151.86	$113.78	$96.85	69	$125.84	$174.56	$130.78	$111.33
$112.94	$158.12	$118.51	$100.85	70	$129.81	$181.75	$136.22	$115.92
$114.59	$165.17	$123.84	$105.35	71	$131.71	$189.85	$142.34	$121.10
$116.26	$172.28	$129.20	$109.88	72	$133.63	$198.02	$148.51	$126.30
$117.35	$178.76	$134.12	$114.00	73	$134.88	$205.47	$154.16	$131.04
$118.92	$185.27	$139.07	$118.17	74	$136.69	$212.95	$159.85	$135.82
$120.57	$191.72	$144.07	$122.28	75	$138.59	$220.36	$165.60	$140.55
$124.71	$198.12	$149.11	$126.36	76	$143.35	$227.72	$171.39	$145.24
$128.48	$204.58	$154.19	$130.48	77	$147.67	$235.15	$177.23	$149.98
$130.91	$208.81	$157.57	$133.18	78	$150.47	$240.02	$181.12	$153.08
$133.43	$213.22	$161.08	$135.98	79	$153.37	$245.08	$185.15	$156.30
$135.37	$217.81	$164.74	$138.92	80	$155.60	$250.36	$189.36	$159.68
$136.94	$222.60	$168.54	$141.98	81	$157.40	$255.87	$193.72	$163.19
$138.62	$227.59	$172.50	$145.17	82	$159.33	$261.60	$198.27	$166.86
$140.76	$233.40	$177.06	$148.87	83	$161.79	$268.27	$203.52	$171.11
$143.03	$239.45	$181.80	$152.72	84	$164.40	$275.23	$208.97	$175.54
$146.10	$245.74	$186.74	$156.73	85	$167.93	$282.46	$214.65	$180.15
$148.88	$252.30	$191.87	$160.91	86	$171.13	$290.00	$220.54	$184.95
$152.59	$259.09	$197.22	$165.25	87	$175.39	$297.81	$226.69	$189.95
$156.44	$266.11	$202.70	$169.73	88	$179.82	$305.87	$232.99	$195.09
$160.84	$273.49	$208.49	$174.44	89	$184.88	$314.36	$239.64	$200.50
$165.54	$281.31	$214.62	$179.42	90	$190.28	$323.34	$246.69	$206.22
$170.73	$289.48	$221.01	$184.63	91	$196.24	$332.73	$254.04	$212.22
$176.37	$298.06	$227.76	$190.10	92	$202.72	$342.60	$261.79	$218.51
$182.67	$307.05	$234.80	$195.84	93	$209.97	$352.93	$269.88	$225.10
$189.44	$316.60	$242.29	$201.93	94	$217.75	$363.90	$278.50	$232.10
$196.82	$326.60	$250.14	$208.30	95	$226.23	$375.40	$287.52	$239.42
$204.65	$337.14	$258.42	$215.03	96	$235.23	$387.52	$297.04	$247.16
$212.76	$348.15	$267.06	$222.04	97	$244.55	$400.17	$306.96	$255.22
$221.53	$359.81	$276.22	$229.48	98	$254.63	$413.57	$317.49	$263.77
$231.30	$372.11	$285.88	$237.33	99	$265.86	$427.72	$328.60	$272.80

***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: *ALL ZIP CODES*

Female					Male			
Std. Plan A RENA10ST-WY	Std. Plan F RENF10ST-WY	Std. Plan G RENG10ST-WY	Std. Plan N RENN10ST-WY	Attained Age	Std. Plan A RENA10ST-WY	Std. Plan F RENF10ST-WY	Std. Plan G RENG10ST-WY	Std. Plan N RENN10ST-WY
$117.23	$160.10	$119.92	$102.10	65	$134.75	$184.02	$137.84	$117.36
$117.23	$160.10	$119.92	$102.10	66	$134.75	$184.02	$137.84	$117.36
$117.23	$160.10	$119.92	$102.10	67	$134.75	$184.02	$137.84	$117.36
$121.49	$167.34	$125.36	$106.73	68	$139.64	$192.34	$144.09	$122.68
$125.84	$174.56	$130.78	$111.33	69	$144.64	$200.64	$150.32	$127.96
$129.81	$181.75	$136.22	$115.92	70	$149.21	$208.91	$156.57	$133.24
$131.71	$189.85	$142.34	$121.10	71	$151.39	$218.22	$163.61	$139.19
$133.63	$198.02	$148.51	$126.30	72	$153.60	$227.61	$170.70	$145.17
$134.88	$205.47	$154.16	$131.04	73	$155.04	$236.17	$177.19	$150.62
$136.69	$212.95	$159.85	$135.82	74	$157.12	$244.77	$183.74	$156.12
$138.59	$220.36	$165.60	$140.55	75	$159.30	$253.29	$190.34	$161.55
$143.35	$227.72	$171.39	$145.24	76	$164.77	$261.75	$197.00	$166.94
$147.67	$235.15	$177.23	$149.98	77	$169.74	$270.29	$203.71	$172.39
$150.47	$240.02	$181.12	$153.08	78	$172.95	$275.88	$208.18	$175.95
$153.37	$245.08	$185.15	$156.30	79	$176.29	$281.70	$212.82	$179.66
$155.60	$250.36	$189.36	$159.68	80	$178.85	$287.77	$217.65	$183.54
$157.40	$255.87	$193.72	$163.19	81	$180.92	$294.10	$222.67	$187.58
$159.33	$261.60	$198.27	$166.86	82	$183.14	$300.69	$227.90	$191.79
$161.79	$268.27	$203.52	$171.11	83	$185.97	$308.36	$233.93	$196.68
$164.40	$275.23	$208.97	$175.54	84	$188.97	$316.36	$240.19	$201.77
$167.93	$282.46	$214.65	$180.15	85	$193.02	$324.67	$246.72	$207.07
$171.13	$290.00	$220.54	$184.95	86	$196.70	$333.33	$253.49	$212.59
$175.39	$297.81	$226.69	$189.95	87	$201.60	$342.31	$260.56	$218.33
$179.82	$305.87	$232.99	$195.09	88	$206.69	$351.58	$267.80	$224.24
$184.88	$314.36	$239.64	$200.50	89	$212.50	$361.33	$275.45	$230.46
$190.28	$323.34	$246.69	$206.22	90	$218.71	$371.66	$283.55	$237.04
$196.24	$332.73	$254.04	$212.22	91	$225.56	$382.45	$292.00	$243.93
$202.72	$342.60	$261.79	$218.51	92	$233.01	$393.79	$300.91	$251.16
$209.97	$352.93	$269.88	$225.10	93	$241.34	$405.67	$310.21	$258.74
$217.75	$363.90	$278.50	$232.10	94	$250.29	$418.28	$320.11	$266.78
$226.23	$375.40	$287.52	$239.42	95	$260.03	$431.50	$330.48	$275.20
$235.23	$387.52	$297.04	$247.16	96	$270.38	$445.42	$341.42	$284.09
$244.55	$400.17	$306.96	$255.22	97	$281.09	$459.97	$352.83	$293.36
$254.63	$413.57	$317.49	$263.77	98	$292.68	$475.37	$364.93	$303.18
$265.86	$427.72	$328.60	$272.80	99	$305.59	$491.63	$377.70	$313.56

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

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

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

SERVICES	MEDICARE PAYS	PLAN A PAYS	YOU PAY
HOSPITALIZATION* 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: - 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	$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 You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited 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 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* (the Part B Deductible)	$0	$0	$198 (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 $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* 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* 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 You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited 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 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* (the Part B Deductible)	$0	$198 (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 $198 of Medicare-approved amounts*	$0	$198 (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 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* 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* 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 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 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* (the Part B Deductible)	$0	$0	$198 (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 $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

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* 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* 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 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 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 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* (the Part B Deductible) Remainder of Medicare-approved amounts	 $0 Generally 80%	 $0 Balance, other than up to $20 per office visit and up to $50 per emergency room visit. The 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.	 $198 (Part B Deductible) 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 Next $198 of Medicare-approved amounts* Remainder of Medicare-approved amounts	 $0 $0 80%	 All costs $0 20%	 $0 $198 (Part B Deductible) $0
CLINICAL LABORATORY SERVICES - 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