

<i>SERFF Tracking Number:</i>	<i>IASL-126474143</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Royal Neighbors of America</i>	<i>State Tracking Number:</i>	<i>45082</i>
<i>Company Tracking Number:</i>	<i>MSAI2010AR</i>		
<i>TOI:</i>	<i>MS08I Individual Medicare Supplement - Standard Plans 2010</i>	<i>Sub-TOI:</i>	<i>MS08I.001 Plan A 2010</i>
<i>Product Name:</i>	<i>RN 2010 AR Forms</i>		
<i>Project Name/Number:</i>	<i>RN 2010 AR Forms/</i>		

## Filing at a Glance

Company: Royal Neighbors of America

Product Name: RN 2010 AR Forms

TOI: MS08I Individual Medicare Supplement -  
Standard Plans 2010

Sub-TOI: MS08I.001 Plan A 2010

Filing Type: Form/Rate

SERFF Tr Num: IASL-126474143

SERFF Status: Closed-Approved-  
Closed

Co Tr Num: MSAI2010AR

Author: Beth Clark

Date Submitted: 03/02/2010

State: Arkansas

State Tr Num: 45082

State Status: Approved-Closed

Reviewer(s): Stephanie Fowler

Disposition Date: 04/07/2010

Disposition Status: Approved-  
Closed

Implementation Date Requested:

Implementation Date: 06/01/2010

State Filing Description:

## General Information

Project Name: RN 2010 AR Forms

Project Number:

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 04/07/2010

Status of Filing in Domicile: Pending

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Individual

Group Market Size:

Group Market Type:

Explanation for Other Group Market Type:

State Status Changed: 04/07/2010

Created By: Beth Clark

Corresponding Filing Tracking Number:

Deemer Date:

Submitted By: Beth Clark

Filing Description:

This is a new filing to submit Medicare Supplement 2010 Standard Plans A, F and G, a new application, outline of coverage and a new application for reinstatement. These forms are being filed in compliance with the requirements of the Federal Medicare Improvements for Patients and Providers Act (MIPPA) and the State specific Medicare Supplement Regulation.

Other ancillary forms used but not included in this filing are the Replacement Notice, form number 3530; Rev. 6-2004 approved July 6, 2004 and the Amendment to Application, form number 3540; Rev. 6-2004 approved July 6, 2004.

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These policies will be sold to individuals through independent agents and issued to persons eligible for Medicare.

## Company and Contact

### Filing Contact Information

Beth Clark, Compliance Analyst beth.clark@iasadmin.com  
 8545 126th Avenue North 727-584-0007 [Phone] 2169 [Ext]  
 Suite 200 727-584-5613 [FAX]  
 Largo, FL 33773-1502

### Filing Company Information

(This filing was made by a third party - insuranceadministrativesolutions)

Royal Neighbors of America CoCode: 57657 State of Domicile: Illinois  
 230 16th Street Group Code: -99 Company Type: Fraternal Benefit  
 Society  
 Rock Island, IL 61201-8645 Group Name: State ID Number:  
 (309) 788-4561 ext. [Phone] FEIN Number: 36-1711198

## Filing Fees

Fee Required? Yes  
 Fee Amount: \$300.00  
 Retaliatory? No  
 Fee Explanation: \$50/Form x 6 Forms  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Royal Neighbors of America	\$300.00	03/02/2010	34552189

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## Correspondence Summary

### Dispositions

<b>Status</b>	<b>Created By</b>	<b>Created On</b>	<b>Date Submitted</b>
Approved- Closed	Stephanie Fowler	04/07/2010	04/07/2010

### Amendments

<b>Schedule</b>	<b>Schedule Item Name</b>	<b>Created By</b>	<b>Created On</b>	<b>Date Submitted</b>
Form	Outline of Coverage	Beth Clark	04/01/2010	04/01/2010
Form	Outline of Coverage	Beth Clark	03/25/2010	03/25/2010
Form	Plan B	Beth Clark	03/25/2010	03/25/2010
Form	Plan C	Beth Clark	03/25/2010	03/25/2010
Form	Plan D	Beth Clark	03/25/2010	03/25/2010
Rate	Rate Page Plan B	Beth Clark	03/25/2010	03/25/2010
Rate	Rate Page Plan C	Beth Clark	03/25/2010	03/25/2010
Rate	Rate Page Plan D	Beth Clark	03/25/2010	03/25/2010
Supporting Document	Flesch Certification	Beth Clark	03/25/2010	03/25/2010
Supporting Document	Health - Actuarial Justification	Beth Clark	03/25/2010	03/25/2010

*SERFF Tracking Number:* IASL-126474143      *State:* Arkansas  
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*TOI:* MS08I Individual Medicare Supplement -      *Sub-TOI:* MS08I.001 Plan A 2010  
Standard Plans 2010  
*Product Name:* RN 2010 AR Forms  
*Project Name/Number:* RN 2010 AR Forms/

## **Disposition**

Disposition Date: 04/07/2010

Implementation Date: 06/01/2010

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: IASL-126474143 State: Arkansas  
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 Standard Plans 2010  
 Product Name: RN 2010 AR Forms  
 Project Name/Number: RN 2010 AR Forms/

Schedule	Schedule Item	Schedule Item Status	Public Access
<b>Supporting Document (revised)</b>	Flesch Certification	Accepted for Informational Purposes	Yes
<b>Supporting Document</b>	Flesch Certification	Replaced	Yes
<b>Supporting Document</b>	Application	Approved	Yes
<b>Supporting Document (revised)</b>	Health - Actuarial Justification	Approved	No
<b>Supporting Document</b>	Health - Actuarial Justification	Replaced	No
<b>Supporting Document</b>	Outline of Coverage	Approved	Yes
<b>Supporting Document</b>	Letter of Authorization	Accepted for Informational Purposes	Yes
<b>Form</b>	Plan A	Approved	Yes
<b>Form</b>	Plan F	Approved	Yes
<b>Form</b>	Plan G	Approved	Yes
<b>Form</b>	Application	Approved	Yes
<b>Form</b>	Reinstatement Application	Approved	Yes
<b>Form (revised)</b>	Outline of Coverage	Approved	Yes
<b>Form</b>	Outline of Coverage	Replaced	Yes
<b>Form</b>	Outline of Coverage	Replaced	Yes
<b>Form</b>	Plan B	Approved	Yes
<b>Form</b>	Plan C	Approved	Yes
<b>Form</b>	Plan D	Approved	Yes
<b>Rate</b>	Rate Page Plan A	Approved	Yes
<b>Rate</b>	Rate Page Plan F	Approved	Yes
<b>Rate</b>	Rate Page Plan G	Approved	Yes
<b>Rate</b>	Rate Page Plan B	Approved	Yes
<b>Rate</b>	Rate Page Plan C	Approved	Yes
<b>Rate</b>	Rate Page Plan D	Approved	Yes

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**Amendment Letter**

Submitted Date: 04/01/2010

**Comments:**

We are replacing the outline of coverage due to a typo.

**Changed Items:**

**Form Schedule Item Changes:**

**Form Schedule Item Changes:**

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
3510AR2010	Outline of Coverage	Outline of Coverage	Initial					3510AR201004.pdf

SERFF Tracking Number: IASL-126474143 State: Arkansas  
 Filing Company: Royal Neighbors of America State Tracking Number: 45082  
 Company Tracking Number: MSAI2010AR  
 TOI: MS08I Individual Medicare Supplement - Sub-TOI: MS08I.001 Plan A 2010  
 Standard Plans 2010  
 Product Name: RN 2010 AR Forms  
 Project Name/Number: RN 2010 AR Forms/

**Amendment Letter**

Submitted Date: 03/25/2010

**Comments:**

We would like to add Plans B, C and D. The actuarial memorandum and outline of coverage have been revised, certificates and rates for plans B, C and D have been added. Also revised is the Flesch Certification.

Thank you for your time with this review.

**Changed Items:**

**Form Schedule Item Changes:**

**Form Schedule Item Changes:**

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
3510AR2010	Outline of Coverage	Outline of Coverage	Initial					3510AR201004.pdf
MSBI2010A R	Certificate	Plan B	Initial				52.500	MSBI2010AR.pdf
MSCI2010A R	Certificate	Plan C	Initial				54.000	MSCI2010AR.pdf
MSDI2010A R	Certificate	Plan D	Initial				51.300	MSDI2010AR.pdf

**Rate/Rule Schedule Item Changes:**

Document Name:	Affected Form Numbers: (Comma Separated list)	Rate Action:	Rate Action Information:	Attach Document:
Rate Page Plan B	BMSBI2010AR	New		Plan B Rate Page.pdf
Rate Page Plan C	Rate Page Plan C	MSCI2010AR	New	
Rate Page Plan C	Plan C Rate Page.pdf	Rate Page Plan D	MSDI2010AR	New
Rate Page Plan D	Plan D Rate Page.pdf	Plan D Rate Page.pdf		

SERFF Tracking Number: IASL-126474143 State: Arkansas  
Filing Company: Royal Neighbors of America State Tracking Number: 45082  
Company Tracking Number: MSAI2010AR  
TOI: MS08I Individual Medicare Supplement - Sub-TOI: MS08I.001 Plan A 2010  
Standard Plans 2010  
Product Name: RN 2010 AR Forms  
Project Name/Number: RN 2010 AR Forms/

**Supporting Document Schedule Item Changes:**

**Satisfied -Name: Flesch Certification**

Comment:

ISSUE AGE - FleschCertification.pdf

**Satisfied -Name: Health - Actuarial Justification**

Comment:

AJ Adds New Plans B, C, and D.pdf

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## Form Schedule

### Lead Form Number: MSAI2010AR

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved 04/07/2010	MSAI2010 AR	Policy/Cont ract/Fratern al Certificate	Plan A	Initial		52.200	MSAI2010AR. pdf
Approved 04/07/2010	MSFI2010A R	Policy/Cont ract/Fratern al Certificate	Plan F	Initial		50.200	MSFI2010AR. pdf
Approved 04/07/2010	MSGI2010 AR	Policy/Cont ract/Fratern al Certificate	Plan G	Initial		53.800	MSGI2010AR .pdf
Approved 04/07/2010	3500AR2010	Application/ Enrollment Form	Application	Initial			3500AR2010. pdf
Approved 04/07/2010	3550GN2010	Application/ Enrollment Form	Reinstatement Application	Initial			3550GN2010. pdf
Approved 04/07/2010	3510AR2010	Outline of Coverage	Outline of Coverage	Initial			3510AR2010 04.pdf
Approved 04/07/2010	MSBI2010 AR	Certificate	Plan B	Initial		52.500	MSBI2010AR. pdf
Approved 04/07/2010	MSCI2010 AR	Certificate	Plan C	Initial		54.000	MSCI2010AR .pdf
Approved 04/07/2010	MSDI2010 AR	Certificate	Plan D	Initial		51.300	MSDI2010AR .pdf



**INSURING LIVES • SUPPORTING WOMEN • SERVING COMMUNITIES™**

**MEDICARE SUPPLEMENT INSURANCE CERTIFICATE - PLAN A  
READ YOUR CERTIFICATE CAREFULLY**

**This Certificate is a legal contract between the Owner of the Certificate and Royal Neighbors of America (the Society).**

This Certificate provides benefits to supplement hospital and medical coverage of Medicare. Only persons eligible for Medicare may apply for this Certificate. In this Certificate, “You” and “Your” means the Insured named on the application and shown on the Certificate Schedule. “We”, “Our” and “Us” means Royal Neighbors of America.

**NOTICE TO BUYER. THIS CERTIFICATE MAY NOT COVER ALL OF YOUR MEDICAL EXPENSES.**

**IMPORTANT NOTICE:** Issuance of this Medicare Supplement Insurance Certificate is based on Your answers to the questions on Your application. A copy of the application is attached. Omissions or misstatements on the application could cause Your claim to be denied or Your Certificate to be rescinded. If, for any reason, Your answers are incorrect, contact Us immediately at Medicare Supplement Administration, [P.O. Box 10851, Clearwater Florida 33757-8851, Telephone Number 877-815-8877.]

**CERTIFICATE EFFECTIVE DATE AND CONSIDERATION**

We have issued this Certificate in consideration of the payment of premium and the statements made on the application. The application is attached to and made a part of this Certificate. The term of this Certificate begins at, 12:01 a.m. Standard Time, at the place where You reside on the Certificate Effective Date shown on the Certificate Schedule. It ends at 11:59 p.m., at the place where You reside, on the day before Your premium is due. The date Your premium is due is determined by the mode of payment. The mode of payment for the original term of the Certificate is shown on the Certificate Schedule. An annual premium will maintain the Certificate in force for twelve (12) months, semi-annual for six (6) months, quarterly for three (3) months and monthly for one (1) month.

**THIRTY DAY RIGHT TO EXAMINE AND RETURN CERTIFICATE**

Please read Your Certificate carefully. If, for any reason, You are not satisfied, You may return Your Certificate to Us at Medicare Supplement Administration, [P.O. Box 10851, Clearwater Florida 33757-8851], within thirty (30) days after receiving it. If returned, the Certificate will be void from its beginning and any premium paid will be refunded. If payment of a claim is made under this Certificate during the thirty (30) day period, the amount will be deducted from the premium refund.

**GUARANTEED RENEWABLE FOR LIFE - PREMIUMS SUBJECT TO CHANGE**

This Certificate is renewable for as long as You live, provided You continue to pay premiums when due. At no time while You continue Your Certificate in force, may We place any restrictive riders on Your coverage. The premium may change on any premium due date if a new table of rates is applicable to the Certificate. The change in the table of rates will apply to all covered persons in the same class. Class is defined as underwriting class, state, plan and zip code of residence. You will be notified in advance before any change in the table of rates.

**THIS CERTIFICATE DOES NOT CONTAIN A PRE-EXISTING CONDITION LIMITATION**

**THIS IS A NON-PARTICIPATING CERTIFICATE**

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**POLICYHOLDER INFORMATION**

For support and information regarding certificate terms, premium payments, claims processing and payment, contact us at:

Medicare Supplement Administration  
[P. O. Box 10851  
Clearwater, Florida 33757-8851  
1-877-815-8877]

For your information, the following is the name, address and telephone number of your agent:

[Mr. Fred Smith]  
[123 First Street  
Anywhere, USA 12345  
1-555-555-1234]

The Arkansas Insurance Department can be contacted at:

Arkansas Insurance Department  
Consumer Services  
1200 West Third Street  
Little Rock, Arkansas 72201-1904  
1-501-371-2640

Toll Free Consumer Information Telephone Number  
1-800-852-5494

**CERTIFICATE SCHEDULE**

**INSURED:**

**CERTIFICATE EFFECTIVE DATE:**

**CERTIFICATE NUMBER:**

**ISSUE AGE:**

**STATE OF ISSUE:**

**MODE AT ISSUE:**

**MODAL PREMIUM:**

**PREMIUM TERM:**

**UNDERWRITING CLASS:**

**CHAPTER:**

\*\*\*\*\*

**TYPE OF COVERAGE: MEDICARE SUPPLEMENT CERTIFICATE PLAN A**

## DEFINITIONS

**Benefit Period** means the period as determined by Medicare which begins on the date, You are first confined in a Hospital. It ends following a period of sixty (60) consecutive days during which You have not been confined in a Hospital or a Skilled Nursing Facility.

**Calendar Year** means the period of time beginning on January 1 and ending on December 31 of that same year.

**Certificate Effective Date** means the effective date of this Certificate and is shown on the Certificate Schedule. The Certificate Effective Date is not the date You signed the application for coverage.

**Coinsurance Amount** means the part of Medicare Eligible Expenses You have to pay. It does not include Part A or Part B deductible amounts.

**Hospital** means a hospital that is approved, or eligible to be approved to receive payments from Medicare and is accredited by the Joint Commission on Accreditation of Hospitals.

**Hospitalized or Hospitalization** means being confined in a Hospital on an inpatient basis.

**Immediate Family** means Your spouse, parents, grandparents, children, or siblings, as well as their spouses.

**Injury** means a bodily injury which is the direct result of an accident and independent of all other causes.

**Lifetime Inpatient Reserve Days** means a total of sixty (60) extra days in the Hospital provided to You by Medicare. These reserve days must be used if You are Hospitalized for more than ninety (90) days in a Benefit Period, unless previously used. When a lifetime reserve day is used, it is subtracted from the number of days You have left.

**Medicaid** means the Health Insurance for the Aged Act, Title XIX of the Social Security Amendment of 1965, as then constituted or later amended.

**Medically Necessary** means a service or supply that is recognized by Medicare as necessary to diagnose or treat an Injury or Sickness and is: (1) prescribed by a Physician; (2) consistent with the diagnosis and treatment of the Injury or Sickness; (3) in accordance with the generally accepted standards of medical practice; and (4) not solely for the convenience of You or the Physician.

**Medicare** means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendment of 1965, as then constituted or later amended.

**Medicare Eligible Expenses** means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and Medically Necessary by Medicare.

**Physician** means any practitioner of the healing arts acting within the scope of his/her license. It does not include You or any member of Your Immediate Family.

**Sickness** means illness or disease which first manifests itself after the Certificate Effective Date and while this Certificate is in force.

**Skilled Nursing Facility** means an institution licensed as such by the state in which it is located and is operating within the scope and intent of its license. It does not include a facility or any of its sections which is primarily a place for drug addicts, alcoholics or persons suffering from mental disease.

## **BENEFIT PROVISIONS**

We will pay only the following Medicare Eligible Expenses not paid by Medicare. Benefits are only paid to the extent specified in this provision.

**The benefits paid under this Certificate will not duplicate benefits paid by Medicare.**

### **Basic (Core) Benefits**

Coverage of Part A Medicare Eligible Expenses for Hospitalization to the extent not covered by Medicare from the sixty first (61<sup>st</sup>) day through the ninetieth (90<sup>th</sup>) day in any Medicare Benefit Period.

Coverage of Part A Medicare Eligible Expenses incurred for Hospitalization to the extent not covered by Medicare for each Medicare Lifetime Inpatient Reserve Day used.

Upon exhaustion of Medicare Hospital inpatient coverage, including the lifetime reserve days, coverage of 100% of the Medicare Part A eligible expenses for hospitalization paid at applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional three hundred sixty-five (365) days. The provider shall accept Our payment as payment in full and may not bill You for any balance.

Coverage under Medicare Parts A and B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations.

Coverage for the Coinsurance Amount, or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount, of Medicare Eligible Expenses under Part B regardless of Hospital confinement, subject to the Medicare Part B deductible.

Hospice Care: Coverage of cost sharing for all Part A Medicare Eligible Expenses for hospice care and respite care expenses.

## **GUARANTEE REGARDING CHANGES IN MEDICARE BENEFITS**

We guarantee that the benefits and payment schedule of this Certificate will automatically change to reflect any changes which will become effective under Medicare. Only those provisions of the Certificate which are affected by the legislation are changed. Your coverage will automatically provide for such changes to whatever extent necessary. Premiums may be modified to correspond with such changes in accordance with the **GUARANTEE RENEWABLE FOR LIFE - PREMIUMS SUBJECT TO CHANGE** provision on page 1.

**MEDICAL ASSISTANCE UNDER MEDICAID  
AND SUSPENSION UNDER GROUP HEALTH PLAN**

Benefits and premiums under this Certificate are suspended at Your request for a period not to exceed twenty-four (24) months, in which You have applied for and are determined to be entitled to medical assistance under Title XIX of the Social Security Act. You must notify Us within ninety (90) days after the day You become entitled to such assistance.

If such a suspension occurs and You lose entitlement of such medical assistance, Your Certificate is automatically reinstated effective as of the date of termination of such entitlement if You provide notice of loss of such entitlement within ninety (90) days after the date of such loss and pay the premiums attributable to the period. Your reinstated Certificate is effective as of the date of termination of such entitlement.

Benefits and premiums under this Certificate shall be suspended for any period that may be provided by federal regulation at Your request if You are entitled to benefits under section 226(b) of the Social Security Act and are covered under a group health plan, as defined in section 1862(b)(1)(A)(v) of the Social Security Act. If suspension occurs and You lose coverage under the group health plan, Your Certificate shall be automatically reinstated, effective as of the date of loss of such coverage, if You provide notice of loss of coverage within ninety (90) days after the date of such loss and pay the premiums attributable to the period, effective as of the date of termination of such entitlement.

Reinstitution of Your coverage provides for:

1. Coverage equivalent to coverage in effect before the date of suspension;
2. Your classification of premium remains as favorable to You as the premium classification terms that would have applied to You had the coverage not been suspended; and
3. No waiting period with respect to treatment of preexisting conditions.

**TERMINATION OF CERTIFICATE AND EXTENSION OF BENEFITS**

Termination of the Certificate shall be without prejudice to a continuous loss which commenced while the Certificate was in force but the extension of benefits beyond the period during which the Certificate was in force may be continued upon Your continuous total disability, limited to the duration of the Certificate benefit period, if any, or payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

**EXCLUSIONS**

This Certificate does not pay expenses related to any coverage that is limited or excluded by Medicare related to services not "reasonable and Medically Necessary" under the Medicare Program Standards for diagnosis or treatment of Injury or Sickness.

## CLAIM PROVISIONS

**NOTICE OF CLAIMS:** We must receive written notice of claim within twenty (20) days after any covered loss occurs or begins. If notice cannot be given at that time, it must be given as soon as reasonably possible. Notice may be given to Us at Medicare Supplement Claims, [P.O. Box 10850, Clearwater, Florida 33757-8850.]

**CLAIM FORMS:** When We get the notice, We will send You forms for filing proof of loss. If We do not send the forms within fifteen (15) working days after receiving written notice, Our requirements will be met if We receive written proof of the event and type and extent of the loss within the time stated below.

**PROOF OF LOSS:** We must receive written proof of loss within ninety (90) days after the date the loss began or occurred. If it is not reasonably possible to give this timely proof, the claim will not be affected if it is sent as soon as is reasonable. However, unless the person making the claim is legally incapacitated, proof must be given within one (1) year from the time it is otherwise due.

**TIME OF PAYMENT OF CLAIMS:** All benefits payable under this Certificate will be payable immediately upon receipt of due written proof of such loss. For continuing losses, We will pay the benefits due monthly on receipt of due proofs of loss. All benefits due will be paid to You or to any health care provider to whom You have assigned benefits.

**PAYMENT OF CLAIMS:** Any accrued benefits unpaid at Your death will be paid to Your estate or to any health care providers to whom You have assigned benefits. Should We fail to pay the benefits payable upon receipt of due written proof of loss, We shall have fifteen (15) working days thereafter within which to mail You a letter or notice which states the reasons We have for failing to pay the claim, either in whole or in part, and which also gives You a written itemization of any documents or other information needed to process the claim or any portions thereof which are not being paid. When all of the listed documents or other information needed to process the claim have been received, We shall then have fifteen (15) working days within which to process and either pay the claim or deny it, in whole or in part, giving You the reasons We may have for denying such claim or any portion thereof.

We shall pay interest to You equal to twelve percent (12%) per annum on the proceeds or benefits due under the terms of this Policy for failure to comply with the requirements of this provision.

**PHYSICAL EXAMINATIONS:** At Our expense, We may have You examined as often as reasonably necessary while the claim is pending.

**TIME LIMIT ON CERTAIN DEFENSES:** After three (3) years from the date of issue of this Certificate no misstatements, except fraudulent misstatements, made by You in the application for the Certificate shall be used to void the Certificate or to deny a claim for loss incurred commencing after the expiration of the three (3) year period.

**LEGAL ACTION:** No action at law or in equity shall be brought to recover on this Certificate prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this Certificate. No such action shall be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

**ASSIGNMENT:** No assignment of any benefit or claim shall bind Us unless the same is filed in writing prior to the payment of any benefit claimed. We assume no responsibility for the validity of any assignment. Notice may be given to Us at Medicare Supplement Claims, [P.O. Box 10850, Clearwater, Florida 33757-8850.]

## GENERAL PROVISIONS

**OWNER OF CERTIFICATE:** You, the Insured shall be the Owner of this Certificate. You may exercise all options and rights under this Certificate.

**MAINTENANCE OF RESERVE:** If Our reserves become impaired, You shall pay Us this Certificate's equitable proportion of the deficiency. However, there shall be no personal liability for such payment except against this Certificate's reserve. The amounts of such payment and deficiency shall be determined by the Society's Board of Directors. If such payment is not made in cash, it shall stand as a debt against this Certificate. Such debt shall bear the lesser of 5% or the rate used to compute certificate reserves. In lieu of the foregoing, or in combination with it, You may consent to a corresponding decrease of the insurance benefits. Such decrease shall be in the same proportion as the amount of such payment bears to the reserve immediately before such decrease.

**SUSPENSION OR EXPULSION:** If You should be expelled or suspended from the membership in the Society for any reason, except for nonpayment of premium or within the contestable period for misrepresentation in Your application for membership, You shall have the privilege of maintaining this Certificate in force by continuing payment of the required premium.

**CONTRACT:** This Certificate is between You and Us. It includes articles of incorporation and the by-laws of the Society; this Certificate; the application, a copy of which is attached; and all present or future amendments to each. However, no future amendment to the articles of incorporation or the by-laws of the Society shall reduce benefits given to You as of the Certificate Effective Date.

**MODIFICATIONS:** No agent of this Society is allowed to make changes to this Certificate. Only authorized officers of the Society can waive any terms of or make any changes to this Certificate. All changes must be in writing.

**GRACE PERIOD:** A grace period of thirty-one (31) days will be granted for the payment of each premium falling due after the first premium, during which grace period, this Certificate shall continue in force.

**REINSTATEMENT:** If any renewal premium is not paid within the time granted by Us for payment, a subsequent acceptance of any premium by Us or by any of Our authorized agents, without requiring an application for reinstatement, shall reinstate the Certificate; provided, however that, if We or any of Our authorized agents require an application for reinstatement and issues a conditional receipt for the premium tendered, the Certificate will be reinstated upon approval of such application by Us or, lacking such approval, upon the forty-fifth (45th) day following the date of such conditional receipt unless We have previously notified You in writing of Our disapproval of such application. The reinstated Certificate shall cover only loss resulting from an Injury or Sickness as may begin on or after the date of reinstatement. In all other respects the Society and the Insured shall have the same rights under the Certificate as they had under the Certificate immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with reinstatement.

**UNPAID PREMIUM:** Upon the payment of a claim under this Certificate, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

**CONFORMITY WITH STATE LAWS:** Any provision of the Certificate which, on its Certificate Effective Date, is in conflict with the laws of the state in which You reside on such date is hereby amended to conform to the minimum requirements of such statutes.

**CLERICAL ERROR:** Clerical error on Our part will not invalidate insurance otherwise in force nor continue insurance otherwise terminated. Upon discovery of any error, an equitable adjustment will be made in the premiums. Complete proof must be supplied documenting any clerical errors.

**GENERAL PROVISIONS CONTINUED**

**MISSTATEMENT OF AGE:** If Your age has been misstated, all amounts payable under this Certificate shall be such as the premium paid would have purchased at the correct age.

**PRO RATA REFUND:** If We receive written proof of death which terminates coverage, We will refund that part of any premium You have paid which covers a period after death occurs.

**CANCELLATION BY INSURED:** You may cancel this Certificate at any time by written notice delivered or mailed to Us at Medicare Supplement Administration, [P.O. Box 10851, Clearwater, Florida 33757-8851], effective upon receipt or on such later date as may be specified in such notice. In the event of cancellation we will make a pro-rata refund of any premium paid beyond the date of cancellation. Cancellation will be without prejudice to any claim originating prior to the effective date of cancellation.

This Certificate is signed for the Society by its [Secretary] [and] [President].

[SIGNATURE]

**[Secretary and General Counsel]**

[SIGNATURE]

**[President-CEO]**



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## **MEDICARE SUPPLEMENT INSURANCE CERTIFICATE - PLAN F**

### **READ YOUR CERTIFICATE CAREFULLY**

**This Certificate is a legal contract between the Owner of the Certificate and Royal Neighbors of America (the Society).**

This Certificate provides benefits to supplement hospital and medical coverage of Medicare. Only persons eligible for Medicare may apply for this Certificate. In this Certificate, “You” and “Your” means the Insured named on the application and shown on the Certificate Schedule. “We”, “Our” and “Us” means Royal Neighbors of America.

### **NOTICE TO BUYER. THIS CERTIFICATE MAY NOT COVER ALL OF YOUR MEDICAL EXPENSES.**

**IMPORTANT NOTICE:** Issuance of this Medicare Supplement Insurance Certificate is based on Your answers to the questions on Your application. A copy of the application is attached. Omissions or misstatements on the application could cause Your claim to be denied or Your Certificate to be rescinded. If, for any reason, Your answers are incorrect, contact Us immediately at Medicare Supplement Administration, [P.O. Box 10851, Clearwater Florida 33757-8851, Telephone Number 877-815-8877.]

### **CERTIFICATE EFFECTIVE DATE AND CONSIDERATION**

We have issued this Certificate in consideration of the payment of premium and the statements made on the application. The application is attached to and made a part of this Certificate. The term of this Certificate begins at, 12:01 a.m. Standard Time, at the place where You reside on the Certificate Effective Date shown on the Certificate Schedule. It ends at 11:59 p.m., at the place where You reside, on the day before Your premium is due. The date Your premium is due is determined by the mode of payment. The mode of payment for the original term of the Certificate is shown on the Certificate Schedule. An annual premium will maintain the Certificate in force for twelve (12) months, semi-annual for six (6) months, quarterly for three (3) months and monthly for one (1) month.

### **THIRTY DAY RIGHT TO EXAMINE AND RETURN CERTIFICATE**

Please read Your Certificate carefully. If, for any reason, You are not satisfied, You may return Your Certificate to Us at Medicare Supplement Administration, [P.O. Box 10851, Clearwater Florida 33757-8851], within thirty (30) days after receiving it. If returned, the Certificate will be void from its beginning and any premium paid will be refunded. If payment of a claim is made under this Certificate during the thirty (30) day period, the amount will be deducted from the premium refund.

### **GUARANTEED RENEWABLE FOR LIFE - PREMIUMS SUBJECT TO CHANGE**

This Certificate is for renewable as long as You live, provided You continue to pay premiums when due. At no time while You continue Your Certificate in force, may We place any restrictive riders on Your coverage. The premium may change on any premium due date if a new table of rates is applicable to the Certificate. The change in the table of rates will apply to all covered persons in the same class. Class is defined as underwriting class, state, plan and zip code of residence. You will be notified in advance before any change in the table of rates.

### **THIS CERTIFICATE DOES NOT CONTAIN A PRE-EXISTING CONDITION LIMITATION**

### **THIS IS A NON-PARTICIPATING CERTIFICATE**

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## **POLICYHOLDER INFORMATION**

For support and information regarding certificate terms, premium payments, claims processing and payment, contact us at:

Medicare Supplement Administration  
[P. O. Box 10851  
Clearwater, Florida 33757-8851  
1-877-815-8877]

For your information, the following is the name, address and telephone number of your agent:

[Mr. Fred Smith]  
[123 First Street  
Anywhere, USA 12345  
1-555-555-1234]

The Arkansas Insurance Department can be contacted at:

Arkansas Insurance Department  
Consumer Services  
1200 West Third Street  
Little Rock, Arkansas 72201-1904  
1-501-371-2640

Toll Free Consumer Information Telephone Number  
1-800-852-5494

**CERTIFICATE SCHEDULE**

**INSURED:**

**CERTIFICATE EFFECTIVE DATE:**

**CERTIFICATE NUMBER:**

**ISSUE AGE:**

**STATE OF ISSUE:**

**MODE AT ISSUE:**

**MODAL PREMIUM:**

**PREMIUM TERM:**

**UNDERWRITING CLASS:**

**CHAPTER:**

\*\*\*\*\*

**TYPE OF COVERAGE:  MEDICARE SUPPLEMENT CERTIFICATE PLAN F**

## DEFINITIONS

**Benefit Period** means the period as determined by Medicare which begins on the date You are first confined in a Hospital. It ends following a period of sixty (60) consecutive days during which You have not been confined in a Hospital or a Skilled Nursing Facility.

**Calendar Year** means the period of time beginning on January 1 and ending on December 31 of that same year.

**Certificate Effective Date** means the effective date of this Certificate and is shown on the Certificate Schedule. The Certificate Effective Date is not the date You signed the application for coverage.

**Coinsurance Amount** means the part of Medicare Eligible Expenses You have to pay. It does not include Part A or Part B deductible amounts.

**Emergency Care** means care needed immediately because of an Injury or an illness of sudden and unexpected onset.

**Hospital** means a hospital that is approved, or eligible to be approved to receive payments from Medicare and is accredited by the Joint Commission on Accreditation of Hospitals.

**Hospitalized** or **Hospitalization** means being confined in a Hospital on an inpatient basis.

**Immediate Family** means Your spouse, parents, grandparents, children, or siblings, as well as their spouses.

**Injury** means a bodily injury which is the direct result of an accident and independent of all other causes.

**Lifetime Inpatient Reserve Days** means a total of sixty (60) extra days in the Hospital provided to You by Medicare. These reserve days must be used if You are Hospitalized for more than ninety (90) days in a Benefit Period, unless previously used. When a lifetime reserve day is used, it is subtracted from the number of days You have left.

**Medicaid** means the Health Insurance for the Aged Act, Title XIX of the Social Security Amendment of 1965, as then constituted or later amended.

**Medically Necessary** means a service or supply that is recognized by Medicare as necessary to diagnose or treat an Injury or Sickness and is: (1) prescribed by a Physician; (2) consistent with the diagnosis and treatment of the Injury or Sickness; (3) in accordance with the generally accepted standards of medical practice; and (4) not solely for the convenience of You or the Physician.

**Medicare** means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendment of 1965, as then constituted or later amended.

**Medicare Eligible Expenses** means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and Medically Necessary by Medicare.

**Medicare Part A Initial Deductible** means the fixed amount Medicare does not pay during the first sixty (60) days of Hospital confinement in a Benefit Period. This amount is set each year by Medicare. Medicare does not pay this amount.

**Medicare Part B Deductible** means the fixed amount You must pay each Calendar Year before Medicare starts paying Part B expenses. This amount is set each year by Medicare. Medicare does not pay this amount. A Calendar Year begins on January 1 and ends on December 31.

**Physician** means any practitioner of the healing arts acting within the scope of his/her license. It does not include You or any member of Your Immediate Family.

## DEFINITIONS CONTINUED

**Sickness** means illness or disease which first manifests itself after the Certificate Effective Date and while this Certificate is in force.

**Skilled Nursing Facility** means an institution licensed as such by the state in which it is located and is operating within the scope and intent of its license. It does not include a facility or any of its sections which is primarily a place for drug addicts, alcoholics or persons suffering from mental disease.

## BENEFIT PROVISIONS

We will pay only the following Medicare Eligible Expenses not paid by Medicare. Benefits are only paid to the extent specified in this provision.

**The benefits paid under this Certificate will not duplicate benefits paid by Medicare.**

### Basic Core Benefits

Coverage of Part A Medicare Eligible Expenses for Hospitalization to the extent not covered by Medicare from the sixty first (61<sup>st</sup>) day through the ninetieth (90<sup>th</sup>) day in any Medicare Benefit Period.

Coverage of Part A Medicare Eligible Expenses incurred for Hospitalization to the extent not covered by Medicare for each Medicare Lifetime Inpatient Reserve Day used.

Upon exhaustion of Medicare Hospital inpatient coverage, including the lifetime reserve days, coverage of 100% of the Medicare Part A eligible expenses for hospitalization paid at applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional three hundred sixty-five (365) days. The provider shall accept Our payment as payment in full and may not bill You for any balance.

Coverage under Medicare Parts A and B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations.

Coverage for the Coinsurance Amount, or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount, of Medicare Eligible Expenses under Part B regardless of Hospital confinement, subject to the Medicare Part B Deductible.

Hospice Care: Coverage of cost sharing for all Part A Medicare Eligible Expenses for hospice care and respite care expenses.

### Additional Benefits For Plan F

**Medicare Part A Deductible:** Coverage for all of the Medicare Part A Initial Deductible amount per Benefit Period.

**Skilled Nursing Facility Care:** Coverage for the actual billed charges up to the Coinsurance Amount from the twenty-first (21<sup>st</sup>) day through the one hundredth (100<sup>th</sup>) day in a Medicare benefit period for posthospital Skilled Nursing Facility care eligible under Medicare Part A.

**Medicare Part B Deductible:** Coverage for all of the Medicare Part B Deductible amount per Calendar Year regardless of Hospital confinement.

## **Additional Benefits For Plan F Continued**

**One Hundred Percent (100%) of the Medicare Part B Excess Charges:** Coverage for all of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

**Medically Necessary Emergency Care in a Foreign Country:** Coverage to the extent not covered by Medicare for eighty percent (80%) of the billed charges for Medicare-Eligible Expenses for Medically Necessary emergency Hospital, Physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first sixty (60) consecutive days of each trip outside the United States, subject to a Calendar Year deductible of two hundred fifty dollars (\$250), and a lifetime maximum benefit of fifty thousand dollars (\$50,000).

### **GUARANTEE REGARDING CHANGES IN MEDICARE BENEFITS**

We guarantee that the benefits and payment schedule of this Certificate will automatically change to reflect any changes which will become effective under Medicare. Only those provisions of the Certificate which are affected by the legislation are changed. Your coverage will automatically provide for such changes to whatever extent necessary. Premiums may be modified to correspond with such changes in accordance with the **GUARANTEE RENEWABLE FOR LIFE - PREMIUMS SUBJECT TO CHANGE** provision on page 1.

### **MEDICAL ASSISTANCE UNDER MEDICAID AND SUSPENSION UNDER GROUP HEALTH PLAN**

Benefits and premiums under this Certificate are suspended at Your request for a period not to exceed twenty-four (24) months, in which You have applied for and are determined to be entitled to medical assistance under Title XIX of the Social Security Act. You must notify Us within ninety (90) days after the day You become entitled to such assistance.

If such a suspension occurs and You lose entitlement of such medical assistance, Your Certificate is automatically reinstated effective as of the date of termination of such entitlement if You provide notice of loss of such entitlement within ninety (90) days after the date of such loss and pay the premiums attributable to the period. Your reinstated Certificate is effective as of the date of termination of such entitlement.

Benefits and premiums under this Certificate shall be suspended for any period that may be provided by federal regulation at Your request if You are entitled to benefits under section 226(b) of the Social Security Act and are covered under a group health plan, as defined in section 1862(b)(1)(A)(v) of the Social Security Act. If suspension occurs and You lose coverage under the group health plan, Your Certificate shall be automatically reinstated, effective as of the date of loss of such coverage, if You provide notice of loss of coverage within ninety (90) days after the date of such loss and pay the premiums attributable to the period, effective as of the date of termination of such entitlement.

Reinstitution of Your coverage provides for:

1. Coverage equivalent to coverage in effect before the date of suspension;
2. Your classification of premium remains as favorable to You as the premium classification terms that would have applied to You had the coverage not been suspended; and
3. No waiting period with respect to treatment of preexisting conditions.

### **TERMINATION OF CERTIFICATE AND EXTENSION OF BENEFITS**

Termination of the Certificate shall be without prejudice to a continuous loss which commenced while the Certificate was in force but the extension of benefits beyond the period during which the Certificate was in force may be continued upon Your continuous total disability, limited to the duration of the Certificate benefit period, if any, or payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

## EXCLUSIONS

This Certificate does not pay expenses related to any coverage that is limited or excluded by Medicare related to services not "reasonable and Medically Necessary" under the Medicare Program Standards for diagnosis or treatment of Injury or Sickness.

## CLAIM PROVISIONS

**NOTICE OF CLAIMS:** We must receive written notice of claim within twenty (20) days after any covered loss occurs or begins. If notice cannot be given at that time, it must be given as soon as reasonably possible. Notice may be given to Us at Medicare Supplement Claims, [P.O. Box 10850, Clearwater, Florida 33757-8850.]

**CLAIM FORMS:** When We get the notice, We will send You forms for filing proof of loss. If We do not send the forms within fifteen (15) working days after receiving written notice, Our requirements will be met if We receive written proof of the event and type and extent of the loss within the time stated below.

**PROOF OF LOSS:** We must receive written proof of loss within ninety (90) days after the date the loss began or occurred. If it is not reasonably possible to give this timely proof, the claim will not be affected if it is sent as soon as is reasonable. However, unless the person making the claim is legally incapacitated, proof must be given within one (1) year from the time it is otherwise due.

**TIME OF PAYMENT OF CLAIMS:** All benefits payable under this Certificate will be payable immediately upon receipt of due written proof of such loss. For continuing losses, We will pay the benefits due monthly on receipt of due proofs of loss. All benefits due will be paid to You or to any health care provider to whom You have assigned benefits.

**PAYMENT OF CLAIMS:** Any accrued benefits unpaid at Your death will be paid to Your estate or to any health care providers to whom You have assigned benefits. Should We fail to pay the benefits payable upon receipt of due written proof of loss, We shall have fifteen (15) working days thereafter within which to mail You a letter or notice which states the reasons We have for failing to pay the claim, either in whole or in part, and which also gives You a written itemization of any documents or other information needed to process the claim or any portions thereof which are not being paid. When all of the listed documents or other information needed to process the claim have been received, We shall then have fifteen (15) working days within which to process and either pay the claim or deny it, in whole or in part, giving You the reasons We may have for denying such claim or any portion thereof.

We shall pay interest to You equal to twelve percent (12%) per annum on the proceeds or benefits due under the terms of this Policy for failure to comply with the requirements of this provision.

**PHYSICAL EXAMINATIONS:** At Our expense, We may have You examined as often as reasonably necessary while the claim is pending.

**TIME LIMIT ON CERTAIN DEFENSES:** After three (3) years from the date of issue of this Certificate no misstatements, except fraudulent misstatements, made by You in the application for the Certificate shall be used to void the Certificate or to deny a claim for loss incurred commencing after the expiration of the three (3) year period.

**LEGAL ACTION:** No action at law or in equity shall be brought to recover on this Certificate prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this Certificate. No such action shall be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

**ASSIGNMENT:** No assignment of any benefit or claim shall bind Us unless the same is filed in writing prior to the payment of any benefit claimed. We assume no responsibility for the validity of any assignment. Notice may be given to Us at Medicare Supplement Claims, [P.O. Box 10850, Clearwater, Florida 33757-8850.]

## GENERAL PROVISIONS

**OWNER OF CERTIFICATE:** You, the Insured shall be the Owner of this Certificate. You may exercise all options and rights under this Certificate.

**MAINTENANCE OF RESERVE:** If Our reserves become impaired, You shall pay Us this Certificate's equitable proportion of the deficiency. However, there shall be no personal liability for such payment except against this Certificate's reserve. The amounts of such payment and deficiency shall be determined by the Society's Board of Directors. If such payment is not made in cash, it shall stand as a debt against this Certificate. Such debt shall bear the lesser of 5% or the rate used to compute certificate reserves. In lieu of the foregoing, or in combination with it, You may consent to a corresponding decrease of the insurance benefits. Such decrease shall be in the same proportion as the amount of such payment bears to the reserve immediately before such decrease.

**SUSPENSION OR EXPULSION:** If You should be expelled or suspended from the membership in the Society for any reason, except for nonpayment of premium or within the contestable period for misrepresentation in Your application for membership, You shall have the privilege of maintaining this Certificate in force by continuing payment of the required premium.

**CONTRACT:** This Certificate is between You and Us. It includes articles of incorporation and the by-laws of the Society; this Certificate; the application, a copy of which is attached; and all present or future amendments to each. However, no future amendment to the articles of incorporation or the by-laws of the Society shall reduce benefits given to You as of the Certificate Effective Date.

**MODIFICATIONS:** No agent of this Society is allowed to make changes to this Certificate. Only authorized officers of the Society can waive any terms of or make any changes to this Certificate. All changes must be in writing.

**GRACE PERIOD:** A grace period of thirty-one (31) days will be granted for the payment of each premium falling due after the first premium, during which grace period, this Certificate shall continue in force.

**REINSTATEMENT:** If any renewal premium is not paid within the time granted by Us for payment, a subsequent acceptance of any premium by Us or by any of Our authorized agents, without requiring an application for reinstatement, shall reinstate the Certificate; provided, however that, if We or any of Our authorized agents require an application for reinstatement and issues a conditional receipt for the premium tendered, the Certificate will be reinstated upon approval of such application by Us or, lacking such approval, upon the forty-fifth (45th) day following the date of such conditional receipt unless We have previously notified You in writing of Our disapproval of such application. The reinstated Certificate shall cover only loss resulting from an Injury or Sickness as may begin on or after the date of reinstatement. In all other respects the Society and the Insured shall have the same rights under the Certificate as they had under the Certificate immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with reinstatement.

**UNPAID PREMIUM:** Upon the payment of a claim under this Certificate, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

**CONFORMITY WITH STATE LAWS:** Any provision of the Certificate which, on its Certificate Effective Date, is in conflict with the laws of the state in which You reside on such date is hereby amended to conform to the minimum requirements of such statutes.

**CLERICAL ERROR:** Clerical error on Our part will not invalidate insurance otherwise in force nor continue insurance otherwise terminated. Upon discovery of any error, an equitable adjustment will be made in the premiums. Complete proof must be supplied documenting any clerical errors.

**GENERAL PROVISIONS CONTINUED**

**MISSTATEMENT OF AGE:** If Your age has been misstated, all amounts payable under this Certificate shall be such as the premium paid would have purchased at the correct age.

**PRO RATA REFUND:** If We receive written proof of death which terminates coverage, We will refund that part of any premium You have paid which covers a period after death occurs.

**CANCELLATION BY INSURED:** You may cancel this Certificate at any time by written notice delivered or mailed to Us at Medicare Supplement Administration, [P.O. Box 10851, Clearwater, Florida 33757-8851], effective upon receipt or on such later date as may be specified in such notice. In the event of cancellation we will make a pro-rata refund of any premium paid beyond the date of cancellation. Cancellation will be without prejudice to any claim originating prior to the effective date of cancellation.

**This Certificate is signed for the Society by its [Secretary] [and] [President].**

[SIGNATURE]

**[Secretary and General Counsel]**

[SIGNATURE]

**[President-CEO]**



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## **MEDICARE SUPPLEMENT INSURANCE CERTIFICATE - PLAN G**

### **READ YOUR CERTIFICATE CAREFULLY**

**This Certificate is a legal contract between the Owner of the Certificate and Royal Neighbors of America (the Society).**

This Certificate provides benefits to supplement hospital and medical coverage of Medicare. Only persons eligible for Medicare may apply for this Certificate. In this Certificate, “You” and “Your” means the Insured named on the application and shown on the Certificate Schedule. “We”, “Our” and “Us” means Royal Neighbors of America.

**NOTICE TO BUYER. THIS CERTIFICATE MAY NOT COVER ALL OF YOUR MEDICAL EXPENSES.**

**IMPORTANT NOTICE:** Issuance of this Medicare Supplement Insurance Certificate is based on Your answers to the questions on Your application. A copy of the application is attached. Omissions or misstatements on the application could cause Your claim to be denied or Your Certificate to be rescinded. If, for any reason, Your answers are incorrect, contact Us immediately at Medicare Supplement Administration, [P.O. Box 10851, Clearwater Florida 33757-8851, Telephone Number 877-815-8877.]

### **CERTIFICATE EFFECTIVE DATE AND CONSIDERATION**

We have issued this Certificate in consideration of the payment of premium and the statements made on the application. The application is attached to and made a part of this Certificate. The term of this Certificate begins at, 12:01 a.m. Standard Time, at the place where You reside on the Certificate Effective Date shown on the Certificate Schedule. It ends at 11:59 p.m., at the place where You reside, on the day before Your premium is due. The date Your premium is due is determined by the mode of payment. The mode of payment for the original term of the Certificate is shown on the Certificate Schedule. An annual premium will maintain the Certificate in force for twelve (12) months, semi-annual for six (6) months, quarterly for three (3) months and monthly for one (1) month.

### **THIRTY DAY RIGHT TO EXAMINE AND RETURN CERTIFICATE**

Please read Your Certificate carefully. If, for any reason, You are not satisfied, You may return Your Certificate to Us at Medicare Supplement Administration, [P.O. Box 10851, Clearwater Florida 33757-8851], within thirty (30) days after receiving it. If returned, the Certificate will be void from its beginning and any premium paid will be refunded. If payment of a claim is made under this Certificate during the thirty (30) day period, the amount will be deducted from the premium refund.

### **GUARANTEED RENEWABLE FOR LIFE - PREMIUMS SUBJECT TO CHANGE**

This Certificate is renewable for as long as You live, provided You continue to pay premiums when due. At no time while You continue Your Certificate in force, may We place any restrictive riders on Your coverage. The premium may change on any premium due date if a new table of rates is applicable to the Certificate. The change in the table of rates will apply to all covered persons in the same class. Class is defined as underwriting class, state, plan and zip code of residence. You will be notified in advance before any change in the table of rates.

**THIS CERTIFICATE DOES NOT CONTAIN A PRE-EXISTING CONDITION LIMITATION**

**THIS IS A NON-PARTICIPATING CERTIFICATE**

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## **POLICYHOLDER INFORMATION**

For support and information regarding certificate terms, premium payments, claims processing and payment, contact us at:

Medicare Supplement Administration  
[P. O. Box 10851  
Clearwater, Florida 33757-8851  
1-877-815-8877]

For your information, the following is the name, address and telephone number of your agent:

[Mr. Fred Smith]  
[123 First Street  
Anywhere, USA 12345  
1-555-555-1234]

The Arkansas Insurance Department can be contacted at:

Arkansas Insurance Department  
Consumer Services  
1200 West Third Street  
Little Rock, Arkansas 72201-1904  
1-501-371-2640

Toll Free Consumer Information Telephone Number  
1-800-852-5494

**CERTIFICATE SCHEDULE**

**INSURED:**

**CERTIFICATE EFFECTIVE DATE:**

**CERTIFICATE NUMBER:**

**ISSUE AGE:**

**STATE OF ISSUE:**

**MODE AT ISSUE:**

**MODAL PREMIUM:**

**PREMIUM TERM:**

**UNDERWRITING CLASS:**

**CHAPTER:**

\*\*\*\*\*

**TYPE OF COVERAGE: MEDICARE SUPPLEMENT CERTIFICATE PLAN G**

## DEFINITIONS

**Benefit Period** means the period as determined by Medicare which begins on the date, You are first confined in a Hospital. It ends following a period of sixty (60) consecutive days during which You have not been confined in a Hospital or a Skilled Nursing Facility.

**Calendar Year** means the period of time beginning on January 1 and ending on December 31 of that same year.

**Certificate Effective Date** means the effective date of this Certificate and is shown on the Certificate Schedule. The Certificate Effective Date is not the date You signed the application for coverage.

**Coinsurance Amount** means the part of Medicare Eligible Expenses You have to pay. It does not include Part A or Part B deductible amounts.

**Emergency Care** means care needed immediately because of an Injury or illness of sudden and unexpected onset.

**Hospital** means a hospital that is approved, or eligible to be approved to receive payments from Medicare and is accredited by the Joint Commission on Accreditation of Hospitals.

**Hospitalized** or **Hospitalization** means being confined in a Hospital on an inpatient basis.

**Immediate Family** means Your spouse, parents, grandparents, children, or siblings, as well as their spouses.

**Injury** means a bodily injury which is the direct result of an accident and independent of all other causes.

**Lifetime Inpatient Reserve Days** means a total of sixty (60) extra days in the Hospital provided to You by Medicare. These reserve days must be used if You are Hospitalized for more than ninety (90) days in a Benefit Period, unless previously used. When a lifetime reserve day is used, it is subtracted from the number of days You have left.

**Medicaid** means the Health Insurance for the Aged Act, Title XIX of the Social Security Amendment of 1965, as then constituted or later amended.

**Medically Necessary** means a service or supply that is recognized by Medicare as necessary to diagnose or treat an Injury or Sickness and is: (1) prescribed by a Physician; (2) consistent with the diagnosis and treatment of the Injury or Sickness; (3) in accordance with the generally accepted standards of medical practice; and (4) not solely for the convenience of You or the Physician.

**Medicare** means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendment of 1965, as then constituted or later amended.

**Medicare Eligible Expenses** means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and Medically Necessary by Medicare.

**Medicare Part A Initial Deductible** means the fixed amount Medicare does not pay during the first sixty (60) days of Hospital confinement in a Benefit Period. This amount is set each year by Medicare. Medicare does not pay this amount.

**Physician** means any practitioner of the healing arts acting within the scope of his/her license. It does not include You or any member of Your Immediate Family.

**Sickness** means illness or disease which first manifests itself after the Certificate Effective Date and while this Certificate is in force.

## DEFINITIONS CONTINUED

**Skilled Nursing Facility** means an institution licensed as such by the state in which it is located and is operating within the scope and intent of its license. It does not include a facility or any of its sections which is primarily a place for drug addicts, alcoholics or persons suffering from mental disease.

## BENEFIT PROVISIONS

We will pay only the following Medicare Eligible Expenses not paid by Medicare. Benefits are only paid to the extent specified in this provision.

**The benefits paid under this Certificate will not duplicate benefits paid by Medicare.**

### Basic (Core) Benefits

Coverage of Part A Medicare Eligible Expenses for Hospitalization to the extent not covered by Medicare from the sixty first ( 61<sup>st</sup> ) day through the ninetieth (90<sup>th</sup>) day in any Medicare Benefit Period.

Coverage of Part A Medicare Eligible Expenses incurred for Hospitalization to the extent not covered by Medicare for each Medicare Lifetime Inpatient Reserve Day used.

Upon exhaustion of Medicare Hospital inpatient coverage, including the lifetime reserve days, coverage of 100% of the Medicare Part A eligible expenses for hospitalization paid at applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional three hundred sixty-five (365) days. The provider shall accept Our payment as payment in full and may not bill You for any balance.

Coverage under Medicare Parts A and B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations.

Coverage for the Coinsurance Amount, or in the case of outpatient department services paid under a prospective payment system, the copayment amount, of Medicare Eligible Expenses under Part B regardless of Hospital Confinement, subject to the Medicare Part B deductible.

Hospice Care: Coverage of cost sharing for all Part A Medicare Eligible Expenses for hospice care and respite care expenses.

### Additional Benefits For Plan G

**Medicare Part A Deductible:** Coverage for all of the Medicare Part A Initial Deductible amount per Benefit Period.

**One Hundred Percent (100%) of the Medicare Part B Excess Charges:** Coverage for all of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

**Skilled Nursing Facility Care:** Coverage for the actual billed charges up to the Coinsurance Amount from the twenty-first (21<sup>st</sup>) day through the one hundredth (100<sup>th</sup>) day in a Medicare Benefit Period for posthospital Skilled Nursing Facility care eligible under Medicare Part A.

## **Additional Benefits For Plan G Continued**

**Medically Necessary Emergency Care in a Foreign Country:** Coverage to the extent not covered by Medicare for eighty percent (80%) of the billed charges for Medicare-Eligible Expenses for Medically Necessary emergency Hospital, Physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first sixty (60) consecutive days of each trip outside the United States, subject to a Calendar Year deductible of two hundred fifty dollars (\$250), and a lifetime maximum benefit of fifty thousand dollars (\$50,000).

### **GUARANTEE REGARDING CHANGES IN MEDICARE BENEFITS**

We guarantee that the benefits and payment schedule of this Certificate will automatically change to reflect any changes which will become effective under Medicare. Only those provisions of the Certificate which are affected by the legislation are changed. Your coverage will automatically provide for such changes to whatever extent necessary. Premiums may be modified to correspond with such changes in accordance with the **GUARANTEE RENEWABLE FOR LIFE - PREMIUMS SUBJECT TO CHANGE** provision on page 1.

### **MEDICAL ASSISTANCE UNDER MEDICAID AND SUSPENSION UNDER GROUP HEALTH PLAN**

Benefits and premiums under this Certificate are suspended at Your request for a period not to exceed twenty-four (24) months, in which You have applied for and are determined to be entitled to medical assistance under Title XIX of the Social Security Act. You must notify Us within ninety (90) days after the day You become entitled to such assistance.

If such a suspension occurs and You lose entitlement of such medical assistance, Your Certificate is automatically reinstated effective as of the date of termination of such entitlement if You provide notice of loss of such entitlement within ninety (90) days after the date of such loss and pay the premiums attributable to the period. Your reinstated Certificate is effective as of the date of termination of such entitlement.

Benefits and premiums under this Certificate shall be suspended for any period that may be provided by federal regulation at Your request if You are entitled to benefits under section 226(b) of the Social Security Act and are covered under a group health plan, as defined in section 1862(b)(1)(A)(v) of the Social Security Act. If suspension occurs and You lose coverage under the group health plan, Your Certificate shall be automatically reinstated, effective as of the date of loss of such coverage, if You provide notice of loss of coverage within ninety (90) days after the date of such loss and pay the premiums attributable to the period, effective as of the date of termination of such entitlement.

Reinstitution of Your coverage provides for:

1. Coverage equivalent to coverage in effect before the date of suspension;
2. Your classification of premium remains as favorable to You as the premium classification terms that would have applied to You had the coverage not been suspended; and
3. No waiting period with respect to treatment of preexisting conditions.

### **TERMINATION OF CERTIFICATE AND EXTENSION OF BENEFITS**

Termination of the Certificate shall be without prejudice to a continuous loss which commenced while the Certificate was in force but the extension of benefits beyond the period during which the Certificate was in force may be continued upon Your continuous total disability, limited to the duration of the Certificate benefit period, if any, or payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

## EXCLUSIONS

This Certificate does not pay expenses related to any coverage that is limited or excluded by Medicare related to services not "reasonable and Medically Necessary" under the Medicare Program Standards for diagnosis or treatment of Injury or Sickness.

## CLAIM PROVISIONS

**NOTICE OF CLAIMS:** We must receive written notice of claim within twenty (20) days after any covered loss occurs or begins. If notice cannot be given at that time, it must be given as soon as reasonably possible. Notice may be given to Us at Medicare Supplement Claims, [P.O. Box 10850, Clearwater, Florida 33757-8850.]

**CLAIM FORMS:** When We get the notice, We will send You forms for filing proof of loss. If We do not send the forms within fifteen (15) working days after receiving written notice, Our requirements will be met if We receive written proof of the event and type and extent of the loss within the time stated below.

**PROOF OF LOSS:** We must receive written proof of loss within ninety (90) days after the date the loss began or occurred. If it is not reasonably possible to give this timely proof, the claim will not be affected if it is sent as soon as is reasonable. However, unless the person making the claim is legally incapacitated, proof must be given within one (1) year from the time it is otherwise due.

**TIME OF PAYMENT OF CLAIMS:** All benefits payable under this Certificate will be payable immediately upon receipt of due written proof of such loss. For continuing losses, We will pay the benefits due monthly on receipt of due proofs of loss. All benefits due will be paid to You or to any health care provider to whom You have assigned benefits.

**PAYMENT OF CLAIMS:** Any accrued benefits unpaid at Your death will be paid to Your estate or to any health care providers to whom You have assigned benefits. Should We fail to pay the benefits payable upon receipt of due written proof of loss, We shall have fifteen (15) working days thereafter within which to mail You a letter or notice which states the reasons We have for failing to pay the claim, either in whole or in part, and which also gives You a written itemization of any documents or other information needed to process the claim or any portions thereof which are not being paid. When all of the listed documents or other information needed to process the claim have been received, We shall then have fifteen (15) working days within which to process and either pay the claim or deny it, in whole or in part, giving You the reasons We may have for denying such claim or any portion thereof.

We shall pay interest to You equal to twelve percent (12%) per annum on the proceeds or benefits due under the terms of this Policy for failure to comply with the requirements of this provision.

**PHYSICAL EXAMINATIONS:** At Our expense, We may have You examined as often as reasonably necessary while the claim is pending.

**TIME LIMIT ON CERTAIN DEFENSES:** After three (3) years from the date of issue of this Certificate no misstatements, except fraudulent misstatements, made by You in the application for the Certificate shall be used to void the Certificate or to deny a claim for loss incurred commencing after the expiration of the three (3) year period.

**LEGAL ACTION:** No action at law or in equity shall be brought to recover on this Certificate prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this Certificate. No such action shall be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

**ASSIGNMENT:** No assignment of any benefit or claim shall bind Us unless the same is filed in writing prior to the payment of any benefit claimed. We assume no responsibility for the validity of any assignment. Notice may be given to Us at Medicare Supplement Claims, [P.O. Box 10850, Clearwater, Florida 33757-8850.]

## GENERAL PROVISIONS

**OWNER OF CERTIFICATE:** You, the Insured shall be the Owner of this Certificate. You may exercise all options and rights under this Certificate.

**MAINTENANCE OF RESERVE:** If Our reserves become impaired, You shall pay Us this Certificate's equitable proportion of the deficiency. However, there shall be no personal liability for such payment except against this Certificate's reserve. The amounts of such payment and deficiency shall be determined by the Society's Board of Directors. If such payment is not made in cash, it shall stand as a debt against this Certificate. Such debt shall bear the lesser of 5% or the rate used to compute certificate reserves. In lieu of the foregoing, or in combination with it, You may consent to a corresponding decrease of the insurance benefits. Such decrease shall be in the same proportion as the amount of such payment bears to the reserve immediately before such decrease.

**SUSPENSION OR EXPULSION:** If You should be expelled or suspended from the membership in the Society for any reason, except for nonpayment of premium or within the contestable period for misrepresentation in Your application for membership, You shall have the privilege of maintaining this Certificate in force by continuing payment of the required premium.

**CONTRACT:** This Certificate is between You and Us. It includes articles of incorporation and the by-laws of the Society; this Certificate; the application, a copy of which is attached; and all present or future amendments to each. However, no future amendment to the articles of incorporation or the by-laws of the Society shall reduce benefits given to You as of the Certificate Effective Date.

**MODIFICATIONS:** No agent of this Society is allowed to make changes to this Certificate. Only authorized officers of the Society can waive any terms of or make any changes to this Certificate. All changes must be in writing.

**GRACE PERIOD:** A grace period of thirty-one (31) days will be granted for the payment of each premium falling due after the first premium, during which grace period, this Certificate shall continue in force.

**REINSTATEMENT:** If any renewal premium is not paid within the time granted by Us for payment, a subsequent acceptance of any premium by Us or by any of Our authorized agents, without requiring an application for reinstatement, shall reinstate the Certificate; provided, however that, if We or any of Our authorized agents require an application for reinstatement and issues a conditional receipt for the premium tendered, the Certificate will be reinstated upon approval of such application by Us or, lacking such approval, upon the forty-fifth (45th) day following the date of such conditional receipt unless We have previously notified You in writing of Our disapproval of such application. The reinstated Certificate shall cover only loss resulting from an Injury or Sickness as may begin on or after the date of reinstatement. In all other respects the Society and the Insured shall have the same rights under the Certificate as they had under the Certificate immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with reinstatement.

**UNPAID PREMIUM:** Upon the payment of a claim under this Certificate, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

**CONFORMITY WITH STATE LAWS:** Any provision of the Certificate which, on its Certificate Effective Date, is in conflict with the laws of the state in which You reside on such date is hereby amended to conform to the minimum requirements of such statutes.

**CLERICAL ERROR:** Clerical error on Our part will not invalidate insurance otherwise in force nor continue insurance otherwise terminated. Upon discovery of any error, an equitable adjustment will be made in the premiums. Complete proof must be supplied documenting any clerical errors.

**GENERAL PROVISIONS CONTINUED**

**MISSTATEMENT OF AGE:** If Your age has been misstated, all amounts payable under this Certificate shall be such as the premium paid would have purchased at the correct age.

**PRO RATA REFUND:** If We receive written proof of death which terminates coverage, We will refund that part of any premium You have paid which covers a period after death occurs.

**CANCELLATION BY INSURED:** You may cancel this Certificate at any time by written notice delivered or mailed to Us at Medicare Supplement Administration, [P.O. Box 10851, Clearwater, Florida 33757-8851], effective upon receipt or on such later date as may be specified in such notice. In the event of cancellation we will make a pro-rata refund of any premium paid beyond the date of cancellation. Cancellation will be without prejudice to any claim originating prior to the effective date of cancellation.

**This Certificate is signed for the Society by its [Secretary] [and] [President].**

[SIGNATURE]

**[Secretary and General Counsel]**

[SIGNATURE]

**[President-CEO]**



INSURING LIVES • SUPPORTING WOMEN • SERVING COMMUNITIES™

[230 Sixteenth Street • Rock Island, IL 61201 ]

Medicare Supplement Administration

[P.O. Box 10851 • Clearwater, FL 33757-8851]

[ (877) 815-8877 ]

*Royal Neighbors of America  
is dedicated to enriching the lives  
of women and those they care about.*

**APPLICATION FOR  
Medicare Supplement Insurance  
and Membership**

# ROYAL NEIGHBORS OF AMERICA

Home Office: Rock Island, Illinois

Mail Application To: Administrative Office: Medicare Supplement Administration, [P.O. Box 10851, Clearwater, FL 33757-8851]

## APPLICATION FOR MEDICARE SUPPLEMENT INSURANCE

**APPLICATION #:**

*(Exactly as shown on your Medicare ID Card)*

Last Name First Name MI

**RESIDENCE ADDRESS**

Street:

City:

State:

Zip Code:

EMAIL Address: \_\_\_\_\_

**Indicate the Medicare Supplement Plan applied for:**

Plan \_\_\_\_\_

AGE	DATE OF BIRTH			SEX
	<i>Month</i>	<i>Day</i>	<i>Year</i>	<input type="checkbox"/> Male
				<input type="checkbox"/> Female

AREA CODE	TELEPHONE NUMBER

**SOCIAL SECURITY NUMBER**

\_\_\_\_\_

**MEDICARE INFORMATION**

Medicare Part A Effective Date: \_\_\_\_\_

Medicare Part B Effective Date: \_\_\_\_\_

Medicare Claim Number: \_\_\_\_\_

**Requested Effective Date:** \_\_\_\_\_ **Special Requests:** \_\_\_\_\_

**Mailing Preference:**  Mail to Agent  Mail to Applicant If unanswered, the certificate will be mailed to Agent.

**Are you a member of Royal Neighbors of America?**  Yes  No

**Camp/Chapter Number:** \_\_\_\_\_ **Camp/Chapter Location (City & State)** \_\_\_\_\_

**PLEASE SELECT THE METHOD OF PAYMENT YOU WANT**

Bank Draft  Annual  Semiannual  Quarterly  Monthly Bank Draft

**\*Draft Preference:**  Draft on Effective Date  Draft on Issue If unanswered, will draft on issue.

**UNDERWRITING RISK CLASSIFICATION QUESTION**

**Have you used any form of tobacco in the past five years?**  Yes  No  
*(If answer is "No", you are eligible for preferred rates, if "Yes", standard rates apply.)*

**Do you take prescription drugs?**  Yes  No

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

**PREMIUM CALCULATION:**

**PREMIUM:** \$ \_\_\_\_\_

**INITIAL PAYMENT:** \$ \_\_\_\_\_

### PART I – HEALTH QUESTIONS

**YOU ARE NOT REQUIRED TO ANSWER HEALTH QUESTIONS 1-10 IF YOU ARE IN AN OPEN ENROLLMENT OR A GUARANTEED ISSUE PERIOD. PLEASE SEE PAGE 5 FOR AN EXPLANATION OF OPEN ENROLLMENT/GUARANTEED ISSUE PERIOD INFORMATION.**

**IF YOU ANSWER "YES" TO ANY OF THE HEALTH QUESTIONS 1-10, YOU ARE NOT ELIGIBLE FOR COVERAGE.**

1. Are you bedridden or confined to a wheelchair?  Yes  No
2. Are you currently hospitalized or confined to a nursing facility; or have you been hospitalized two or more times within the past year?  Yes  No
3. Within the past two years, have you been advised to have kidney dialysis?  Yes  No
4. Within the past two years have you had coronary or carotid artery disease (not including high blood pressure), a heart attack, atrial fibrillation, congestive heart failure, stroke, Transient Ischemic Attack (TIA), heart valve surgery or peripheral vascular disease or been treated with a heart defibrillating device or pacemaker?  Yes  No
5. Within the past two years, have you had or been treated for internal cancer, leukemia or malignant melanoma, Hodgkin's Disease, disabling arthritis, degenerative disc disease, cirrhosis of the liver, or alcohol or drug abuse?  Yes  No
6. Within the past two years, have you been advised to have surgery for cataracts, joint replacement, a heart condition or other surgery but not had such surgery?  Yes  No

**PART I – HEALTH QUESTIONS CONTINUED**

7. Have you had or been told by your physician you have Parkinson’s disease, osteoporosis with fractures, Paget’s disease of the bone, spinal stenosis, Alzheimer’s disease, Organic Brain Syndrome, senile dementia or other senility disorders, emphysema, chronic bronchitis, Chronic Obstructive Pulmonary Disease (COPD), other chronic lung disease, Myasthenia Gravis, Lupus, Multiple or Amyotrophic Lateral Sclerosis, paralysis; Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC), or Human Immunodeficiency Virus (HIV) infection?  Yes  No
8. Have you had or been told by your physician you needed an organ transplant or amputation due to disease?  Yes  No
9. Have you been advised by a physician to have medical tests, treatment or therapy that has not been performed?  Yes  No
10. Are you an insulin dependent diabetic?  Yes  No

**PART II – MEDICAL COVERAGE REPLACEMENT (MUST BE COMPLETED)**

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

To the best of your knowledge:

1. (a) Did you turn 65 in the last 6 months?  Yes  No  
 (b) Did you enroll in Medicare Part B in the last 6 months?  Yes  No  
 (c) If yes, what is the effective date? \_\_\_\_\_
2. Are you covered for medical assistance through the state Medicaid program? NOTE TO APPLICANT: If you are participating in a “Spend-Down Program” and have not met your “Share of Cost” please answer NO to this question.  Yes  No  
 IF YES, (a) Will Medicaid pay your premiums for this Medicare supplement certificate?  Yes  No  
 (b) Did you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?  Yes  No
3. (a) If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates. If you are still covered under this plan, leave “END” blank.  START  END  
 \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_      \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
 If yes, with what company \_\_\_\_\_  
 Company telephone number \_\_\_\_\_ Certificate/Policy number \_\_\_\_\_
- (b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement certificate?  Yes  No
- (c) Was this your first time in this type of plan (for example, a Medicare Advantage plan or a Medicare HMO or PPO)?  Yes  No
- (d) Did you drop a Medicare supplement certificate/policy to enroll in the Medicare plan?  Yes  No
4. (a) Do you have another Medicare supplement certificate/policy in force?  Yes  No  
 (b) If so, with which company: \_\_\_\_\_  
 with which plan: \_\_\_\_\_  
 and what paid-to-date do you have? \_\_\_\_\_
- (c) If yes, do you intend to replace your current Medicare supplement certificate/policy with this certificate?  Yes  No
5. Have you had coverage under any other health insurance within the past 63 days (for example, an employer, union, or individual plan)?  Yes  No
- (a) If yes, with what company and what kind of certificate/ policy? \_\_\_\_\_  
 \_\_\_\_\_  
 Company telephone number \_\_\_\_\_ Certificate/Policy number \_\_\_\_\_
- (b) What are the dates of coverage under the other certificate/policy? (If you are still covered under the other certificate/policy, leave “END” blank.)  START  END  
 \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_      \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_

**IMPORTANT STATEMENTS TO BE READ AND SIGNED BY THE APPLICANT**

- (1) You do not need more than one Medicare Supplement Insurance Certificate/Policy.
- (2) If you purchase this certificate, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
- (3) You may be eligible for benefits under Medicaid and may not need a Medicare Supplement Insurance Certificate/Policy.
- (4) If, after purchasing this certificate, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement Insurance Certificate can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement certificate (or, if that is no longer available, a substantially equivalent certificate) will be reinstated, if requested, within 90 days of losing Medicaid eligibility. If the Medicare supplement certificate/policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your certificate/policy was suspended, the reinstated certificate/policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension
- (5) If you are eligible for, and have enrolled in a Medicare supplement certificate by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement certificate can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement certificate/policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement certificate/policy (or, if that is no longer available a substantially equivalent certificate) will be reinstated if requested within 90 days of losing your employer or union based group health plan. If the Medicare supplement certificate/policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.
- (6) Counseling services may be available in your state to provide advice concerning your purchase of a Medicare Supplement Insurance Certificate and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

To the best of my knowledge and belief, all answers to the questions contained in this application are true and complete. I understand that any change in my health prior to delivery of this certificate may be used in the underwriting evaluation. I have received an outline of coverage for the certificate applied for and a *Guide To Health Insurance for People With Medicare*.

Pre-existing conditions are covered immediately upon effective date under a Royal Neighbors of America Medicare Supplement Certificate. You are not required to satisfy any waiting period.

**If not a current member of Royal Neighbors of America, I apply to become a member as indicated by my signature below. As a member of RNA I will uphold the principles of Faith, Courage, Modesty, Unselfishness, and Endurance on which RNA was founded more than 100 years ago.**

**ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.**

Signed At: \_\_\_\_\_  
(City /State)

Applicant's Signature \_\_\_\_\_

Dated: \_\_\_\_\_  
(Month/Day/Year)

## OPEN ENROLLMENT/GUARANTEED ISSUE PERIOD INFORMATION

**Open Enrollment:** You are eligible for Open Enrollment and will not need to answer Health Questions 1-10 on Pages 2 and 3 of this application if (a) you are within six months of age 65 and purchasing Medicare Part B coverage for the first time; or (b) you were eligible for early Medicare and you are now within six months of turning age 65.

**Guaranteed Issue For Eligible Persons Under the Balanced Budget Act of 1997:**

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

- (a) Enrolled under an employee welfare benefit plan that: (1) provides health benefits that supplement the benefits under Medicare and the plan terminates or the plan ceases to provide some or all such supplemental benefits to the individual; or (2) the individual is enrolled under an employee welfare benefit plan that is primary to Medicare and the plan terminates or the plan ceases to provide some or all health benefits to the individual; or (3) the individual leaves the plan whether the plan is primary or secondary with Medicare; or Enrolled in a Medicare Advantage plan or Program of All-Inclusive Care for the Elderly (PACE) and the organization's certification or plan is terminated or specific circumstances permit discontinuance including, but not limited to, a change in residence of the individual, the plan is terminated within a residence area, the organization substantially violated a material policy provision, or a material misrepresentation was made to the individual; or
- (b) Enrolled in a Medicare risk contract, health care prepayment plan, cost contract or Medicare Select plan, or similar organization, and the organization's certification or plan is terminated or specific circumstances permit discontinuance including, but not limited to, a change in residence of the individual, the plan is terminated within a residence area, the organization substantially violated a material certificate/policy provision, or a material misrepresentation was made to the individual; or
- (c) Enrolled in a Medicare Supplement certificate/policy and coverage discontinues due to insolvency, substantial violation of a material certificate/policy provision, or material misrepresentation; or
- (d) Enrolled under a Medicare Supplement certificate/policy, terminates and enrolls for the first time in a Medicare Advantage, a risk or cost contract, or a Medicare Select plan, a PACE provider, and then the insured person terminates coverage within 12 months of enrollment; or
- (e) Upon *first* becoming eligible for benefits under Part A and enrolled in Part B, if eligible, you enrolled in a Medicare Advantage or PACE provider and then disenrolled within 12 months.

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

## AUTHORIZATION MUST BE COMPLETED AND SIGNED

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager or other medical facility, insurance or reinsurance company, Medicare, Medical Information Bureau (MIB), consumer reporting agency, Division of Motor Vehicles, or the Veterans Administration having information as to diagnosis, treatment or prognosis with respect to the physical or mental condition concerning me to release and disclose the entire medical record and any other protected health information concerning me within the past ten (10) years, without restrictions, to **Royal Neighbors of America (RNA)**, its agents, employees, representatives or its reinsurers. This includes information on the treatment of alcohol, drug and tobacco abuse, and psychiatric diagnosis and treatment. In order to facilitate the rapid transmission of such information, I authorize all the sources named above, except MIB, Inc., to give such information to any legal representative or agent employed by **RNA**. Medical information will not be used to decline coverage if you are in Open Enrollment or Guaranteed Issue Period.

I understand that the protected information is to be disclosed under this authorization so that **RNA** may underwrite my application for Medicare Supplement insurance, determine eligibility for insurance, risk rating or certificate (policy) issuance determinations; obtain reinsurance; administer claims and determine or fulfill responsibility for coverage and provision of benefits; administer coverage; and conduct other legally permissible activities that relate to any coverage I have, or have applied for, with **RNA**. Any protected information obtained will not be released by **RNA**, or its reinsurers, to any person or organization **EXCEPT** to reinsuring companies, MIB, Inc., other life/health insurance organizations or fraternal benefit societies with which I have insurance contracts or to whom I may apply for insurance or to whom a claim for benefits may be submitted in connection with my application, insurance certificate or claim for benefit, or as may be otherwise lawfully required or as I may further authorize.

I understand that this authorization shall remain in force for **thirty (30) months** from the date shown below if used in connection with an application for an insurance certificate, an application for reinstatement of an insurance certificate, or a request for change in certificate benefits.

I understand and agree that a copy of this authorization is as valid as the original and that I or my authorized representative will receive a copy of this authorization with my certificate. I understand and agree that this authorization may be revoked by me at anytime in writing, by sending a written notice of revocation to **RNA**, Medicare Supplement Administration, [P. O. Box 10851, Clearwater, Florida 33757-8851.] I agree that **RNA** shall be fully protected if it acts in reliance on this authorization prior to receiving notice of revocation or to the extent that **RNA** has a legal right to contest a claim under an insurance contract. Any information that is disclosed pursuant to this authorization may be redisclosed as provided herein or as required or authorized by law and may then no longer be covered by federal rules governing privacy and confidentiality of health information.

I understand that if I refuse to sign this authorization to release the complete medical records and protected health information or have any restriction on the release of the protected health information of me, **RNA** will not be able to process the application, or if coverage has been issued, may not be able to make any benefit payments.

Printed Name of Applicant \_\_\_\_\_

Signature of Applicant \_\_\_\_\_

Signed this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

## AGENT'S CERTIFICATION

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

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

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

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

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I certify that:

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

Agent's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Agent's Printed Name: \_\_\_\_\_

Agent No.: \_\_\_\_\_

(Attach Voided Check)

## AUTHORITY TO HONOR PREMIUM CHECKS

<b>AUTHORIZATION</b>	<b>IN FAVOR OF:</b> <u>Royal Neighbors of America</u>		<b>AUTHORIZATION</b>
	<b>Administrative office</b> <u>[P.O. Box 10851, Clearwater, FL 33757-8851]</u>		
	<b>Name of Bank Customer:</b> _____	<b>Certificate Numbers</b>	
	<b>Insured's Name:</b> _____		
	<b>Account Number :</b> _____	<b>Routing Number:</b> _____	
	<b>To (Name of Bank):</b> _____		
	<b>Address of Bank:</b> _____		
<p>You are hereby authorized, as a convenience to me, to honor and charge my account for checks, drafts and other orders, including without limitation any order initiated by electronic means, drawn by The Society indicated above, (hereinafter referred to as THE SOCIETY), on my account by and payable to the order of The Society for the payment of premiums provided there are sufficient collected funds in such account to pay the same upon presentation. I agree that your rights in respect to each such check or other order drawn by The Society shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice I agree that you shall be fully protected in honoring any such check or other orders drawn by The Society. I further agree that if any such checks or other orders drawn by The Society be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in forfeiture of insurance.</p>			
<b>Date</b>	<b>Signature of Depositor</b>		
<b>Signature must be the same as on the signature card at bank, and if a company account the name of the account must be shown.</b>			
<b>To:    The Bank above</b>			
<p>In consideration of your compliance with the individual authorization of your depositors to pay checks, drafts or orders, drawn and signed by us to our order, we agree:</p> <ul style="list-style-type: none"> <li>➤ To indemnify you and hold you harmless from any loss you may suffer as a consequence of your actions resulting from or in connection with the execution and issuance of any check, draft or order, whether or not genuine, purporting to be executed and received by you in the regular course of business for the purpose of payment of such insurance premiums including any costs or expenses reasonably incurred in connection therewith.</li> <li>➤ In the event that any such check, draft or order shall be dishonored, whether with or without cause, and whether intentionally or inadvertently, to indemnify you for such loss even though dishonor results in forfeiture of the insurance.</li> <li>➤ To defend at our own cost and expense any action which might be brought by any depositor or any other persons because of your actions taken pursuant to said authorization and direction or in any manner arising by reason of your participation in this plan of premium collection.</li> </ul>			



INSURING LIVES • SUPPORTING WOMEN • SERVING COMMUNITIES™

Home Office: Rock Island, Illinois

Mail Reinstatement Application To: Medicare Supplement Administration, [P.O. Box 10851, Clearwater, FL 33757-8851]

## Reinstatement Application For Medicare Supplement Insurance

Certificate Number: \_\_\_\_\_

(Exactly as shown on your Medicare ID Card)

Applicant's Name: \_\_\_\_\_

Last Name

First Name

Middle Initial

Address: \_\_\_\_\_

Street

City

State

Zip Code

Telephone Home Number: (\_\_\_\_\_) \_\_\_\_\_  
Area Code

Social Security Number: \_\_\_\_\_

### Underwriting Risk Classification Questions

Have you used any form of tobacco in the past five years?  Yes  No

Do you take prescription drugs?  Yes  No

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

### Health Questions – Must be Answered

1. Are you bedridden or confined to a wheelchair?  Yes  No
2. Are you currently hospitalized or confined to a nursing facility; or have you been hospitalized two or more times within the past year?  Yes  No
3. Within the past two years, have you been advised to have kidney dialysis?  Yes  No
4. Within the past two years have you had coronary or carotid artery disease (not including high blood pressure), a heart attack, atrial fibrillation, congestive heart failure, stroke, Transient Ischemic Attack (TIA), heart valve surgery or peripheral vascular disease or been treated with a heart defibrillating device or pacemaker?  Yes  No
5. Within the past two years, have you had or been treated for internal cancer, leukemia or malignant melanoma, Hodgkin's Disease, disabling arthritis, degenerative disc disease, cirrhosis of the liver, or alcohol or drug abuse?  Yes  No
6. Within the past two years, have you been advised to have surgery for cataracts, joint replacement, a heart condition or other surgery but not had such surgery?  Yes  No
7. Have you had or been told by your physician you have Parkinson's disease, osteoporosis with fractures, Paget's disease of the bone, spinal stenosis, Alzheimer's disease, Organic Brain Syndrome, senile dementia or other senility disorders, emphysema, chronic bronchitis, Chronic Obstructive Pulmonary Disease (COPD), other chronic lung disease, Myasthenia Gravis, Lupus, Multiple or Amyotrophic Lateral Sclerosis, paralysis; Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or Human Immunodeficiency Virus (HIV) infection?  Yes  No
8. Have you had or been told by your physician you needed an organ transplant or amputation due to disease?  Yes  No
9. Have you been advised by a physician to have medical tests, treatment or therapy that has not been performed?  Yes  No
10. Are you an insulin dependent diabetic?  Yes  No

**Authorization  
Must Be Completed And Signed**

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager or other medical facility, insurance or reinsurance company, Medicare, Medical Information Bureau (MIB), consumer reporting agency, Division of Motor Vehicles, or the Veterans Administration having information as to diagnosis, treatment or prognosis with respect to the physical or mental condition concerning me to release and disclose the entire medical record and any other protected health information concerning me within the past ten (10) years, without restrictions, to **Royal Neighbors of America (RNA)**, its agents, employees, representatives or its reinsurers. This includes information on the treatment of alcohol, drug and tobacco abuse, and psychiatric diagnosis and treatment. In order to facilitate the rapid transmission of such information, I authorize all the sources named above, except MIB, Inc., to give such information to any legal representative or agent employed by **RNA**.

I understand that the protected information is to be disclosed under this authorization so that **RNA** may underwrite my application for Medicare Supplement insurance, determine eligibility for insurance, risk rating or certificate (policy) issuance determinations; obtain reinsurance and conduct other legally permissible activities that relate to any coverage I have, or have applied for, with **RNA**. Any protected information obtained will not be released by **RNA**, or its reinsurers, to any person or organization **EXCEPT** to reinsuring companies, MIB, Inc., other life/health insurance organizations or fraternal benefit societies with which I have insurance contracts or to whom I may apply for insurance or to whom a claim for benefits may be submitted in connection with my application, insurance certificate or claim for benefit, or as may be otherwise lawfully required or as I may further authorize.

I understand that this authorization shall remain in force for **thirty (30) months** from the date shown below if used in connection with an application for an insurance certificate, an application for reinstatement of an insurance certificate, or a request for change in certificate benefits if used for the purpose of collecting information in connection with a claim for benefits under a certificate.

I understand and agree that a copy of this authorization is as valid as the original and that I, or my authorized representative, is entitled to receive a copy of this authorization. I understand and agree that this authorization may be revoked by me at anytime in writing, by sending a written notice of revocation to **RNA**, Medicare Supplement Administration, [P. O. Box 10851, Clearwater, Florida 33757-8851.] I agree that **RNA** shall be fully protected if it acts in reliance on this authorization prior to receiving notice of revocation or to the extent that **RNA** has a legal right to contest a claim under an insurance contract. Any information that is disclosed pursuant to this authorization may be redisclosed as provided herein or as required or authorized by law and may then no longer be covered by federal rules governing privacy and confidentiality of health information.

**Check here if a copy of this authorization is desired.**

I understand that if I refuse to sign this authorization to release the complete medical records and protected health or have any restriction on the release of the protected health information of me, **RNA** will not be able to process the application, or if coverage has been issued may not be able to make any benefit payments.

To the best of my knowledge and belief, all answers to the questions contained in this application are true and complete. If this certificate is reinstated, such reinstatement shall be in accordance with the terms of the certificate and shall not take effect until this reinstatement application is approved and the premium payment accompanying this application have been accepted and approved by Royal Neighbors of America.

**Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.**

\_\_\_\_\_  
Printed Name of Applicant

\_\_\_\_\_  
Signature of Applicant

Signed this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.



**Royal Neighbors of America**  
**Outline of Medicare Supplement Coverage**  
**Benefit Plans A, B, C, D, F and G**

**Benefit Chart of Medicare Supplement Plans Sold for Effective Dates on or After June 1, 2010**

These charts show the benefits included in each of the standard Medicare supplement plans. Every company must make available Plan “A”. Some plans may not be available in your state. [Plans E, H, I and J are no longer available for sale.]

**Basic Benefits:**

- **Hospitalization-** Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
- **Medical Expenses-** Part B coinsurance (generally 20% of Medicare-approved expenses) or copayments for hospital outpatient services. Plans K, L and N require insureds to pay a portion of Part B coinsurance or copayments.
- **Blood-** First three pints of blood each year.
- **Hospice -** Part A coinsurance

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

\*Plan F also has an option called a high deductible Plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year \$[2000] deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses are \$[2000]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the Policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan’s separate foreign travel emergency deductible.

Effective [June 1, 2010]

ROYAL NEIGHBORS OF AMERICA  
ANNUAL PREMIUM RATES

[ ]  
RATES

Semi-Annual  
0.5000

Quarterly  
0.2500

Monthly  
0.0833

## **PREMIUM INFORMATION**

Royal Neighbors of America may change your premium on any premium due date if a new table of rates is applicable to the certificate. The change in the table of rates will apply to all covered persons in the same class. Class is defined as underwriting class, state, plan and zip code of residence.

Premiums will change on Your Certificate Anniversary Date.

## **DISCLOSURES**

Use this outline to compare benefits and premiums among policies.

**[This outline shows benefits and premiums of certificates sold for effective dates on or after June 1, 2010. Certificates sold for effective dates prior to June 1, 2010 have different benefits and premiums. Plans E, H, I, and J are no longer available for sale. ]**

## **READ YOUR CERTIFICATE VERY CAREFULLY**

This is only an outline describing your certificate's most important features. The certificate is your insurance contract. You must read the certificate itself to understand all of the rights and duties of both you and Royal Neighbors of America.

## **RIGHT TO RETURN CERTIFICATE**

If you find that you are not satisfied with your certificate, you may return it to: Royal Neighbors of America, Medicare Supplement Administration, [P.O. Box 10851, Clearwater, Florida 33757-8851]. If you send the certificate back to us within 30 days after you receive it, we will treat the certificate as if it had never been issued and return all of your payments.

## **POLICY OR CERTIFICATE REPLACEMENT**

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

## **NOTICE**

This certificate may not fully cover all of your medical costs. Neither Royal Neighbors 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 *Medicare and You* for more details.

## **COMPLETE ANSWERS ARE VERY IMPORTANT**

When you fill out the application for the new certificate, be sure to answer truthfully and completely all questions about your medical and health history. Royal Neighbors of America may cancel your certificate and refuse to pay any claims if you leave out or falsify important medical information.

**Review the application carefully before you sign it. Be certain that all information has been properly recorded.**

**Please refer to your certificate for details.**

**PLAN A**

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days  61 <sup>st</sup> thru 90 <sup>th</sup> day 91 <sup>st</sup> day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days  — Beyond the additional 365 days	All but \$[1100]  All but \$[275] a day  All but \$[550] a day  \$0  \$0	\$0  \$[275] a day  \$[550] a day  100% of Medicare eligible expenses \$0	\$[1100] (Part A deductible) \$0  \$0  \$0**  All costs
<b>SKILLED NURSING FACILITY CARE*</b> 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 21 <sup>st</sup> thru 100 <sup>th</sup> day 101 <sup>st</sup> day and after	All approved amounts All but \$[137.50] a day \$0	\$0 \$0 \$0	\$0 Up to \$[137.50] a day All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> You must meet Medicare’s requirements, including a doctor’s certification of terminal illness.	All but very limited co-payment/ coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/coinsurance	\$0

**\*\*NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to 365 days as provided in the policy’s “Core Benefits.” During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

**PLAN A**

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

\*Once you have been billed \$[155] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>MEDICAL EXPENSES –</b> IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$[155] of Medicare Approved Amounts*	\$0	\$0	\$[155] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
<b>PART B EXCESS CHARGES</b> (Above Medicare Approved Amounts)	\$0	\$0	All costs
<b>BLOOD</b> First 3 pints	\$0	All costs	\$0
Next \$[155] of Medicare Approved Amounts*	\$0	\$0	\$[155] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
<b>CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

**PARTS A & B**

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

**PLAN B**

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

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

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 <sup>st</sup> thru 90 <sup>th</sup> day 91 <sup>st</sup> day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the additional 365 days	All but \$[1068] All but \$[267] a day  All but \$[534] a day  \$0  \$0	\$[1068] (Part A deductible) \$[267] a day  \$[534] a day  100% of Medicare eligible expenses  \$0	\$0 \$0  \$0  \$0**  All costs
<b>SKILLED NURSING FACILITY CARE*</b> 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 21 <sup>st</sup> thru 100 <sup>th</sup> day 101 <sup>st</sup> day and after	All approved amounts All but \$[133.50] a day \$0	\$0 \$0 \$0	\$0 Up to \$[133.50] a day All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/ coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/coinsurance	\$0

\*\***NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

**PLAN B**

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

\*Once you have been billed \$[135] 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
<b>MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , such as Physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$[135] of Medicare Approved Amounts*	\$0	\$0	\$[135] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
<b>PART B EXCESS CHARGES</b> (Above Medicare Approved Amounts)	\$0	\$0	All costs
<b>BLOOD</b> First 3 pints	\$0	All costs	\$0
Next \$[135] of Medicare Approved Amounts*	\$0	\$0	\$[135] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
<b>CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

**PARTS A & B**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE MEDICARE APPROVED SERVICES</b> — Medically necessary skilled care services and medical supplies	100%	\$0	\$0
— Durable medical equipment First \$[135] of Medicare Approved Amounts*	\$0	\$0	\$[135] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

**PLAN C**

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

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

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 <sup>st</sup> thru 90 <sup>th</sup> day 91 <sup>st</sup> day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the additional 365 days	All but \$[1068] All but \$[267] a day  All but \$[534] a day  \$0  \$0	\$[1068] (Part A deductible) \$[267] a day  \$[534] a day  100% of Medicare eligible expenses  \$0	\$0 \$0  \$0  \$0**  All costs
<b>SKILLED NURSING FACILITY                      CARE*</b> 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 21 <sup>st</sup> thru 100 <sup>th</sup> day 101 <sup>st</sup> day and after	All approved amounts All but \$[133.50] a day \$0	\$0 Up to \$[133.50] a day \$0	\$0 \$0 All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> You must meet Medicare’s requirements, including a doctor’s certification of terminal illness.	All but very limited co- payment/ coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/coinsurance	\$0

**\*\*NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to 365 days as provided in the policy’s “Core Benefits.” During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

**PLAN C**

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

\*Once you have been billed \$[135] 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
<b>MEDICAL EXPENSES –</b> 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 \$[135] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 Generally 80%	\$[135] (Part B deductible) Generally 20%	\$0 \$0
<b>PART B EXCESS CHARGES</b> (Above Medicare Approved Amounts)	\$0	\$0	All costs
<b>BLOOD</b> First 3 pints Next \$[135] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All costs \$[135] (Part B deductible) 20%	\$0 \$0 \$0
<b>CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

**PARTS A & B**

<b>HOME HEALTH CARE</b> MEDICARE APPROVED SERVICES — Medically necessary skilled care services and medical supplies — Durable medical equipment First \$[135] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% \$0 80%	\$0 \$[135] (Part B deductible) 20%	\$0 \$0 \$0
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**OTHER BENEFITS – NOT COVERED BY MEDICARE**

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

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

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

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 <sup>st</sup> thru 90 <sup>th</sup> day 91 <sup>st</sup> day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the additional 365 days	All but \$[1068] All but \$[267] a day  All but \$[534] a day  \$0 \$0	\$[1068] (Part A deductible) \$[267] a day  \$[534] a day  100% of Medicare eligible expenses \$0	\$0 \$0  \$0 \$0**  All costs
<b>SKILLED NURSING FACILITY CARE*</b> 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 21 <sup>st</sup> thru 100 <sup>th</sup> day 101 <sup>st</sup> day and after	All approved amounts All but \$[133.50] a day \$0	\$0 Up to \$[133.50] a day \$0	\$0 \$0 All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> You must meet Medicare’s requirements, including a doctor’s certification of terminal illness.	All but very limited co-payment/ coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/coinsurance	\$0

\*\*NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to 365 days as provided in the policy’s “Core Benefits.” During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

**PLAN D**

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

\*Once you have been billed \$[135] 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.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>MEDICAL EXPENSES –</b> 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 \$[135] of Medicare Approved Amounts*	\$0	\$0	\$[135] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
<b>PART B EXCESS CHARGES</b> (Above Medicare Approved Amounts)	\$0	\$0	All costs
<b>BLOOD</b> First 3 pints	\$0	All costs	\$0
Next \$[135] of Medicare Approved Amounts*	\$0	\$0	\$[135] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
<b>CLINICAL LABORATORY                      SERVICES – TESTS FOR                      DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

(continued)

**PLAN D**  
**PARTS A & B**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE</b> MEDICARE APPROVED SERVICES			
— Medically necessary skilled care services and medical supplies	100%	\$0	\$0
— Durable medical equipment First \$[135] of Medicare Approved Amounts*	\$0	\$0	\$[135] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

**OTHER BENEFITS – NOT COVERED BY MEDICARE**

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

**PLAN F**

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

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

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 <sup>st</sup> thru 90 <sup>th</sup> day 91 <sup>st</sup> day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the additional 365 days	All but \$[1100] All but \$[275] a day  All but \$[550] a day  \$0  \$0	\$[1100] (Part A deductible) \$[275] a day  \$[550] a day  100% of Medicare eligible expenses  \$0	\$0 \$0  \$0  \$0**  All costs
<b>SKILLED NURSING FACILITY CARE*</b> 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 21 <sup>st</sup> thru 100 <sup>th</sup> day 101 <sup>st</sup> day and after	All approved amounts All but \$[137.50] a day \$0	\$0 Up to \$[137.50] a day \$0	\$0 \$0 All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> You must meet Medicare’s requirements, including a doctor’s certification of terminal illness.	All but very limited co-payment/ coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/coinsurance	\$0

(continued)

\*\***NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to 365 days as provided in the policy’s “Core Benefits.” During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

**PLAN F**

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

\*Once you have been billed \$[155] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>MEDICAL EXPENSES –</b> IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$[155] of Medicare Approved Amounts*	\$0	\$[155] (Part B deductible)	\$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
<b>PART B EXCESS CHARGES</b> (Above Medicare Approved Amounts)	\$0	100%	\$0
<b>BLOOD</b> First 3 pints	\$0	All costs	\$0
Next \$[155] of Medicare Approved amounts*	\$0	\$[155] (Part B deductible)	\$0
Remainder of Medicare Approved amounts	80%	20%	\$0
<b>CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

(continued)

**PLAN F**  
**PARTS A & B**

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

**OTHER SERVICES – NOT COVERED BY MEDICARE**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</b>			
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.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 <sup>st</sup> thru 90 <sup>th</sup> day 91 <sup>st</sup> day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the additional 365 days	All but \$[1100] All but \$[275] a day  All but \$[550] a day  \$0  \$0	\$[1100] (Part A deductible) \$[275] a day  \$[550] a day  100% of Medicare eligible expenses  \$0	\$0 \$0  \$0  \$0**  All costs
<b>SKILLED NURSING FACILITY CARE*</b> 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 21 <sup>st</sup> thru 100 <sup>th</sup> day 101 <sup>st</sup> day and after	All approved amounts All but \$[137.50] a day \$0	\$0 Up to \$[137.50] a day \$0	\$0 \$0 All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> You must meet Medicare’s requirements, including a doctor’s certification of terminal illness.	All but very limited co-payment/ coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/coinsurance	\$0

\*\***NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to 365 days as provided in the policy’s “Core Benefits.” During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

**PLAN G**

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

\*Once you have been billed \$[155] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>MEDICAL EXPENSES –</b> IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$[155] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0  Generally 80%	\$0  Generally 20%	\$[155] (Part B deductible)  \$0
<b>PART B EXCESS CHARGES</b> (Above Medicare Approved Amounts)	\$0	100%	\$0
<b>BLOOD</b> First 3 pints Next \$[155] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$[155] (Part B deductible) \$0
<b>CLINICAL LABORATORY</b> <b>SERVICES – TESTS FOR</b> <b>DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

(continued)

**PLAN G  
PARTS A & B**

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

**OTHER BENEFITS – NOT COVERED BY MEDICARE**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</b>			
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



INSURING LIVES • SUPPORTING WOMEN • SERVING COMMUNITIES<sup>SM</sup>

**MEDICARE SUPPLEMENT INSURANCE CERTIFICATE - PLAN B**  
**READ YOUR CERTIFICATE CAREFULLY**

**This Certificate is a legal contract between the Owner of the Certificate and Royal Neighbors of America (the Society).**

This Certificate provides benefits to supplement hospital and medical coverage of Medicare. Only persons eligible for Medicare may apply for this Certificate. In this Certificate, “You” and “Your” means the Insured named on the application and shown on the Certificate Schedule. “We”, “Our” and “Us” means Royal Neighbors of America.

**NOTICE TO BUYER. THIS CERTIFICATE MAY NOT COVER ALL OF YOUR MEDICAL EXPENSES.**

**IMPORTANT NOTICE:** Issuance of this Medicare Supplement Insurance Certificate is based on Your answers to the questions on Your application. A copy of the application is attached. Omissions or misstatements on the application could cause Your claim to be denied or Your Certificate to be rescinded. If, for any reason, Your answers are incorrect, contact Us immediately at Medicare Supplement Administration, [P.O. Box 10851, Clearwater Florida 33757-8851, Telephone Number 877-815-8877.]

**CERTIFICATE EFFECTIVE DATE AND CONSIDERATION**

We have issued this Certificate in consideration of the payment of premium and the statements made on the application. The application is attached to and made a part of this Certificate. The term of this Certificate begins at, 12:01 a.m. Standard Time, at the place where You reside on the Certificate Effective Date shown on the Certificate Schedule. It ends at 11:59 p.m., at the place where You reside, on the day before Your premium is due. The date Your premium is due is determined by the mode of payment. The mode of payment for the original term of the Certificate is shown on the Certificate Schedule. An annual premium will maintain the Certificate in force for twelve (12) months, semi-annual for six (6) months, quarterly for three (3) months and monthly for one (1) month.

**THIRTY DAY RIGHT TO EXAMINE AND RETURN CERTIFICATE**

Please read Your Certificate carefully. If, for any reason, You are not satisfied, You may return Your Certificate to Us at Medicare Supplement Administration, [P.O. Box 10851, Clearwater Florida 33757-8851], within thirty (30) days after receiving it. If returned, the Certificate will be void from its beginning and any premium paid will be refunded. If payment of a claim is made under this Certificate during the thirty (30) day period, the amount will be deducted from the premium refund.

**GUARANTEED RENEWABLE FOR LIFE - PREMIUMS SUBJECT TO CHANGE**

This Certificate is renewable for as long as You live, provided You continue to pay premiums when due. At no time while You continue Your Certificate in force, may We place any restrictive riders on Your coverage. The premium may change on any premium due date if a new table of rates is applicable to the Certificate. The change in the table of rates will apply to all covered persons in the same class. Class is defined as underwriting class, state, plan and zip code of residence. You will be notified in advance before any change in the table of rates.

**THIS CERTIFICATE DOES NOT CONTAIN A PRE-EXISTING CONDITION LIMITATION**

**THIS IS A NON-PARTICIPATING CERTIFICATE**

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## **POLICYHOLDER INFORMATION**

For support and information regarding certificate terms, premium payments, claims processing and payment, contact us at:

Medicare Supplement Administration  
[P. O. Box 10851  
Clearwater, Florida 33757-8851  
1-877-815-8877]

For your information, the following is the name, address and telephone number of your agent:

[Mr. Fred Smith]  
[123 First Street  
Anywhere, USA 12345  
1-555-555-1234]

The Arkansas Insurance Department can be contacted at:

Arkansas Insurance Department  
Consumer Services  
1200 West Third Street  
Little Rock, Arkansas 72201-1904  
1-501-371-2640

Toll Free Consumer Information Telephone Number  
1-800-852-5494

**CERTIFICATE SCHEDULE**

**INSURED:**

**CERTIFICATE EFFECTIVE DATE:**

**CERTIFICATE NUMBER:**

**ISSUE AGE:**

**STATE OF ISSUE:**

**MODE AT ISSUE:**

**MODAL PREMIUM:**

**PREMIUM TERM:**

**UNDERWRITING CLASS:**

**CHAPTER:**

\*\*\*\*\*

**TYPE OF COVERAGE: MEDICARE SUPPLEMENT CERTIFICATE PLAN B**

## DEFINITIONS

**Benefit Period** means the period as determined by Medicare which begins on the date, You are first confined in a Hospital. It ends following a period of sixty (60) consecutive days during which You have not been confined in a Hospital or a Skilled Nursing Facility.

**Calendar Year** means the period of time beginning on January 1 and ending on December 31 of that same year.

**Certificate Effective Date** means the effective date of this Certificate and is shown on the Certificate Schedule. The Certificate Effective Date is not the date You signed the application for coverage.

**Coinsurance Amount** means the part of Medicare Eligible Expenses You have to pay. It does not include Part A or Part B deductible amounts.

**Hospital** means a hospital that is approved, or eligible to be approved to receive payments from Medicare and is accredited by the Joint Commission on Accreditation of Hospitals.

**Hospitalized or Hospitalization** means being confined in a Hospital on an inpatient basis.

**Immediate Family** means Your spouse, parents, grandparents, children, or siblings, as well as their spouses.

**Injury** means a bodily injury which is the direct result of an accident and independent of all other causes.

**Lifetime Inpatient Reserve Days** means a total of sixty (60) extra days in the Hospital provided to You by Medicare. These reserve days must be used if You are Hospitalized for more than ninety (90) days in a Benefit Period, unless previously used. When a lifetime reserve day is used, it is subtracted from the number of days You have left.

**Medicaid** means the Health Insurance for the Aged Act, Title XIX of the Social Security Amendment of 1965, as then constituted or later amended.

**Medically Necessary** means a service or supply that is recognized by Medicare as necessary to diagnose or treat an Injury or Sickness and is: (1) prescribed by a Physician; (2) consistent with the diagnosis and treatment of the Injury or Sickness; (3) in accordance with the generally accepted standards of medical practice; and (4) not solely for the convenience of You or the Physician.

**Medicare** means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendment of 1965, as then constituted or later amended.

**Medicare Eligible Expenses** means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and Medically Necessary by Medicare.

**Medicare Part A Initial Deductible** means the fixed amount Medicare does not pay during the first sixty (60) days of Hospital confinement in a Benefit Period. This amount is set each year by Medicare. Medicare does not pay this amount.

**Physician** means any practitioner of the healing arts acting within the scope of his/her license. It does not include You or any member of Your Immediate Family.

**Sickness** means illness or disease which first manifests itself after the Certificate Effective Date and while this Certificate is in force.

**Skilled Nursing Facility** means an institution licensed as such by the state in which it is located and is operating within the scope and intent of its license. It does not include a facility or any of its sections which is primarily a place for drug addicts, alcoholics or persons suffering from mental disease.

## **BENEFIT PROVISIONS**

We will pay only the following Medicare Eligible Expenses not paid by Medicare. Benefits are only paid to the extent specified in this provision.

**The benefits paid under this Certificate will not duplicate benefits paid by Medicare.**

### **Basic (Core) Benefits**

Coverage of Part A Medicare Eligible Expenses for Hospitalization to the extent not covered by Medicare from the sixty first (61<sup>st</sup>) day through the ninetieth (90<sup>th</sup>) day in any Medicare Benefit Period.

Coverage of Part A Medicare Eligible Expenses incurred for Hospitalization to the extent not covered by Medicare for each Medicare Lifetime Inpatient Reserve Day used.

Upon exhaustion of Medicare Hospital inpatient coverage, including the lifetime reserve days, coverage of 100% of the Medicare Part A eligible expenses for hospitalization paid at applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional three hundred sixty-five (365) days. The provider shall accept Our payment as payment in full and may not bill You for any balance.

Coverage under Medicare Parts A and B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations.

Coverage for the Coinsurance Amount, or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount, of Medicare Eligible Expenses under Part B regardless of Hospital confinement, subject to the Medicare Part B deductible.

Hospice Care: Coverage of cost sharing for all Part A Medicare Eligible Expenses for hospice care and respite care expenses.

### **Additional Benefits For Plan B**

**Medicare Part A Deductible:** Coverage for all of the Medicare Part A Initial Deductible amount per Benefit Period.

## **GUARANTEE REGARDING CHANGES IN MEDICARE BENEFITS**

We guarantee that the benefits and payment schedule of this Certificate will automatically change to reflect any changes which will become effective under Medicare. Only those provisions of the Certificate which are affected by the legislation are changed. Your coverage will automatically provide for such changes to whatever extent necessary. Premiums may be modified to correspond with such changes in accordance with the **GUARANTEE RENEWABLE FOR LIFE - PREMIUMS SUBJECT TO CHANGE** provision on page 1.

**MEDICAL ASSISTANCE UNDER MEDICAID  
AND SUSPENSION UNDER GROUP HEALTH PLAN**

Benefits and premiums under this Certificate are suspended at Your request for a period not to exceed twenty-four (24) months, in which You have applied for and are determined to be entitled to medical assistance under Title XIX of the Social Security Act. You must notify Us within ninety (90) days after the day You become entitled to such assistance.

If such a suspension occurs and You lose entitlement of such medical assistance, Your Certificate is automatically reinstated effective as of the date of termination of such entitlement if You provide notice of loss of such entitlement within ninety (90) days after the date of such loss and pay the premiums attributable to the period. Your reinstated Certificate is effective as of the date of termination of such entitlement.

Benefits and premiums under this Certificate shall be suspended for any period that may be provided by federal regulation at Your request if You are entitled to benefits under section 226(b) of the Social Security Act and are covered under a group health plan, as defined in section 1862(b)(1)(A)(v) of the Social Security Act. If suspension occurs and You lose coverage under the group health plan, Your Certificate shall be automatically reinstated, effective as of the date of loss of such coverage, if You provide notice of loss of coverage within ninety (90) days after the date of such loss and pay the premiums attributable to the period, effective as of the date of termination of such entitlement.

Reinstitution of Your coverage provides for:

1. Coverage equivalent to coverage in effect before the date of suspension;
2. Your classification of premium remains as favorable to You as the premium classification terms that would have applied to You had the coverage not been suspended; and
3. No waiting period with respect to treatment of preexisting conditions.

**TERMINATION OF CERTIFICATE AND EXTENSION OF BENEFITS**

Termination of the Certificate shall be without prejudice to a continuous loss which commenced while the Certificate was in force but the extension of benefits beyond the period during which the Certificate was in force may be continued upon Your continuous total disability, limited to the duration of the Certificate benefit period, if any, or payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

**EXCLUSIONS**

This Certificate does not pay expenses related to any coverage that is limited or excluded by Medicare related to services not "reasonable and Medically Necessary" under the Medicare Program Standards for diagnosis or treatment of Injury or Sickness.

## CLAIM PROVISIONS

**NOTICE OF CLAIMS:** We must receive written notice of claim within twenty (20) days after any covered loss occurs or begins. If notice cannot be given at that time, it must be given as soon as reasonably possible. Notice may be given to Us at Medicare Supplement Claims, [P.O. Box 10850, Clearwater, Florida 33757-8850.]

**CLAIM FORMS:** When We get the notice, We will send You forms for filing proof of loss. If We do not send the forms within fifteen (15) working days after receiving written notice, Our requirements will be met if We receive written proof of the event and type and extent of the loss within the time stated below.

**PROOF OF LOSS:** We must receive written proof of loss within ninety (90) days after the date the loss began or occurred. If it is not reasonably possible to give this timely proof, the claim will not be affected if it is sent as soon as is reasonable. However, unless the person making the claim is legally incapacitated, proof must be given within one (1) year from the time it is otherwise due.

**TIME OF PAYMENT OF CLAIMS:** All benefits payable under this Certificate will be payable immediately upon receipt of due written proof of such loss. For continuing losses, We will pay the benefits due monthly on receipt of due proofs of loss. All benefits due will be paid to You or to any health care provider to whom You have assigned benefits.

**PAYMENT OF CLAIMS:** Any accrued benefits unpaid at Your death will be paid to Your estate or to any health care providers to whom You have assigned benefits. Should We fail to pay the benefits payable upon receipt of due written proof of loss, We shall have fifteen (15) working days thereafter within which to mail You a letter or notice which states the reasons We have for failing to pay the claim, either in whole or in part, and which also gives You a written itemization of any documents or other information needed to process the claim or any portions thereof which are not being paid. When all of the listed documents or other information needed to process the claim have been received, We shall then have fifteen (15) working days within which to process and either pay the claim or deny it, in whole or in part, giving You the reasons We may have for denying such claim or any portion thereof.

We shall pay interest to You equal to twelve percent (12%) per annum on the proceeds or benefits due under the terms of this Policy for failure to comply with the requirements of this provision.

**PHYSICAL EXAMINATIONS:** At Our expense, We may have You examined as often as reasonably necessary while the claim is pending.

**TIME LIMIT ON CERTAIN DEFENSES:** After three (3) years from the date of issue of this Certificate no misstatements, except fraudulent misstatements, made by You in the application for the Certificate shall be used to void the Certificate or to deny a claim for loss incurred commencing after the expiration of the three (3) year period.

**LEGAL ACTION:** No action at law or in equity shall be brought to recover on this Certificate prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this Certificate. No such action shall be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

**ASSIGNMENT:** No assignment of any benefit or claim shall bind Us unless the same is filed in writing prior to the payment of any benefit claimed. We assume no responsibility for the validity of any assignment. Notice may be given to Us at Medicare Supplement Claims, [P.O. Box 10850, Clearwater, Florida 33757-8850.]

## GENERAL PROVISIONS

**OWNER OF CERTIFICATE:** You, the Insured shall be the Owner of this Certificate. You may exercise all options and rights under this Certificate.

**MAINTENANCE OF RESERVE:** If Our reserves become impaired, You shall pay Us this Certificate's equitable proportion of the deficiency. However, there shall be no personal liability for such payment except against this Certificate's reserve. The amounts of such payment and deficiency shall be determined by the Society's Board of Directors. If such payment is not made in cash, it shall stand as a debt against this Certificate. Such debt shall bear the lesser of 5% or the rate used to compute certificate reserves. In lieu of the foregoing, or in combination with it, You may consent to a corresponding decrease of the insurance benefits. Such decrease shall be in the same proportion as the amount of such payment bears to the reserve immediately before such decrease.

**SUSPENSION OR EXPULSION:** If You should be expelled or suspended from the membership in the Society for any reason, except for nonpayment of premium or within the contestable period for misrepresentation in Your application for membership, You shall have the privilege of maintaining this Certificate in force by continuing payment of the required premium.

**CONTRACT:** This Certificate is between You and Us. It includes articles of incorporation and the by-laws of the Society; this Certificate; the application, a copy of which is attached; and all present or future amendments to each. However, no future amendment to the articles of incorporation or the by-laws of the Society shall reduce benefits given to You as of the Certificate Effective Date.

**MODIFICATIONS:** No agent of this Society is allowed to make changes to this Certificate. Only authorized officers of the Society can waive any terms of or make any changes to this Certificate. All changes must be in writing.

**GRACE PERIOD:** A grace period of thirty-one (31) days will be granted for the payment of each premium falling due after the first premium, during which grace period, this Certificate shall continue in force.

**REINSTATEMENT:** If any renewal premium is not paid within the time granted by Us for payment, a subsequent acceptance of any premium by Us or by any of Our authorized agents, without requiring an application for reinstatement, shall reinstate the Certificate; provided, however that, if We or any of Our authorized agents require an application for reinstatement and issues a conditional receipt for the premium tendered, the Certificate will be reinstated upon approval of such application by Us or, lacking such approval, upon the forty-fifth (45th) day following the date of such conditional receipt unless We have previously notified You in writing of Our disapproval of such application. The reinstated Certificate shall cover only loss resulting from an Injury or Sickness as may begin on or after the date of reinstatement. In all other respects the Society and the Insured shall have the same rights under the Certificate as they had under the Certificate immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with reinstatement.

**UNPAID PREMIUM:** Upon the payment of a claim under this Certificate, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

**CONFORMITY WITH STATE LAWS:** Any provision of the Certificate which, on its Certificate Effective Date, is in conflict with the laws of the state in which You reside on such date is hereby amended to conform to the minimum requirements of such statutes.

**CLERICAL ERROR:** Clerical error on Our part will not invalidate insurance otherwise in force nor continue insurance otherwise terminated. Upon discovery of any error, an equitable adjustment will be made in the premiums. Complete proof must be supplied documenting any clerical errors.

**GENERAL PROVISIONS CONTINUED**

**MISSTATEMENT OF AGE:** If Your age has been misstated, all amounts payable under this Certificate shall be such as the premium paid would have purchased at the correct age.

**PRO RATA REFUND:** If We receive written proof of death which terminates coverage, We will refund that part of any premium You have paid which covers a period after death occurs.

**CANCELLATION BY INSURED:** You may cancel this Certificate at any time by written notice delivered or mailed to Us at Medicare Supplement Administration, [P.O. Box 10851, Clearwater, Florida 33757-8851], effective upon receipt or on such later date as may be specified in such notice. In the event of cancellation we will make a pro-rata refund of any premium paid beyond the date of cancellation. Cancellation will be without prejudice to any claim originating prior to the effective date of cancellation.

This Certificate is signed for the Society by its [Secretary] [and] [President].

[SIGNATURE]

**[Secretary and General Counsel]**

[SIGNATURE]

**[President-CEO]**



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**MEDICARE SUPPLEMENT INSURANCE CERTIFICATE - PLAN C**  
**READ YOUR CERTIFICATE CAREFULLY**

**This Certificate is a legal contract between the Owner of the Certificate and Royal Neighbors of America (the Society).**

This Certificate provides benefits to supplement hospital and medical coverage of Medicare. Only persons eligible for Medicare may apply for this Certificate. In this Certificate, “You” and “Your” means the Insured named on the application and shown on the Certificate Schedule. “We”, “Our” and “Us” means Royal Neighbors of America.

**NOTICE TO BUYER. THIS CERTIFICATE MAY NOT COVER ALL OF YOUR MEDICAL EXPENSES.**

**IMPORTANT NOTICE:** Issuance of this Medicare Supplement Insurance Certificate is based on Your answers to the questions on Your application. A copy of the application is attached. Omissions or misstatements on the application could cause Your claim to be denied or Your Certificate to be rescinded. If, for any reason, Your answers are incorrect, contact Us immediately at Medicare Supplement Administration, [P.O. Box 10851, Clearwater Florida 33757-8851, Telephone Number 877-815-8877.]

**CERTIFICATE EFFECTIVE DATE AND CONSIDERATION**

We have issued this Certificate in consideration of the payment of premium and the statements made on the application. The application is attached to and made a part of this Certificate. The term of this Certificate begins at, 12:01 a.m. Standard Time, at the place where You reside on the Certificate Effective Date shown on the Certificate Schedule. It ends at 11:59 p.m., at the place where You reside, on the day before Your premium is due. The date Your premium is due is determined by the mode of payment. The mode of payment for the original term of the Certificate is shown on the Certificate Schedule. An annual premium will maintain the Certificate in force for twelve (12) months, semi-annual for six (6) months, quarterly for three (3) months and monthly for one (1) month.

**THIRTY DAY RIGHT TO EXAMINE AND RETURN CERTIFICATE**

Please read Your Certificate carefully. If, for any reason, You are not satisfied, You may return Your Certificate to Us at Medicare Supplement Administration, [P.O. Box 10851, Clearwater Florida 33757-8851], within thirty (30) days after receiving it. If returned, the Certificate will be void from its beginning and any premium paid will be refunded. If payment of a claim is made under this Certificate during the thirty (30) day period, the amount will be deducted from the premium refund.

**GUARANTEED RENEWABLE FOR LIFE - PREMIUMS SUBJECT TO CHANGE**

This Certificate is renewable for as long as You live, provided You continue to pay premiums when due. At no time while You continue Your Certificate in force, may We place any restrictive riders on Your coverage. The premium may change on any premium due date if a new table of rates is applicable to the Certificate. The change in the table of rates will apply to all covered persons in the same class. Class is defined as underwriting class, state, plan and zip code of residence. You will be notified in advance before any change in the table of rates.

**THIS CERTIFICATE DOES NOT CONTAIN A PRE-EXISTING CONDITION LIMITATION**

**THIS IS A NON-PARTICIPATING CERTIFICATE**

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## **POLICYHOLDER INFORMATION**

For support and information regarding certificate terms, premium payments, claims processing and payment, contact us at:

Medicare Supplement Administration  
[P. O. Box 10851  
Clearwater, Florida 33757-8851  
1-877-815-8877]

For your information, the following is the name, address and telephone number of your agent:

[Mr. Fred Smith]  
[123 First Street  
Anywhere, USA 12345  
1-555-555-1234]

The Arkansas Insurance Department can be contacted at:

Arkansas Insurance Department  
Consumer Services  
1200 West Third Street  
Little Rock, Arkansas 72201-1904  
1-501-371-2640

Toll Free Consumer Information Telephone Number  
1-800-852-5494

**CERTIFICATE SCHEDULE**

**INSURED:**

**CERTIFICATE EFFECTIVE DATE:**

**CERTIFICATE NUMBER:**

**ISSUE AGE:**

**STATE OF ISSUE:**

**MODE AT ISSUE:**

**MODAL PREMIUM:**

**PREMIUM TERM:**

**UNDERWRITING CLASS:**

**CHAPTER:**

\*\*\*\*\*

**TYPE OF COVERAGE: MEDICARE SUPPLEMENT CERTIFICATE PLAN C**

## DEFINITIONS

**Benefit Period** means the period as determined by Medicare which begins on the date, You are first confined in a Hospital. It ends following a period of sixty (60) consecutive days during which You have not been confined in a Hospital or a Skilled Nursing Facility.

**Calendar Year** means the period of time beginning on January 1 and ending on December 31 of that same year.

**Certificate Effective Date** means the effective date of this Certificate and is shown on the Certificate Schedule. The Certificate Effective Date is not the date You signed the application for coverage.

**Coinsurance Amount** means the part of Medicare Eligible Expenses You have to pay. It does not include Part A or Part B deductible amounts.

**Emergency Care** means care needed immediately because of an Injury or an illness of sudden and unexpected onset.

**Hospital** means a hospital that is approved, or eligible to be approved to receive payments from Medicare and is accredited by the Joint Commission on Accreditation of Hospitals.

**Hospitalized or Hospitalization** means being confined in a Hospital on an inpatient basis.

**Immediate Family** means Your spouse, parents, grandparents, children, or siblings, as well as their spouses.

**Injury** means a bodily injury which is the direct result of an accident and independent of all other causes.

**Lifetime Inpatient Reserve Days** means a total of sixty (60) extra days in the Hospital provided to You by Medicare. These reserve days must be used if You are Hospitalized for more than ninety (90) days in a Benefit Period, unless previously used. When a lifetime reserve day is used, it is subtracted from the number of days You have left.

**Medicaid** means the Health Insurance for the Aged Act, Title XIX of the Social Security Amendment of 1965, as then constituted or later amended.

**Medically Necessary** means a service or supply that is recognized by Medicare as necessary to diagnose or treat an Injury or Sickness and is: (1) prescribed by a Physician; (2) consistent with the diagnosis and treatment of the Injury or Sickness; (3) in accordance with the generally accepted standards of medical practice; and (4) not solely for the convenience of You or the Physician.

**Medicare** means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendment of 1965, as then constituted or later amended.

**Medicare Eligible Expenses** means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and Medically Necessary by Medicare.

**Medicare Part A Initial Deductible** means the fixed amount Medicare does not pay during the first sixty (60) days of Hospital confinement in a Benefit Period. This amount is set each year by Medicare. Medicare does not pay this amount.

**Medicare Part B Deductible** means the fixed amount You must pay each calendar year before Medicare starts paying Part B expenses. This amount is set each year by Medicare. Medicare does not pay this amount. A Calendar Year begins on January 1 and ends on December 31.

**Physician** means any practitioner of the healing arts acting within the scope of his/her license. It does not include You or any member of Your Immediate Family.

## DEFINITIONS CONTINUED

**Sickness** means illness or disease which first manifests itself after the Certificate Effective Date and while this Certificate is in force.

**Skilled Nursing Facility** means an institution licensed as such by the state in which it is located and is operating within the scope and intent of its license. It does not include a facility or any of its sections which is primarily a place for drug addicts, alcoholics or persons suffering from mental disease.

## **BENEFIT PROVISIONS**

We will pay only the following Medicare Eligible Expenses not paid by Medicare. Benefits are only paid to the extent specified in this provision.

**The benefits paid under this Certificate will not duplicate benefits paid by Medicare.**

### **Basic (Core) Benefits**

Coverage of Part A Medicare Eligible Expenses for Hospitalization to the extent not covered by Medicare from the sixty first (61<sup>st</sup>) day through the ninetieth (90<sup>th</sup>) day in any Medicare Benefit Period.

Coverage of Part A Medicare Eligible Expenses incurred for Hospitalization to the extent not covered by Medicare for each Medicare Lifetime Inpatient Reserve Day used.

Upon exhaustion of Medicare Hospital inpatient coverage, including the lifetime reserve days, coverage of 100% of the Medicare Part A eligible expenses for hospitalization paid at applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional three hundred sixty-five (365) days. The provider shall accept Our payment as payment in full and may not bill You for any balance.

Coverage under Medicare Parts A and B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations.

Coverage for the Coinsurance Amount, or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount, of Medicare Eligible Expenses under Part B regardless of Hospital confinement, subject to the Medicare Part B deductible.

Hospice Care: Coverage of cost sharing for all Part A Medicare Eligible Expenses for hospice care and respite care expenses.

### **Additional Benefits For Plan C**

**Medicare Part A Deductible:** Coverage for all of the Medicare Part A Initial Deductible amount per Benefit Period.

**Skilled Nursing Facility Care:** Coverage for the actual billed charges up to the Coinsurance Amount from the twenty- first (21<sup>st</sup>) day through the one hundredth (100<sup>th</sup>)day in a Medicare Benefit Period for posthospital Skilled Nursing Facility care eligible under Medicare Part A.

**Medicare Part B Deductible:** Coverage for all of the Medicare Part B Deductible amount per Calendar Year regardless of Hospital confinement.

**Medically Necessary Emergency Care in a Foreign Country:** Coverage to the extent not covered by Medicare for eighty percent (80%) of the billed charges for Medicare-Eligible Expenses for Medically Necessary emergency Hospital, Physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first sixty (60) consecutive days of each trip outside the United States, subject to a Calendar Year deductible of two hundred fifty dollars (\$250), and a lifetime maximum benefit of fifty thousand dollars (\$50,000).

## **GUARANTEE REGARDING CHANGES IN MEDICARE BENEFITS**

We guarantee that the benefits and payment schedule of this Certificate will automatically change to reflect any changes which will become effective under Medicare. Only those provisions of the Certificate which are affected by the legislation are changed. Your coverage will automatically provide for such changes to whatever extent necessary. Premiums may be modified to correspond with such changes in accordance with the **GUARANTEE RENEWABLE FOR LIFE - PREMIUMS SUBJECT TO CHANGE** provision on page 1.

### **MEDICAL ASSISTANCE UNDER MEDICAID AND SUSPENSION UNDER GROUP HEALTH PLAN**

Benefits and premiums under this Certificate are suspended at Your request for a period not to exceed twenty-four (24) months, in which You have applied for and are determined to be entitled to medical assistance under Title XIX of the Social Security Act. You must notify Us within ninety (90) days after the day You become entitled to such assistance.

If such a suspension occurs and You lose entitlement of such medical assistance, Your Certificate is automatically reinstated effective as of the date of termination of such entitlement if You provide notice of loss of such entitlement within ninety (90) days after the date of such loss and pay the premiums attributable to the period. Your reinstated Certificate is effective as of the date of termination of such entitlement.

Benefits and premiums under this Certificate shall be suspended for any period that may be provided by federal regulation at Your request if You are entitled to benefits under section 226(b) of the Social Security Act and are covered under a group health plan, as defined in section 1862(b)(1)(A)(v) of the Social Security Act. If suspension occurs and You lose coverage under the group health plan, Your Certificate shall be automatically reinstated, effective as of the date of loss of such coverage, if You provide notice of loss of coverage within ninety (90) days after the date of such loss and pay the premiums attributable to the period, effective as of the date of termination of such entitlement.

Reinstitution of Your coverage provides for:

1. Coverage equivalent to coverage in effect before the date of suspension;
2. Your classification of premium remains as favorable to You as the premium classification terms that would have applied to You had the coverage not been suspended; and
3. No waiting period with respect to treatment of preexisting conditions.

### **TERMINATION OF CERTIFICATE AND EXTENSION OF BENEFITS**

Termination of the Certificate shall be without prejudice to a continuous loss which commenced while the Certificate was in force but the extension of benefits beyond the period during which the Certificate was in force may be continued upon Your continuous total disability, limited to the duration of the Certificate benefit period, if any, or payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

### **EXCLUSIONS**

This Certificate does not pay expenses related to any coverage that is limited or excluded by Medicare related to services not "reasonable and Medically Necessary" under the Medicare Program Standards for diagnosis or treatment of Injury or Sickness.

## CLAIM PROVISIONS

**NOTICE OF CLAIMS:** We must receive written notice of claim within twenty (20) days after any covered loss occurs or begins. If notice cannot be given at that time, it must be given as soon as reasonably possible. Notice may be given to Us at Medicare Supplement Claims, [P.O. Box 10850, Clearwater, Florida 33757-8850.]

**CLAIM FORMS:** When We get the notice, We will send You forms for filing proof of loss. If We do not send the forms within fifteen (15) working days after receiving written notice, Our requirements will be met if We receive written proof of the event and type and extent of the loss within the time stated below.

**PROOF OF LOSS:** We must receive written proof of loss within ninety (90) days after the date the loss began or occurred. If it is not reasonably possible to give this timely proof, the claim will not be affected if it is sent as soon as is reasonable. However, unless the person making the claim is legally incapacitated, proof must be given within one (1) year from the time it is otherwise due.

**TIME OF PAYMENT OF CLAIMS:** All benefits payable under this Certificate will be payable immediately upon receipt of due written proof of such loss. For continuing losses, We will pay the benefits due monthly on receipt of due proofs of loss. All benefits due will be paid to You or to any health care provider to whom You have assigned benefits.

**PAYMENT OF CLAIMS:** Any accrued benefits unpaid at Your death will be paid to Your estate or to any health care providers to whom You have assigned benefits. Should We fail to pay the benefits payable upon receipt of due written proof of loss, We shall have fifteen (15) working days thereafter within which to mail You a letter or notice which states the reasons We have for failing to pay the claim, either in whole or in part, and which also gives You a written itemization of any documents or other information needed to process the claim or any portions thereof which are not being paid. When all of the listed documents or other information needed to process the claim have been received, We shall then have fifteen (15) working days within which to process and either pay the claim or deny it, in whole or in part, giving You the reasons We may have for denying such claim or any portion thereof.

We shall pay interest to You equal to twelve percent (12%) per annum on the proceeds or benefits due under the terms of this Policy for failure to comply with the requirements of this provision.

**PHYSICAL EXAMINATIONS:** At Our expense, We may have You examined as often as reasonably necessary while the claim is pending.

**TIME LIMIT ON CERTAIN DEFENSES:** After three (3) years from the date of issue of this Certificate no misstatements, except fraudulent misstatements, made by You in the application for the Certificate shall be used to void the Certificate or to deny a claim for loss incurred commencing after the expiration of the three (3) year period.

**LEGAL ACTION:** No action at law or in equity shall be brought to recover on this Certificate prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this Certificate. No such action shall be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

**ASSIGNMENT:** No assignment of any benefit or claim shall bind Us unless the same is filed in writing prior to the payment of any benefit claimed. We assume no responsibility for the validity of any assignment. Notice may be given to Us at Medicare Supplement Claims, [P.O. Box 10850, Clearwater, Florida 33757-8850.]

## GENERAL PROVISIONS

**OWNER OF CERTIFICATE:** You, the Insured shall be the Owner of this Certificate. You may exercise all options and rights under this Certificate.

**MAINTENANCE OF RESERVE:** If Our reserves become impaired, You shall pay Us this Certificate's equitable proportion of the deficiency. However, there shall be no personal liability for such payment except against this Certificate's reserve. The amounts of such payment and deficiency shall be determined by the Society's Board of Directors. If such payment is not made in cash, it shall stand as a debt against this Certificate. Such debt shall bear the lesser of 5% or the rate used to compute certificate reserves. In lieu of the foregoing, or in combination with it, You may consent to a corresponding decrease of the insurance benefits. Such decrease shall be in the same proportion as the amount of such payment bears to the reserve immediately before such decrease.

**SUSPENSION OR EXPULSION:** If You should be expelled or suspended from the membership in the Society for any reason, except for nonpayment of premium or within the contestable period for misrepresentation in Your application for membership, You shall have the privilege of maintaining this Certificate in force by continuing payment of the required premium.

**CONTRACT:** This Certificate is between You and Us. It includes articles of incorporation and the by-laws of the Society; this Certificate; the application, a copy of which is attached; and all present or future amendments to each. However, no future amendment to the articles of incorporation or the by-laws of the Society shall reduce benefits given to You as of the Certificate Effective Date.

**MODIFICATIONS:** No agent of this Society is allowed to make changes to this Certificate. Only authorized officers of the Society can waive any terms of or make any changes to this Certificate. All changes must be in writing.

**GRACE PERIOD:** A grace period of thirty-one (31) days will be granted for the payment of each premium falling due after the first premium, during which grace period, this Certificate shall continue in force.

**REINSTATEMENT:** If any renewal premium is not paid within the time granted by Us for payment, a subsequent acceptance of any premium by Us or by any of Our authorized agents, without requiring an application for reinstatement, shall reinstate the Certificate; provided, however that, if We or any of Our authorized agents require an application for reinstatement and issues a conditional receipt for the premium tendered, the Certificate will be reinstated upon approval of such application by Us or, lacking such approval, upon the forty-fifth (45th) day following the date of such conditional receipt unless We have previously notified You in writing of Our disapproval of such application. The reinstated Certificate shall cover only loss resulting from an Injury or Sickness as may begin on or after the date of reinstatement. In all other respects the Society and the Insured shall have the same rights under the Certificate as they had under the Certificate immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with reinstatement.

**UNPAID PREMIUM:** Upon the payment of a claim under this Certificate, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

**CONFORMITY WITH STATE LAWS:** Any provision of the Certificate which, on its Certificate Effective Date, is in conflict with the laws of the state in which You reside on such date is hereby amended to conform to the minimum requirements of such statutes.

**CLERICAL ERROR:** Clerical error on Our part will not invalidate insurance otherwise in force nor continue insurance otherwise terminated. Upon discovery of any error, an equitable adjustment will be made in the premiums. Complete proof must be supplied documenting any clerical errors.

**GENERAL PROVISIONS CONTINUED**

**MISSTATEMENT OF AGE:** If Your age has been misstated, all amounts payable under this Certificate shall be such as the premium paid would have purchased at the correct age.

**PRO RATA REFUND:** If We receive written proof of death which terminates coverage, We will refund that part of any premium You have paid which covers a period after death occurs.

**CANCELLATION BY INSURED:** You may cancel this Certificate at any time by written notice delivered or mailed to Us at Medicare Supplement Administration, [P.O. Box 10851, Clearwater, Florida 33757-8851], effective upon receipt or on such later date as may be specified in such notice. In the event of cancellation we will make a pro-rata refund of any premium paid beyond the date of cancellation. Cancellation will be without prejudice to any claim originating prior to the effective date of cancellation.

This Certificate is signed for the Society by its [Secretary] [and] [President].

[SIGNATURE]

**[Secretary and General Counsel]**

[SIGNATURE]

**[President-CEO]**



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**MEDICARE SUPPLEMENT INSURANCE CERTIFICATE - PLAN D**

**READ YOUR CERTIFICATE CAREFULLY**

**This Certificate is a legal contract between the Owner of the Certificate and Royal Neighbors of America (the Society).**

This Certificate provides benefits to supplement hospital and medical coverage of Medicare. Only persons eligible for Medicare may apply for this Certificate. In this Certificate, “You” and “Your” means the Insured named on the application and shown on the Certificate Schedule. “We”, “Our” and “Us” means Royal Neighbors of America.

**NOTICE TO BUYER. THIS CERTIFICATE MAY NOT COVER ALL OF YOUR MEDICAL EXPENSES.**

**IMPORTANT NOTICE:** Issuance of this Medicare Supplement Insurance Certificate is based on Your answers to the questions on Your application. A copy of the application is attached. Omissions or misstatements on the application could cause Your claim to be denied or Your Certificate to be rescinded. If, for any reason, Your answers are incorrect, contact Us immediately at Medicare Supplement Administration, [P.O. Box 10851, Clearwater Florida 33757-8851, Telephone Number 877-815-8877.]

**CERTIFICATE EFFECTIVE DATE AND CONSIDERATION**

We have issued this Certificate in consideration of the payment of premium and the statements made on the application. The application is attached to and made a part of this Certificate. The term of this Certificate begins at, 12:01 a.m. Standard Time, at the place where You reside on the Certificate Effective Date shown on the Certificate Schedule. It ends at 11:59 p.m., at the place where You reside, on the day before Your premium is due. The date Your premium is due is determined by the mode of payment. The mode of payment for the original term of the Certificate is shown on the Certificate Schedule. An annual premium will maintain the Certificate in force for twelve (12) months, semi-annual for six (6) months, quarterly for three (3) months and monthly for one (1) month.

**THIRTY DAY RIGHT TO EXAMINE AND RETURN CERTIFICATE**

Please read Your Certificate carefully. If, for any reason, You are not satisfied, You may return Your Certificate to Us at Medicare Supplement Administration, [P.O. Box 10851, Clearwater Florida 33757-8851], within thirty (30) days after receiving it. If returned, the Certificate will be void from its beginning and any premium paid will be refunded. If payment of a claim is made under this Certificate during the thirty (30) day period, the amount will be deducted from the premium refund.

**GUARANTEED RENEWABLE FOR LIFE - PREMIUMS SUBJECT TO CHANGE**

This Certificate is renewable for as long as You live, provided You continue to pay premiums when due. At no time while You continue Your Certificate in force, may We place any restrictive riders on Your coverage. The premium may change on any premium due date if a new table of rates is applicable to the Certificate. The change in the table of rates will apply to all covered persons in the same class. Class is defined as underwriting class, state, plan and zip code of residence. You will be notified in advance before any change in the table of rates.

**THIS CERTIFICATE DOES NOT CONTAIN A PRE-EXISTING CONDITION LIMITATION**

**THIS IS A NON-PARTICIPATING CERTIFICATE**

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## **POLICYHOLDER INFORMATION**

For support and information regarding certificate terms, premium payments, claims processing and payment, contact us at:

Medicare Supplement Administration  
[P. O. Box 10851  
Clearwater, Florida 33757-8851  
1-877-815-8877]

For your information, the following is the name, address and telephone number of your agent:

[Mr. Fred Smith]  
[123 First Street  
Anywhere, USA 12345  
1-555-555-1234]

The Arkansas Insurance Department can be contacted at:

Arkansas Insurance Department  
Consumer Services  
1200 West Third Street  
Little Rock, Arkansas 72201-1904  
1-501-371-2640

Toll Free Consumer Information Telephone Number  
1-800-852-5494

**CERTIFICATE SCHEDULE**

**INSURED:**

**CERTIFICATE EFFECTIVE DATE:**

**CERTIFICATE NUMBER:**

**ISSUE AGE:**

**STATE OF ISSUE:**

**MODE AT ISSUE:**

**MODAL PREMIUM:**

**PREMIUM TERM:**

**UNDERWRITING CLASS:**

**CHAPTER:**

\*\*\*\*\*

**TYPE OF COVERAGE: MEDICARE SUPPLEMENT CERTIFICATE PLAN D**

## DEFINITIONS

**Benefit Period** means the period as determined by Medicare which begins on the date, You are first confined in a Hospital. It ends following a period of sixty (60) consecutive days during which You have not been confined in a Hospital or a Skilled Nursing Facility.

**Calendar Year** means the period of time beginning on January 1 and ending on December 31 of that same year.

**Certificate Effective Date** means the effective date of this Certificate and is shown on the Certificate Schedule. The Certificate Effective Date is not the date You signed the application for coverage.

**Coinsurance Amount** means the part of Medicare Eligible Expenses You have to pay. It does not include Part A or Part B deductible amounts.

**Emergency Care** means care needed immediately because of an Injury or an illness of sudden and unexpected onset.

**Hospital** means a hospital that is approved, or eligible to be approved to receive payments from Medicare and is accredited by the Joint Commission on Accreditation of Hospitals.

**Hospitalized or Hospitalization** means being confined in a Hospital on an inpatient basis.

**Immediate Family** means Your spouse, parents, grandparents, children, or siblings, as well as their spouses.

**Injury** means a bodily injury which is the direct result of an accident and independent of all other causes.

**Lifetime Inpatient Reserve Days** means a total of sixty (60) extra days in the Hospital provided to You by Medicare. These reserve days must be used if You are Hospitalized for more than ninety (90) days in a Benefit Period, unless previously used. When a lifetime reserve day is used, it is subtracted from the number of days You have left.

**Medicaid** means the Health Insurance for the Aged Act, Title XIX of the Social Security Amendment of 1965, as then constituted or later amended.

**Medically Necessary** means a service or supply that is recognized by Medicare as necessary to diagnose or treat an Injury or Sickness and is: (1) prescribed by a Physician; (2) consistent with the diagnosis and treatment of the Injury or Sickness; (3) in accordance with the generally accepted standards of medical practice; and (4) not solely for the convenience of You or the Physician.

**Medicare** means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendment of 1965, as then constituted or later amended.

**Medicare Eligible Expenses** means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and Medically Necessary by Medicare.

**Medicare Part A Initial Deductible** means the fixed amount Medicare does not pay during the first sixty (60) days of Hospital confinement in a Benefit Period. This amount is set each year by Medicare. Medicare does not pay this amount.

**Physician** means any practitioner of the healing arts acting within the scope of his/her license. It does not include You or any member of Your Immediate Family.

## DEFINITIONS CONTINUED

**Sickness** means illness or disease which first manifests itself after the Certificate Effective Date and while this Certificate is in force.

**Skilled Nursing Facility** means an institution licensed as such by the state in which it is located and is operating within the scope and intent of its license. It does not include a facility or any of its sections which is primarily a place for drug addicts, alcoholics or persons suffering from mental disease.

## BENEFIT PROVISIONS

We will pay only the following Medicare Eligible Expenses not paid by Medicare. Benefits are only paid to the extent specified in this provision.

**The benefits paid under this Certificate will not duplicate benefits paid by Medicare.**

### Basic (Core) Benefits

Coverage of Part A Medicare Eligible Expenses for Hospitalization to the extent not covered by Medicare from the sixty first (61<sup>st</sup>) day through the ninetieth (90<sup>th</sup>) day in any Medicare Benefit Period.

Coverage of Part A Medicare Eligible Expenses incurred for Hospitalization to the extent not covered by Medicare for each Medicare Lifetime Inpatient Reserve Day used.

Upon exhaustion of Medicare Hospital inpatient coverage, including the lifetime reserve days, coverage of 100% of the Medicare Part A eligible expenses for hospitalization paid at applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional three hundred sixty-five (365) days. The provider shall accept Our payment as payment in full and may not bill You for any balance.

Coverage under Medicare Parts A and B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations.

Coverage for the Coinsurance Amount, or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount, of Medicare Eligible Expenses under Part B regardless of Hospital confinement, subject to the Medicare Part B deductible.

Hospice Care: Coverage of cost sharing for all Part A Medicare Eligible Expenses for hospice care and respite care expenses.

### Additional Benefits For Plan D

**Medicare Part A Deductible:** Coverage for all of the Medicare Part A Initial Deductible amount per Benefit Period.

**Skilled Nursing Facility Care:** Coverage for the actual billed charges up to the Coinsurance Amount from the twenty- first (21<sup>st</sup>) day through the one hundredth (100<sup>th</sup>)day in a Medicare Benefit Period for posthospital Skilled Nursing Facility care eligible under Medicare Part A.

**Medically Necessary Emergency Care in a Foreign Country:** Coverage to the extent not covered by Medicare for eighty percent (80%) of the billed charges for Medicare-Eligible Expenses for Medically Necessary emergency Hospital, Physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first sixty (60) consecutive days of each trip outside the United States, subject to a Calendar Year deductible of two hundred fifty dollars (\$250), and a lifetime maximum benefit of fifty thousand dollars (\$50,000).

## GUARANTEE REGARDING CHANGES IN MEDICARE BENEFITS

We guarantee that the benefits and payment schedule of this Certificate will automatically change to reflect any changes which will become effective under Medicare. Only those provisions of the Certificate which are affected by the legislation are changed. Your coverage will automatically provide for such changes to whatever extent necessary. Premiums may be modified to correspond with such changes in accordance with the **GUARANTEE RENEWABLE FOR LIFE - PREMIUMS SUBJECT TO CHANGE** provision on page 1.

### **MEDICAL ASSISTANCE UNDER MEDICAID AND SUSPENSION UNDER GROUP HEALTH PLAN**

Benefits and premiums under this Certificate are suspended at Your request for a period not to exceed twenty-four (24) months, in which You have applied for and are determined to be entitled to medical assistance under Title XIX of the Social Security Act. You must notify Us within ninety (90) days after the day You become entitled to such assistance.

If such a suspension occurs and You lose entitlement of such medical assistance, Your Certificate is automatically reinstated effective as of the date of termination of such entitlement if You provide notice of loss of such entitlement within ninety (90) days after the date of such loss and pay the premiums attributable to the period. Your reinstated Certificate is effective as of the date of termination of such entitlement.

Benefits and premiums under this Certificate shall be suspended for any period that may be provided by federal regulation at Your request if You are entitled to benefits under section 226(b) of the Social Security Act and are covered under a group health plan, as defined in section 1862(b)(1)(A)(v) of the Social Security Act. If suspension occurs and You lose coverage under the group health plan, Your Certificate shall be automatically reinstated, effective as of the date of loss of such coverage, if You provide notice of loss of coverage within ninety (90) days after the date of such loss and pay the premiums attributable to the period, effective as of the date of termination of such entitlement.

Reinstitution of Your coverage provides for:

1. Coverage equivalent to coverage in effect before the date of suspension;
2. Your classification of premium remains as favorable to You as the premium classification terms that would have applied to You had the coverage not been suspended; and
3. No waiting period with respect to treatment of preexisting conditions.

### **TERMINATION OF CERTIFICATE AND EXTENSION OF BENEFITS**

Termination of the Certificate shall be without prejudice to a continuous loss which commenced while the Certificate was in force but the extension of benefits beyond the period during which the Certificate was in force may be continued upon Your continuous total disability, limited to the duration of the Certificate benefit period, if any, or payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

### **EXCLUSIONS**

This Certificate does not pay expenses related to any coverage that is limited or excluded by Medicare related to services not "reasonable and Medically Necessary" under the Medicare Program Standards for diagnosis or treatment of Injury or Sickness.

## CLAIM PROVISIONS

**NOTICE OF CLAIMS:** We must receive written notice of claim within twenty (20) days after any covered loss occurs or begins. If notice cannot be given at that time, it must be given as soon as reasonably possible. Notice may be given to Us at Medicare Supplement Claims, [P.O. Box 10850, Clearwater, Florida 33757-8850.]

**CLAIM FORMS:** When We get the notice, We will send You forms for filing proof of loss. If We do not send the forms within fifteen (15) working days after receiving written notice, Our requirements will be met if We receive written proof of the event and type and extent of the loss within the time stated below.

**PROOF OF LOSS:** We must receive written proof of loss within ninety (90) days after the date the loss began or occurred. If it is not reasonably possible to give this timely proof, the claim will not be affected if it is sent as soon as is reasonable. However, unless the person making the claim is legally incapacitated, proof must be given within one (1) year from the time it is otherwise due.

**TIME OF PAYMENT OF CLAIMS:** All benefits payable under this Certificate will be payable immediately upon receipt of due written proof of such loss. For continuing losses, We will pay the benefits due monthly on receipt of due proofs of loss. All benefits due will be paid to You or to any health care provider to whom You have assigned benefits.

**PAYMENT OF CLAIMS:** Any accrued benefits unpaid at Your death will be paid to Your estate or to any health care providers to whom You have assigned benefits. Should We fail to pay the benefits payable upon receipt of due written proof of loss, We shall have fifteen (15) working days thereafter within which to mail You a letter or notice which states the reasons We have for failing to pay the claim, either in whole or in part, and which also gives You a written itemization of any documents or other information needed to process the claim or any portions thereof which are not being paid. When all of the listed documents or other information needed to process the claim have been received, We shall then have fifteen (15) working days within which to process and either pay the claim or deny it, in whole or in part, giving You the reasons We may have for denying such claim or any portion thereof.

We shall pay interest to You equal to twelve percent (12%) per annum on the proceeds or benefits due under the terms of this Policy for failure to comply with the requirements of this provision.

**PHYSICAL EXAMINATIONS:** At Our expense, We may have You examined as often as reasonably necessary while the claim is pending.

**TIME LIMIT ON CERTAIN DEFENSES:** After three (3) years from the date of issue of this Certificate no misstatements, except fraudulent misstatements, made by You in the application for the Certificate shall be used to void the Certificate or to deny a claim for loss incurred commencing after the expiration of the three (3) year period.

**LEGAL ACTION:** No action at law or in equity shall be brought to recover on this Certificate prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this Certificate. No such action shall be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

**ASSIGNMENT:** No assignment of any benefit or claim shall bind Us unless the same is filed in writing prior to the payment of any benefit claimed. We assume no responsibility for the validity of any assignment. Notice may be given to Us at Medicare Supplement Claims, [P.O. Box 10850, Clearwater, Florida 33757-8850.]

## GENERAL PROVISIONS

**OWNER OF CERTIFICATE:** You, the Insured shall be the Owner of this Certificate. You may exercise all options and rights under this Certificate.

**MAINTENANCE OF RESERVE:** If Our reserves become impaired, You shall pay Us this Certificate's equitable proportion of the deficiency. However, there shall be no personal liability for such payment except against this Certificate's reserve. The amounts of such payment and deficiency shall be determined by the Society's Board of Directors. If such payment is not made in cash, it shall stand as a debt against this Certificate. Such debt shall bear the lesser of 5% or the rate used to compute certificate reserves. In lieu of the foregoing, or in combination with it, You may consent to a corresponding decrease of the insurance benefits. Such decrease shall be in the same proportion as the amount of such payment bears to the reserve immediately before such decrease.

**SUSPENSION OR EXPULSION:** If You should be expelled or suspended from the membership in the Society for any reason, except for nonpayment of premium or within the contestable period for misrepresentation in Your application for membership, You shall have the privilege of maintaining this Certificate in force by continuing payment of the required premium.

**CONTRACT:** This Certificate is between You and Us. It includes articles of incorporation and the by-laws of the Society; this Certificate; the application, a copy of which is attached; and all present or future amendments to each. However, no future amendment to the articles of incorporation or the by-laws of the Society shall reduce benefits given to You as of the Certificate Effective Date.

**MODIFICATIONS:** No agent of this Society is allowed to make changes to this Certificate. Only authorized officers of the Society can waive any terms of or make any changes to this Certificate. All changes must be in writing.

**GRACE PERIOD:** A grace period of thirty-one (31) days will be granted for the payment of each premium falling due after the first premium, during which grace period, this Certificate shall continue in force.

**REINSTATEMENT:** If any renewal premium is not paid within the time granted by Us for payment, a subsequent acceptance of any premium by Us or by any of Our authorized agents, without requiring an application for reinstatement, shall reinstate the Certificate; provided, however that, if We or any of Our authorized agents require an application for reinstatement and issues a conditional receipt for the premium tendered, the Certificate will be reinstated upon approval of such application by Us or, lacking such approval, upon the forty-fifth (45th) day following the date of such conditional receipt unless We have previously notified You in writing of Our disapproval of such application. The reinstated Certificate shall cover only loss resulting from an Injury or Sickness as may begin on or after the date of reinstatement. In all other respects the Society and the Insured shall have the same rights under the Certificate as they had under the Certificate immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with reinstatement.

**UNPAID PREMIUM:** Upon the payment of a claim under this Certificate, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

**CONFORMITY WITH STATE LAWS:** Any provision of the Certificate which, on its Certificate Effective Date, is in conflict with the laws of the state in which You reside on such date is hereby amended to conform to the minimum requirements of such statutes.

**CLERICAL ERROR:** Clerical error on Our part will not invalidate insurance otherwise in force nor continue insurance otherwise terminated. Upon discovery of any error, an equitable adjustment will be made in the premiums. Complete proof must be supplied documenting any clerical errors.

**GENERAL PROVISIONS CONTINUED**

**MISSTATEMENT OF AGE:** If Your age has been misstated, all amounts payable under this Certificate shall be such as the premium paid would have purchased at the correct age.

**PRO RATA REFUND:** If We receive written proof of death which terminates coverage, We will refund that part of any premium You have paid which covers a period after death occurs.

**CANCELLATION BY INSURED:** You may cancel this Certificate at any time by written notice delivered or mailed to Us at Medicare Supplement Administration, [P.O. Box 10851, Clearwater, Florida 33757-8851], effective upon receipt or on such later date as may be specified in such notice. In the event of cancellation we will make a pro-rata refund of any premium paid beyond the date of cancellation. Cancellation will be without prejudice to any claim originating prior to the effective date of cancellation.

This Certificate is signed for the Society by its [Secretary] [and] [President].

[SIGNATURE]

**[Secretary and General Counsel]**

[SIGNATURE]

**[President-CEO]**

SERFF Tracking Number: IASL-126474143 State: Arkansas  
 Filing Company: Royal Neighbors of America State Tracking Number: 45082  
 Company Tracking Number: MSAI2010AR  
 TOI: MS08I Individual Medicare Supplement - Sub-TOI: MS08I.001 Plan A 2010  
 Standard Plans 2010  
 Product Name: RN 2010 AR Forms  
 Project Name/Number: RN 2010 AR Forms/

## Rate/Rule Schedule

Schedule Item Status:	Document Name:	Affected Form Numbers: (Separated with commas)	Rate Action:	Rate Action Information:	Attachments
Approved 04/07/2010	Rate Page Plan A	MSAI2010AR	New		Rate Page Plan A.pdf
Approved 04/07/2010	Rate Page Plan F	MSFI2010AR	New		Rate Page Plan F.pdf
Approved 04/07/2010	Rate Page Plan G	MSGI2010AR	New		Rate Page Plan G.pdf
Approved 04/07/2010	Rate Page Plan B	MSBI2010AR	New		Plan B Rate Page.pdf
Approved 04/07/2010	Rate Page Plan C	MSCI2010AR	New		Plan C Rate Page.pdf
Approved 04/07/2010	Rate Page Plan D	MSDI2010AR	New		Plan D Rate Page.pdf

**ARKANSAS - COMMUNITY RATES**  
**ROYAL NEIGHBORS OF AMERICA**  
**2010 Standardized Benefit Plan**  
**PLAN A**

Age	Non-Smoker		Smoker	
	Female	Male	Female	Male
All	1660	1660	1843	1843

Modal Factors

Area	Factor
726-729	0.85
All Other 719	0.91
720-722	0.95
	1.00

Mode	Factor
Annual	1.0000
Semi-Annual	0.5000
Quarterly	0.2500
Monthly	0.0833

**ARKANSAS - COMMUNITY RATES**  
**ROYAL NEIGHBORS OF AMERICA**  
**2010 Standardized Benefit Plan**  
**PLAN F**

Age	Non-Smoker		Smoker	
	Female	Male	Female	Male
All	2457	2457	2727	2727

Area	Factor
726-729	0.85
All Other 719	0.91
720-722	0.95
	1.00

Modal Factors

Mode	Factor
Annual	1.0000
Semi-Annual	0.5000
Quarterly	0.2500
Monthly	0.0833

**ARKANSAS - COMMUNITY RATES**  
**ROYAL NEIGHBORS OF AMERICA**  
**2010 Standardized Benefit Plan**  
**PLAN G**

Age	Non-Smoker		Smoker	
	Female	Male	Female	Male
All	1973	1973	2190	2190

Area	Factor
726-729	0.85
All Other 719	0.91
720-722	0.95
	1.00

Modal Factors

Mode	Factor
Annual	1.0000
Semi-Annual	0.5000
Quarterly	0.2500
Monthly	0.0833

**ARKANSAS - COMMUNITY AGE RATES**

**ROYAL NEIGHBORS OF AMERICA**

**2010 Standardized Benefit Plan**

**PLAN B**

Age	Non-Smoker		Smoker	
	Female	Male	Female	Male
All	2095	2095	2326	2326

Modal Factors

Area	Factor
726-729	0.85
All Other	0.91
719	0.95
720-722	1.00

Mode	Factor
Annual	1.0000
Semi-Annual	0.5000
Quarterly	0.2500
Monthly	0.0833

**ARKANSAS - COMMUNITY AGE RATES**

ROYAL NEIGHBORS OF AMERICA

2010 Standardized Benefit Plan

PLAN C

Age	Non-Smoker		Smoker	
	Female	Male	Female	Male
All	2449	2449	2718	2718

Modal Factors

Area	Factor
726-729	0.85
All Other	0.91
719	0.95
720-722	1.00

Mode	Factor
Annual	1.0000
Semi-Annual	0.5000
Quarterly	0.2500
Monthly	0.0833

**ARKANSAS - COMMUNITY AGE RATES**

**ROYAL NEIGHBORS OF AMERICA  
2010 Standardized Benefit Plan  
PLAN D**

Age	Non-Smoker		Smoker	
	Female	Male	Female	Male
All	1966	1966	2182	2182

Modal Factors

Area	Factor
726-729	0.85
All Other	0.91
719	0.95
720-722	1.00

Mode	Factor
Annual	1.0000
Semi-Annual	0.5000
Quarterly	0.2500
Monthly	0.0833

SERFF Tracking Number: IASL-126474143 State: Arkansas  
 Filing Company: Royal Neighbors of America State Tracking Number: 45082  
 Company Tracking Number: MSAI2010AR  
 TOI: MS08I Individual Medicare Supplement - Sub-TOI: MS08I.001 Plan A 2010  
 Standard Plans 2010  
 Product Name: RN 2010 AR Forms  
 Project Name/Number: RN 2010 AR Forms/

## Supporting Document Schedules

		<b>Item Status:</b>	<b>Status</b>
<b>Satisfied - Item:</b>	Flesch Certification	Accepted for Informational Purposes	<b>Date:</b> 04/07/2010

**Comments:**

**Attachment:**

ISSUE AGE - FleschCertification.pdf

		<b>Item Status:</b>	<b>Status</b>
<b>Satisfied - Item:</b>	Application	Approved	<b>Date:</b> 04/07/2010

**Comments:**

Application submitted under Forms Tab

		<b>Item Status:</b>	<b>Status</b>
<b>Satisfied - Item:</b>	Outline of Coverage	Approved	<b>Date:</b> 04/07/2010

**Comments:**

Outline submitted under the forms tab.

		<b>Item Status:</b>	<b>Status</b>
<b>Satisfied - Item:</b>	Letter of Authorization	Accepted for Informational Purposes	<b>Date:</b> 04/07/2010

**Comments:**

**Attachment:**

2010 01 RNA IAS Authorization Letter.pdf

# READABILITY COMPLIANCE CERTIFICATION

## Name and Address of Insurer:

**Royal Neighbors of America  
230 16<sup>th</sup> Street  
Rock Island, IL 61201**

I hereby certify that the Flesch Reading Ease Test Score of the forms listed below are as follows:

<b>Type and/ or Title of Form(s)</b>	<b>Form Number(s)</b>	<b>Flesch Score</b>
Medicare Supplement Certificate - Plan A	MSAI2010AR	52.2
Medicare Supplement Certificate - Plan B	MSBI2010AR	52.5
Medicare Supplement Certificate - Plan C	MSCI2010AR	54.0
Medicare Supplement Certificate - Plan D	MSDI2010AR	51.3
Medicare Supplement Certificate – Plan F	MSFI2010AR	50.2
Medicare Supplement Certificate – Plan G	MSGI2010AR	53.8
Medicare Supplement Application	3500AR2010	Scored as a part of the Certificate.

The type size of the text is at least 10-pointed leaded.

Signed for the Company by an Officer



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Signature

Secretary & General Counsel

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Title

March 19, 2010

---

Date



Brian W. Haynes  
*Treasurer and Chief Financial Officer*

230 16<sup>th</sup> Street | Rock Island, IL 61201

Direct: (309) 732-8209 | Toll-free: (800) 627-4762  
Fax: (309) 788-1439 | E-mail: bhaynes@royalneighbors.org

January 8, 2010

Ms. Darcey Shaffer, ACS, FLMI  
Compliance Manager  
Insurance Administrative Solutions, L.L.C.  
8545 126<sup>th</sup> Avenue North, Suite 200  
Largo, Florida 33773-1502

Re: Filing/Reporting Requirements for RNA Medicare Supplement Insurance  
Certificates

Dear Ms. Shaffer:

This letter authorizes Insurance Administrative Solutions, L.L.C. "IAS" to file on behalf of Royal Neighbors of America, various reports, rate filings and forms for the Medicare Supplement Insurance Certificates with the State Insurance Departments. Prior to submission of any reports or forms including any advertising materials, IAS will obtain written approval of the documents to be filed from the Medicare Supplement Line of Business Manager or CFO of Royal Neighbors. IAS may correspond with the State Insurance Departments regarding any questions they may have concerning the filings, but will notify Royal Neighbors and obtain their consent before making any changes to the submission.

IAS will keep Royal Neighbors fully advised of all such filings submitted on behalf of Royal Neighbors and furnish copies of approved submissions to the attention of John Fleming, Medicare Supplement Line of Business Manager and Debra Zemo, Compliance Assistant.

A copy of this letter is as valid as the original. This authorization will be valid for twelve months from the date of this letter.

Sincerely,

Brian W. Haynes  
Chief Financial Officer and Treasurer

BWH:jag

<i>SERFF Tracking Number:</i>	<i>IASL-126474143</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Royal Neighbors of America</i>	<i>State Tracking Number:</i>	<i>45082</i>
<i>Company Tracking Number:</i>	<i>MSAI2010AR</i>		
<i>TOI:</i>	<i>MS08I Individual Medicare Supplement - Standard Plans 2010</i>	<i>Sub-TOI:</i>	<i>MS08I.001 Plan A 2010</i>
<i>Product Name:</i>	<i>RN 2010 AR Forms</i>		
<i>Project Name/Number:</i>	<i>RN 2010 AR Forms/</i>		

## Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

<b>Creation Date:</b>	<b>Schedule</b>	<b>Schedule Item Name</b>	<b>Replacement Creation Date</b>	<b>Attached Document(s)</b>
03/25/2010	Form	Outline of Coverage	04/01/2010	3510AR201004.pdf (Superseded)
03/02/2010	Form	Outline of Coverage	03/25/2010	3510AR2010.pdf (Superseded)
01/26/2010	Supporting Document	Flesch Certification	03/25/2010	ISSUE AGE - FleschCertification.pdf (Superseded)

# READABILITY COMPLIANCE CERTIFICATION

**Name and Address of Insurer:**

**Royal Neighbors of America  
230 16<sup>th</sup> Street  
Rock Island, IL 61201**

I hereby certify that the Flesch Reading Ease Test Score of the forms listed below are as follows:

<b>Type and/ or Title of Form(s)</b>	<b>Form Number(s)</b>	<b>Flesch Score</b>
Medicare Supplement Certificate - Plan A	MSAI2010AR	52.2
Medicare Supplement Certificate – Plan F	MSFI2010AR	50.2
Medicare Supplement Certificate – Plan G	MSGI2010AR	53.8
Medicare Supplement Application	3500AR2010	Scored as a part of the Certificate.

The type size of the text is at least 10-pointed leaded.

Signed for the Company by an Officer



---

Signature

Secretary & General Counsel

---

Title

December 22, 2009

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Date



**Royal Neighbors of America**  
**Outline of Medicare Supplement Coverage**  
**Benefit Plans A, B, C, D, F and G**

**Benefit Chart of Medicare Supplement Plans Sold for Effective Dates on or After June 1, 2010**

These charts show the benefits included in each of the standard Medicare supplement plans. Every company must make available Plan “A”. Some plans may not be available in your state. [Plans E, H, I and J are no longer available for sale.]

**Basic Benefits:**

- **Hospitalization-** Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
- **Medical Expenses-** Part B coinsurance (generally 20% of Medicare-approved expenses) or copayments for hospital outpatient services. Plans K, L and N require insureds to pay a portion of Part B coinsurance or copayments.
- **Blood-** First three pints of blood each year.
- **Hospice -** Part A coinsurance

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

\*Plan F also has an option called a high deductible Plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year \$[2000] deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses are \$[2000]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the Policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan’s separate foreign travel emergency deductible.

Effective: [06-01-2010]

**ROYAL NEIGHBORS OF AMERICA  
ANNUAL STANDARD PREMIUM RATES**

**[ ]  
RATES**

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

**Semi-Annual  
0.5000**

**Quarterly  
0.2500**

**Monthly  
0.0833**

## **PREMIUM INFORMATION**

Royal Neighbors of America may change your premium on any premium due date if a new table of rates is applicable to the certificate. The change in the table of rates will apply to all covered persons in the same class. Class is defined as underwriting class, state, plan and zip code of residence.

Premiums will change on Your Certificate Anniversary Date.

## **DISCLOSURES**

Use this outline to compare benefits and premiums among policies.

**[This outline shows benefits and premiums of certificates sold for effective dates on or after June 1, 2010. Certificates sold for effective dates prior to June 1, 2010 have different benefits and premiums. Plans E, H, I, and J are no longer available for sale. ]**

## **READ YOUR CERTIFICATE VERY CAREFULLY**

This is only an outline describing your certificate's most important features. The certificate is your insurance contract. You must read the certificate itself to understand all of the rights and duties of both you and Royal Neighbors of America.

## **RIGHT TO RETURN CERTIFICATE**

If you find that you are not satisfied with your certificate, you may return it to: Royal Neighbors of America, Medicare Supplement Administration, [P.O. Box 10851, Clearwater, Florida 33757-8851]. If you send the certificate back to us within 30 days after you receive it, we will treat the certificate as if it had never been issued and return all of your payments.

## **POLICY OR CERTIFICATE REPLACEMENT**

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

## **NOTICE**

This certificate may not fully cover all of your medical costs. Neither Royal Neighbors 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 *Medicare and You* for more details.

## **COMPLETE ANSWERS ARE VERY IMPORTANT**

When you fill out the application for the new certificate, be sure to answer truthfully and completely all questions about your medical and health history. Royal Neighbors of America may cancel your certificate and refuse to pay any claims if you leave out or falsify important medical information.

**Review the application carefully before you sign it. Be certain that all information has been properly recorded.**

**Please refer to your certificate for details.**

**PLAN A**

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

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

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days  61 <sup>st</sup> thru 90 <sup>th</sup> day 91 <sup>st</sup> day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days  — Beyond the additional 365 days	All but \$[1100]  All but \$[275] a day  All but \$[550] a day  \$0  \$0	\$0  \$[275] a day  \$[550] a day  100% of Medicare eligible expenses \$0	\$[1100] (Part A deductible) \$0  \$0  \$0**  All costs
<b>SKILLED NURSING FACILITY CARE*</b> 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 21 <sup>st</sup> thru 100 <sup>th</sup> day 101 <sup>st</sup> day and after	All approved amounts All but \$[137.50] a day \$0	\$0 \$0 \$0	\$0 Up to \$[137.50] a day All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> You must meet Medicare’s requirements, including a doctor’s certification of terminal illness.	All but very limited co-payment/ coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/coinsurance	\$0

**\*\*NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to 365 days as provided in the policy’s “Core Benefits.” During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

**PLAN A**

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

\*Once you have been billed \$[155] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>MEDICAL EXPENSES –</b> IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$[155] of Medicare Approved Amounts*	\$0	\$0	\$[155] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
<b>PART B EXCESS CHARGES</b> (Above Medicare Approved Amounts)	\$0	\$0	All costs
<b>BLOOD</b> First 3 pints	\$0	All costs	\$0
Next \$[155] of Medicare Approved Amounts*	\$0	\$0	\$[155] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
<b>CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

**PARTS A & B**

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

**PLAN B**

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

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

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 <sup>st</sup> thru 90 <sup>th</sup> day 91 <sup>st</sup> day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the additional 365 days	All but \$[1068] All but \$[267] a day  All but \$[534] a day  \$0  \$0	\$[1068] (Part A deductible) \$[267] a day  \$[534] a day  100% of Medicare eligible expenses  \$0	\$0 \$0  \$0  \$0**  All costs
<b>SKILLED NURSING FACILITY CARE*</b> 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 21 <sup>st</sup> thru 100 <sup>th</sup> day 101 <sup>st</sup> day and after	All approved amounts All but \$[133.50] a day \$0	\$0 \$0 \$0	\$0 Up to \$[133.50] a day All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> You must meet Medicare’s requirements, including a doctor’s certification of terminal illness.	All but very limited co-payment/ coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/coinsurance	\$0

**\*\*NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to 365 days as provided in the policy’s “Core Benefits.” During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

**PLAN B**

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

\*Once you have been billed \$[135] 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
<b>MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , such as Physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$[135] of Medicare Approved Amounts*	\$0	\$0	\$[135] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
<b>PART B EXCESS CHARGES</b> (Above Medicare Approved Amounts)	\$0	\$0	All costs
<b>BLOOD</b> First 3 pints	\$0	All costs	\$0
Next \$[135] of Medicare Approved Amounts*	\$0	\$0	\$[135] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
<b>CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

**PARTS A & B**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE MEDICARE APPROVED SERVICES</b> — Medically necessary skilled care services and medical supplies	100%	\$0	\$0
— Durable medical equipment First \$[135] of Medicare Approved Amounts*	\$0	\$0	\$[135] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

**PLAN C**

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

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

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 <sup>st</sup> thru 90 <sup>th</sup> day 91 <sup>st</sup> day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the additional 365 days	All but \$[1068] All but \$[267] a day  All but \$[534] a day  \$0  \$0	\$[1068] (Part A deductible) \$[267] a day  \$[534] a day  100% of Medicare eligible expenses  \$0	\$0 \$0  \$0  \$0**  All costs
<b>SKILLED NURSING FACILITY                      CARE*</b> 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 21 <sup>st</sup> thru 100 <sup>th</sup> day 101 <sup>st</sup> day and after	All approved amounts All but \$[133.50] a day \$0	\$0 Up to \$[133.50] a day \$0	\$0 \$0 All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> You must meet Medicare’s requirements, including a doctor’s certification of terminal illness.	All but very limited co- payment/ coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/coinsurance	\$0

\*\***NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to 365 days as provided in the policy’s “Core Benefits.” During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

**PLAN C**

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

\*Once you have been billed \$[135] 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
<b>MEDICAL EXPENSES –</b> 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 \$[135] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 Generally 80%	\$(135) (Part B deductible) Generally 20%	\$0 \$0
<b>PART B EXCESS CHARGES</b> (Above Medicare Approved Amounts)	\$0	\$0	All costs
<b>BLOOD</b> First 3 pints Next \$[135] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All costs \$(135) (Part B deductible) 20%	\$0 \$0 \$0
<b>CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

**PARTS A & B**

<b>HOME HEALTH CARE</b> MEDICARE APPROVED SERVICES — Medically necessary skilled care services and medical supplies — Durable medical equipment First \$[135] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% \$0 80%	\$0 \$(135) (Part B deductible) 20%	\$0 \$0 \$0
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**OTHER BENEFITS – NOT COVERED BY MEDICARE**

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

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<p><b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61<sup>st</sup> thru 90<sup>th</sup> day 91<sup>st</sup> day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the additional 365 days</p>	<p>All but \$[1068] All but \$[267] a day  All but \$[534] a day  \$0 \$0</p>	<p>\$[1068] (Part A deductible) \$[267] a day  \$[534] a day  100% of Medicare eligible expenses \$0</p>	<p>\$0 \$0  \$0  \$0** All costs</p>
<p><b>SKILLED NURSING FACILITY CARE*</b> 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 21<sup>st</sup> thru 100<sup>th</sup> day 101<sup>st</sup> day and after</p>	<p>All approved amounts All but \$[133.50] a day \$0</p>	<p>\$0 Up to \$[133.50] a day \$0</p>	<p>\$0 \$0 All costs</p>
<p><b>BLOOD</b> First 3 pints Additional amounts</p>	<p>\$0 100%</p>	<p>3 pints \$0</p>	<p>\$0 \$0</p>
<p><b>HOSPICE CARE</b> You must meet Medicare’s requirements, including a doctor’s certification of terminal illness.</p>	<p>All but very limited co-payment/ coinsurance for out-patient drugs and inpatient respite care</p>	<p>Medicare co-payment/coinsurance</p>	<p>\$0</p>

\*\*NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to 365 days as provided in the policy’s “Core Benefits.” During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

**PLAN D**

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

\*Once you have been billed \$[135] 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.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>MEDICAL EXPENSES –</b> 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 \$[135] of Medicare Approved Amounts*	\$0	\$0	\$[135] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
<b>PART B EXCESS CHARGES</b> (Above Medicare Approved Amounts)	\$0	\$0	All costs
<b>BLOOD</b> First 3 pints	\$0	All costs	\$0
Next \$[135] of Medicare Approved Amounts*	\$0	\$0	\$[135] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
<b>CLINICAL LABORATORY                      SERVICES – TESTS FOR                      DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

(continued)

**PLAN D**  
**PARTS A & B**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE</b> MEDICARE APPROVED SERVICES			
— Medically necessary skilled care services and medical supplies	100%	\$0	\$0
— Durable medical equipment			
First \$[135] of Medicare Approved Amounts*	\$0	\$0	\$[135] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

**OTHER BENEFITS – NOT COVERED BY MEDICARE**

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

**PLAN F**

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

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

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 <sup>st</sup> thru 90 <sup>th</sup> day 91 <sup>st</sup> day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the additional 365 days	All but \$[1100] All but \$[275] a day  All but \$[550] a day  \$0  \$0	\$[1100] (Part A deductible) \$[275] a day  \$[550] a day  100% of Medicare eligible expenses  \$0	\$0 \$0  \$0  \$0**  All costs
<b>SKILLED NURSING FACILITY CARE*</b> 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 21 <sup>st</sup> thru 100 <sup>th</sup> day 101 <sup>st</sup> day and after	All approved amounts All but \$[137.50] a day \$0	\$0 Up to \$[137.50] a day \$0	\$0 \$0 All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> You must meet Medicare’s requirements, including a doctor’s certification of terminal illness.	All but very limited co-payment/ coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/coinsurance	\$0

(continued)

\*\***NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to 365 days as provided in the policy’s “Core Benefits.” During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

**PLAN F**

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

\*Once you have been billed \$[155] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>MEDICAL EXPENSES –</b> IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$[155] of Medicare Approved Amounts*	\$0	\$[155] (Part B deductible)	\$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
<b>PART B EXCESS CHARGES</b> (Above Medicare Approved Amounts)	\$0	100%	\$0
<b>BLOOD</b> First 3 pints	\$0	All costs	\$0
Next \$[155] of Medicare Approved amounts*	\$0	\$[155] (Part B deductible)	\$0
Remainder of Medicare Approved amounts	80%	20%	\$0
<b>CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

(continued)

**PLAN F**  
**PARTS A & B**

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

**OTHER SERVICES – NOT COVERED BY MEDICARE**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</b>			
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
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 <sup>st</sup> thru 90 <sup>th</sup> day 91 <sup>st</sup> day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the additional 365 days	All but \$[1100] All but \$[275] a day  All but \$[550] a day  \$0  \$0	\$[1100] (Part A deductible) \$[275] a day  \$[550] a day  100% of Medicare eligible expenses  \$0	\$0 \$0  \$0  \$0**  All costs
<b>SKILLED NURSING FACILITY CARE*</b> 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 21 <sup>st</sup> thru 100 <sup>th</sup> day 101 <sup>st</sup> day and after	All approved amounts All but \$[137.50] a day \$0	\$0 Up to \$[137.50] a day \$0	\$0 \$0 All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/ coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/coinsurance	\$0

\*\***NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

**PLAN G**

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

\*Once you have been billed \$[155] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>MEDICAL EXPENSES –</b> IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$[155] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0  Generally 80%	\$0  Generally 20%	\$[155] (Part B deductible)  \$0
<b>PART B EXCESS CHARGES</b> (Above Medicare Approved Amounts)	\$0	100%	\$0
<b>BLOOD</b> First 3 pints Next \$[155] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$[155] (Part B deductible) \$0
<b>CLINICAL LABORATORY</b> <b>SERVICES – TESTS FOR</b> <b>DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

(continued)

**PLAN G  
PARTS A & B**

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

**OTHER BENEFITS – NOT COVERED BY MEDICARE**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</b>			
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



**Royal Neighbors of America  
Outline of Medicare Supplement Coverage  
Benefit Plans A, F and G**

**Benefit Chart of Medicare Supplement Plans Sold for Effective Dates on or After June 1, 2010**

These charts show the benefits included in each of the standard Medicare supplement plans. Every company must make available Plan “A”. Some plans may not be available in your state. [Plans E, H, I and J are no longer available for sale.]

**Basic Benefits:**

- **Hospitalization-** Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
- **Medical Expenses-** Part B coinsurance (generally 20% of Medicare-approved expenses) or copayments for hospital outpatient services. Plans K, L and N require insureds to pay a portion of Part B coinsurance or copayments.
- **Blood-** First three pints of blood each year.
- **Hospice -** Part A coinsurance

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

\*Plan F also has an option called a high deductible Plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year \$[2000] deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses are \$[2000]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the Policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan’s separate foreign travel emergency deductible.

Effective [June 1, 2010]

ROYAL NEIGHBORS OF AMERICA  
ANNUAL PREMIUM RATES

[ ]  
RATES

Semi-Annual  
0.5000

Quarterly  
0.2500

Monthly  
0.0833

## **PREMIUM INFORMATION**

Royal Neighbors of America may change your premium on any premium due date if a new table of rates is applicable to the certificate. The change in the table of rates will apply to all covered persons in the same class. Class is defined as underwriting class, state, plan and zip code of residence.

## **DISCLOSURES**

Use this outline to compare benefits and premiums among policies.

**[This outline shows benefits and premiums of certificates sold for effective dates on or after June 1, 2010. Certificates sold for effective dates prior to June 1, 2010 have different benefits and premiums. Plans E, H, I, and J are no longer available for sale. ]**

## **READ YOUR CERTIFICATE VERY CAREFULLY**

This is only an outline describing your certificate's most important features. The certificate is your insurance contract. You must read the certificate itself to understand all of the rights and duties of both you and Royal Neighbors of America.

## **RIGHT TO RETURN CERTIFICATE**

If you find that you are not satisfied with your certificate, you may return it to: Royal Neighbors of America, Medicare Supplement Administration, [P.O. Box 10851, Clearwater, Florida 33757-8851.] If you send the certificate back to us within 30 days after you receive it, we will treat the certificate as if it had never been issued and return all of your payments.

## **POLICY OR CERTIFICATE REPLACEMENT**

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

## **NOTICE**

This certificate may not fully cover all of your medical costs. Neither Royal Neighbors 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 *Medicare and You* for more details.

## **COMPLETE ANSWERS ARE VERY IMPORTANT**

When you fill out the application for the new certificate, be sure to answer truthfully and completely all questions about your medical and health history. Royal Neighbors of America may cancel your certificate and refuse to pay any claims if you leave out or falsify important medical information.

**Review the application carefully before you sign it. Be certain that all information has been properly recorded.**

**Please refer to your certificate for details.**

**PLAN A**

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days  61 <sup>st</sup> thru 90 <sup>th</sup> day 91 <sup>st</sup> day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days  — Beyond the additional 365 days	All but \$[1068]  All but \$[267] a day  All but \$[534] a day  \$0  \$0	\$0  \$[267] a day  \$[534] a day  100% of Medicare eligible expenses \$0	\$[1068] (Part A deductible) \$0  \$0  \$0**  All costs
<b>SKILLED NURSING FACILITY CARE*</b> 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 21 <sup>st</sup> thru 100 <sup>th</sup> day 101 <sup>st</sup> day and after	All approved amounts All but \$[133.50] a day \$0	\$0 \$0 \$0	\$0 Up to \$[133.50] a day All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> You must meet Medicare’s requirements, including a doctor’s certification of terminal illness.	All but very limited co-payment/ coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/coinsurance	\$0

**\*\*NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to 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 \$[135] 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.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>MEDICAL EXPENSES –</b> 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 \$[135] of Medicare Approved Amounts*	\$0	\$0	\$[135] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
<b>PART B EXCESS CHARGES</b> (Above Medicare Approved Amounts)	\$0	\$0	All costs
<b>BLOOD</b> First 3 pints	\$0	All costs	\$0
Next \$[135] of Medicare Approved Amounts*	\$0	\$0	\$[135] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
<b>CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

**PARTS A & B**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>HOME HEALTH CARE</b> MEDICARE APPROVED SERVICES — Medically necessary skilled care services and medical supplies	100%	\$0	\$0
— Durable medical equipment First \$[135] of Medicare Approved Amounts*	\$0	\$0	\$[135] (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.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 <sup>st</sup> thru 90 <sup>th</sup> day 91 <sup>st</sup> day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the additional 365 days	All but \$[1068] All but \$[267] a day All but \$[534] a day \$0 \$0	\$[1068] (Part A deductible) \$[267] a day \$[534] a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$0 \$0** All costs
<b>SKILLED NURSING FACILITY CARE*</b> 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 21 <sup>st</sup> thru 100 <sup>th</sup> day 101 <sup>st</sup> day and after	All approved amounts All but \$[133.50] a day \$0	\$0 Up to \$[133.50] a day \$0	\$0 \$0 All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> You must meet Medicare’s requirements, including a doctor’s certification of terminal illness.	All but very limited co-payment/ coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/coinsurance	\$0

(continued)

**\*\*NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to 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 \$[135] 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.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>MEDICAL EXPENSES –</b> 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 \$[135] of Medicare Approved Amounts*	\$0	\$[135] (Part B deductible)	\$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
<b>PART B EXCESS CHARGES</b> (Above Medicare Approved Amounts)	\$0	100%	\$0
<b>BLOOD</b> First 3 pints	\$0	All costs	\$0
Next \$[135] of Medicare Approved amounts*	\$0	\$[135] (Part B deductible)	\$0
Remainder of Medicare Approved amounts	80%	20%	\$0
<b>CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

(continued)

**PLAN F**  
**PARTS A & B**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE</b> MEDICARE APPROVED SERVICES			
— Medically necessary skilled care services and medical supplies	100%	\$0	\$0
— Durable medical equipment			
First \$[135] of Medicare Approved Amounts*	\$0	\$[135] (Part B deductible)	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0

**OTHER SERVICES – NOT COVERED BY MEDICARE**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</b>			
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
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 <sup>st</sup> thru 90 <sup>th</sup> day 91 <sup>st</sup> day and after: — While using 60 lifetime reserve days — Once lifetime reserve days are used: — Additional 365 days — Beyond the additional 365 days	All but \$[1068] All but \$[267] a day  All but \$[534] a day  \$0  \$0	\$[1068] (Part A deductible) \$[267] a day  \$[534] a day  100% of Medicare eligible expenses  \$0	\$0 \$0  \$0  \$0**  All costs
<b>SKILLED NURSING FACILITY CARE*</b> 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 21 <sup>st</sup> thru 100 <sup>th</sup> day 101 <sup>st</sup> day and after	All approved amounts All but \$[133.50] a day \$0	\$0 Up to \$[133.50] a day \$0	\$0 \$0 All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/ coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/coinsurance	\$0

\*\***NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to 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 \$[135] 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.

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>MEDICAL EXPENSES –</b> 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 \$[135] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0  Generally 80%	\$0  Generally 20%	\$[135] (Part B deductible)  \$0
<b>PART B EXCESS CHARGES</b> (Above Medicare Approved Amounts)	\$0	100%	\$0
<b>BLOOD</b> First 3 pints Next \$[135] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$[135] (Part B deductible) \$0
<b>CLINICAL LABORATORY</b> <b>SERVICES – TESTS FOR</b> <b>DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

(continued)

**PLAN G  
PARTS A & B**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>HOME HEALTH CARE MEDICARE APPROVED SERVICES</b>			
— Medically necessary skilled care services and medical supplies	100%	\$0	\$0
— Durable medical equipment			
First \$[135] of Medicare Approved Amounts*	\$0	\$0	[\$135] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

**OTHER BENEFITS – NOT COVERED BY MEDICARE**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>PLAN PAYS</b>	<b>YOU PAY</b>
<b>FOREIGN TRAVEL – NOT COVERED BY MEDICARE</b>			
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