MEDICO®
LIFE AND HEALTH INSURANCE COMPANY

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Outline of Medicare Supplement Plan Benefits
Available Plans: A, F, HdF[1], G, HdG[1], and N

This chart shows the benefits included in each of the standard Medicare Supplement plans. Every company must make Plan "A" available. Some plans may not be available in your state. **Only applicants first eligible for Medicare before 2020 may purchase Plans C, F, and High Deductible F.**

A ✓ means 100% of the benefit is paid. Highlighted plans are available from Medico Life and Health Insurance Company.

Benefits	Plans Available to All Applicants								Medicare first eligible before 2020 only	
	A	B	D	G[1]	K	L	M	N	C	F[1]
Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Medicare Part B coinsurance or copayment	✓	✓	✓	✓	50%	75%	✓	✓ copays apply[3]	✓	✓
Blood (first three pints)	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Part A hospice care coinsurance or copayment	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Skilled nursing facility coinsurance			✓	✓	50%	75%	✓	✓	✓	✓
Medicare Part A deductible		✓	✓	✓	50%	75%	50%	✓	✓	✓
Medicare Part B deductible									✓	✓
Medicare Part B excess charges				✓						✓
Foreign travel emergency (up to plan limits)			✓	✓			✓	✓	✓	✓
Out-of-pocket limit in 2023[2]					$6,940	$3,470				

[1] Plans F and G also have a high deductible option which require first paying a plan deductible of $2,700 before the plan begins to pay. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High deductible plan G does not cover the Medicare Part B deductible. However, high deductible plans F and G count your payment of the Medicare Part B deductible toward meeting the plan deductible.

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

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

Premium Information

We, Medico Life and Health Insurance Company, guarantee to renew your policy for life as long as the premium is paid when due.

We can only raise your premium if we raise the premium for all policies like yours in this state. If it is necessary to change the premium for your policy, we will notify you 30 days in advance of the change in premium. Premiums are based on your attained age.

Household Premium Discount

Although these policy types are issued individually, when you live in the same household with another person who is age 50 or older, regardless of whether they sign up for coverage with us, a discount is applied to your premium rates.

Disclosures

Use this outline to compare benefits and premiums among policies.

Read Your Policy Very Carefully

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

Right To Return Policy

When you receive your policy, please review it along with the attached application. If you find that you are not satisfied with your policy, you may return it to us at PO Box 10386, Des Moines, IA 50306. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments, less any claims paid.

Policy Replacement

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

Notice

This policy may not fully cover all of your medical costs.

Neither Medico Life and Health Insurance Company nor its producers 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 policy, be sure to answer truthfully and completely all questions about your medical and health history. The Company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information. Medical and health history questions are not required to be answered on the application if you apply during Open Enrollment or if you are eligible for a Guaranteed Issue.

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

PLAN A

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,600	$0	$1,600 (Part A deductible)
61st thru 90th day	All but $400 a day	$400 a day	$0
91st day and after: • While using 60 lifetime reserve days	All but $800 a day	$800 a day	$0
• Once lifetime reserve days are used: • Additional 365 days	$0	100% of Medicare Eligible expenses	$0**
• Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare Approved Facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $200 a day	$0	Up to $200 a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a physician's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

* 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.

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

PLAN A (continued)

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $226 of Medicare Approved Amounts* (Part B deductible)	$0	$0	$226 (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES			
Above Medicare Approved Amounts	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $226 of Medicare Approved Amounts* (Part B deductible)	$0	$0	$226 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES			
Tests for Diagnostic Services	100%	$0	$0

MEDICARE (PARTS A AND B) - HOME HEALTH CARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE - MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
• First $226 of Medicare Approved Amounts*	$0	$0	$226 (Part B deductible)
• Remainder of Medicare Approved Amounts	80%	20%	$0

* Once you have been billed for $226 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.

PLAN F

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,600	$1,600 (Part A deductible)	$0
61st thru 90th day	All but $400 a day	$400 a day	$0
91st day and after: • While using 60 lifetime reserve days	All but $800 a day	$800 a day	$0
• Once lifetime reserve days are used: • Additional 365 days	$0	100% of Medicare Eligible expenses	$0**
• Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare Approved Facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $200 a day	Up to $200 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a physician's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

* 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.

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

PLAN F (continued)

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT Such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $226 of Medicare Approved Amounts* (Part B deductible)	$0	$226 (Part B deductible)	$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES			
Above Medicare Approved Amounts	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $226 of Medicare Approved Amounts* (Part B deductible)	$0	$226 (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES			
Tests for Diagnostic Services	100%	$0	$0

MEDICARE (PARTS A AND B) - HOME HEALTH CARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE - MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
• First $226 of Medicare Approved Amounts*	$0	$226 (Part B deductible)	$0
• Remainder of Medicare Approved Amounts	80%	20%	$0

* Once you have been billed for $226 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.

PLAN F (continued)

OTHER BENEFITS - NOT COVERED BY MEDICARE

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

HIGH DEDUCTIBLE PLAN F

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

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,700 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2,700 DEDUCTIBLE** YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,600	$1,600 (Part A deductible)	$0
61st thru 90th day	All but $400 a day	$400 a day	$0
91st day and after: • While using 60 lifetime reserve days	All but $800 a day	$800 a day	$0
• Once lifetime reserve days are used: • Additional 365 days	$0	100% of Medicare Eligible expenses	$0***
• Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare Approved Facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $200 a day	Up to $200 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a physician's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

* 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.

** This high deductible plan pays the same benefits as Plan F after you have paid a calendar year $2,700 deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are $2,700. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

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

HIGH DEDUCTIBLE PLAN F (continued)

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

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,700 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2,700 DEDUCTIBLE** YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT Such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $226 of Medicare Approved Amounts* (Part B deductible)	$0	$226 (Part B deductible)	$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES			
Above Medicare Approved Amounts	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $226 of Medicare Approved Amounts* (Part B deductible)	$0	$226 (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES			
Tests for Diagnostic Services	100%	$0	$0

MEDICARE (PARTS A AND B) - HOME HEALTH CARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,700 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2,700 DEDUCTIBLE** YOU PAY
HOME HEALTH CARE - MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
• First $226 of Medicare Approved Amounts*	$0	$226 (Part B deductible)	$0
• Remainder of Medicare Approved Amounts	80%	20%	$0

* Once you have been billed for $226 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.

** This high deductible plan pays the same benefits as Plan F after you have paid a calendar year $2,700 deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are $2,700. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

HIGH DEDUCTIBLE PLAN F (continued)

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,700 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2,700 DEDUCTIBLE** YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a Lifetime Maximum Benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

** This high deductible plan pays the same benefits as Plan F after you have paid a calendar year $2,700 deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are $2,700. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

PLAN G

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,600	$1,600 (Part A deductible)	$0
61st thru 90th day	All but $400 a day	$400 a day	$0
91st day and after: • While using 60 lifetime reserve days	All but $800 a day	$800 a day	$0
• Once lifetime reserve days are used: • Additional 365 days	$0	100% of Medicare Eligible expenses	$0**
• Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare Approved Facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $200 a day	Up to $200 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a physician's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

* 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.

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

PLAN G (continued)

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT Such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $226 of Medicare Approved Amounts* (Part B deductible)	$0	$0	$226 (Unless Part B deductible has been met)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES			
Above Medicare Approved Amounts	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $226 of Medicare Approved Amounts* (Part B deductible)	$0	$0	$226 (Unless Part B deductible has been met)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES			
Tests for Diagnostic Services	100%	$0	$0

MEDICARE (PARTS A AND B) - HOME HEALTH CARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE - MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
• First $226 of Medicare Approved Amounts*	$0	$0	$226 (Unless Part B deductible has been met)
• Remainder of Medicare Approved Amounts	80%	20%	$0

* Once you have been billed for $226 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.

PLAN G (continued)

OTHER BENEFITS - NOT COVERED BY MEDICARE

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

HIGH DEDUCTIBLE PLAN G

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

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,700 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2,700 DEDUCTIBLE** YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,600	$1,600 (Part A deductible)	$0
61st thru 90th day	All but $400 a day	$400 a day	$0
91st day and after: • While using 60 lifetime reserve days	All but $800 a day	$800 a day	$0
• Once lifetime reserve days are used: • Additional 365 days	$0	100% of Medicare Eligible expenses	$0***
• Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare Approved Facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $200 a day	Up to $200 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a physician's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

* 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.

** This high deductible plan pays the same benefits as Plan G after you have paid a calendar year $2,700 deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are $2,700. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.

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

HIGH DEDUCTIBLE PLAN G (continued)

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

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,700 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2,700 DEDUCTIBLE** YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT Such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $226 of Medicare Approved Amounts* (Part B deductible)	$0	$0	$ 226 (Unless Part B deductible has been met)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES			
Above Medicare Approved Amounts	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $226 of Medicare Approved Amounts* (Part B deductible)	$0	$0	$226 (Unless Part B deductible has been met)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES			
Tests for Diagnostic Services	100%	$0	$0

* Once you have been billed for $226 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.

** This high deductible plan pays the same benefits as Plan G after you have paid a calendar year $2,700 deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are $2,700. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.

HIGH DEDUCTIBLE PLAN G (continued)

MEDICARE (PARTS A AND B) - HOME HEALTH CARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,700 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2,700 DEDUCTIBLE** YOU PAY
HOME HEALTH CARE - MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
• First $226 of Medicare Approved Amounts*	$0	$0	$226 (Unless Part B deductible has been met)
• Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,700 DEDUCTIBLE** PLAN PAYS	IN ADDITION TO $2,700 DEDUCTIBLE** YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a Lifetime Maximum Benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

* Once you have been billed for $226 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.

** This high deductible plan pays the same benefits as Plan G after you have paid a calendar year $2,700 deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are $2,700. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.

PLAN N

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,600	$1,600 (Part A deductible)	$0
61st thru 90th day	All but $400 a day	$400 a day	$0
91st day and after: • While using 60 lifetime reserve days	All but $800 a day	$800 a day	$0
• Once lifetime reserve days are used: • Additional 365 days	$0	100% of Medicare Eligible expenses	$0**
• Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare Approved Facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $200 a day	Up to $200 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a physician's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

* 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.

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

PLAN N (continued)

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $226 of Medicare Approved Amounts* (Part B deductible)	$0	$0	$226 (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Balance, other than up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if you are admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if you are admitted to any hospital and the emergency visit is covered as a Medicare Part A expense
PART B EXCESS CHARGES			
Above Medicare Approved Amounts	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $226 of Medicare Approved Amounts* (Part B deductible)	$0	$0	$226 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES			
Tests for Diagnostic Services	100%	$0	$0

* Once you have been billed for $226 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.

PLAN N (continued)

MEDICARE (PARTS A AND B) - HOME HEALTH CARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE - MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
• First $226 of Medicare Approved Amounts*	$0	$0	$226 (Part B deductible)
• Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS - NOT COVERED BY MEDICARE

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

* Once you have been billed for $226 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.

MEDICO®
LIFE AND HEALTH INSURANCE COMPANY

Illinois

Medicare Supplement Rates

Plans A, F, HdF, G, HdG, and N

Effective 5-1-2022

38 114 5360 1 0822 IL

How to calculate the premium

Utilize QuickQuote.myenroller.com or the worksheet below to calculate the premium.

Step 1: Find the monthly base premium rate
Find the monthly premium rate on the following tables based on the plan, applicant's age, gender, and ZIP code. Write the monthly base premium rate on line 1 below.

Step 2: Determine the rate class
Write 1.25 on line 2 below for all applicants who use tobacco.

Write 1 on line 2 below for applicants in an open enrollment or guaranteed issue period who don't use tobacco.

Use the height and weight chart on page 3 to determine the rate class and factor for all other applicants who don't use tobacco. Write the rate factor on line 2 below.

Step 3: Household discount factor
If the applicant lives in the same household with another person age 50 or older, regardless of whether both sign up for coverage with Medico Life and Health Insurance Company, a discount is applied to the premium rates. Write 0.9 on line 3 below if the applicant is eligible for the household discount. Write 1 on line 3 below if the applicant is not eligible for the household discount.

Step 4: Find the mode factor
Determine the mode factor for the method of premium payment requested by the applicant. Write the mode factor on line 4 below.

Note: If a method of premium payment is not listed here, it is not available.

Mode factors	
Monthly via automatic bank withdrawal	1
Quarterly via automatic bank withdrawal	3
Semi-annually via automatic bank withdrawal	6
Annually via automatic bank withdrawal	12
Monthly via credit or debit card	1.032
Quarterly via credit or debit card	3.096
Semi-annually via credit or debit card	6.18
Annually via credit or debit card	12.36

Step 5: Calculate the premium

Multiply to determine the premium and round to the nearest cent:

$ _____ X _____ X _____ X _____ = $ _____

Line 1 Monthly base premium rate	Line 2 Rate class factor	Line 3 Household discount factor	Line 4 Mode factor	Final premium

Please note: Due to rounding, premium amounts you calculate may differ by a few cents from the final premium.

Height and weight chart

Find the applicant's height in the left column then find their weight in that row. The rate class and factor are shown at the top and bottom of the column.

Rate class →	Decline	Preferred	Standard I	Standard II	Decline
Rate factor →	N/A	1	1.1	1.25	N/A
Height	Weight				
4'5"	<71	72–119	120–149	150–179	>180
4'6"	<74	75–124	125–155	156–186	>187
4'7"	<77	78–128	129–161	162–193	>194
4'8"	<79	80–133	134–167	168–200	>201
4'9"	<82	83–138	139–173	174–207	>208
4'10"	<85	86–143	144–179	180–215	>216
4'11"	<88	89–148	149–185	186–222	>223
5'	<92	93–153	154–192	193–230	>231
5'1"	<94	95–158	159–198	199–238	>239
5'2"	<97	98–163	164–205	206–246	>247
5'3"	<101	102–168	169–211	212–254	>255
5'4"	<104	105–174	175–218	219–262	>263
5'5"	<107	108–179	180–225	226–270	>271
5'6"	<110	111–185	186–232	233–278	>279
5'7"	<114	115–190	191–239	240–287	>288
5'8"	<117	118–196	197–246	247–295	>296
5'9"	<121	122–202	203–253	254–304	>305
5'10"	<124	125–208	209–261	262–313	>314
5'11"	<128	129–214	215–268	269–322	>323
6'	<132	133–220	221–276	277–331	>332
6'1"	<135	136–226	227–284	285–341	>342
6'2"	<139	140–232	233–291	292–350	>351
6'3"	<143	144–239	240–299	300–359	>360
6'4"	<146	147–245	246–307	308–369	>370
6'5"	<150	151–251	252–316	317–379	>380
6'6"	<154	155–258	259–324	325–389	>390
6'7"	<158	159–265	266–332	333–399	>400
6'8"	<162	163–271	272–341	342–409	>410
6'9"	<166	167–278	279–349	350–419	>420
6'10"	<171	172–285	286–358	359–430	>431
6'11"	<175	176–292	293–367	368–441	>442
7'	<179	180–299	300–376	377–451	>452
Rate class →	Decline	Preferred	Standard I	Standard II	Decline
Rate factor →	N/A	1	1.1	1.25	N/A

Illinois

ZIP codes: 611, 615–617, 627
Monthly base rates

Effective May 1, 2022

Female							Male					
Plan A	Plan F	Plan HdF	Plan G	Plan HdG	Plan N	Attained Age	Plan A	Plan F	Plan HdF	Plan G	Plan HdG	Plan N
277.30	361.24	108.37	323.48	102.95	272.69	Under 65	311.97	406.40	121.92	363.91	115.82	306.78
106.26	120.13	36.04	99.23	34.24	77.07	65-68	119.54	135.15	40.55	111.63	38.52	86.70
107.21	121.02	36.31	100.41	34.49	78.00	69	120.61	136.15	40.84	112.96	38.80	87.75
109.21	122.97	36.89	102.43	35.05	80.32	70	122.86	138.34	41.50	115.24	39.43	90.36
112.47	126.89	38.07	106.07	36.16	83.67	71	126.53	142.76	42.83	119.33	40.69	94.13
115.74	130.81	39.24	109.70	37.28	87.02	72	130.20	147.17	44.15	123.41	41.94	97.89
119.00	134.74	40.42	113.33	38.40	90.36	73	133.87	151.58	45.47	127.50	43.20	101.66
122.26	138.66	41.60	116.97	39.52	93.99	74	137.54	155.99	46.80	131.59	44.46	105.74
126.53	143.72	43.12	121.75	40.96	97.45	75	142.35	161.68	48.50	136.97	46.08	109.63
131.53	150.26	45.08	127.64	42.83	102.44	76	147.97	169.05	50.71	143.60	48.18	115.24
136.69	157.05	47.12	133.77	44.76	107.61	77	153.78	176.68	53.01	150.49	50.35	121.06
142.04	164.09	49.23	140.13	46.77	112.96	78	159.80	184.60	55.38	157.65	52.61	127.09
147.58	171.39	51.42	146.74	48.85	118.52	79	166.03	192.82	57.84	165.09	54.95	133.33
153.30	178.96	53.69	153.61	51.00	124.27	80	172.47	201.33	60.40	172.81	57.38	139.81
160.22	188.59	56.58	162.27	53.75	135.42	81	180.25	212.17	63.65	182.55	60.47	152.34
167.27	198.49	59.55	171.36	56.57	142.91	82	188.18	223.30	66.99	192.78	63.64	160.77
174.62	208.86	62.66	180.90	59.52	150.74	83	196.45	234.96	70.49	203.51	66.96	169.58
182.28	219.70	65.91	190.91	62.62	158.93	84	205.07	247.17	74.15	214.78	70.44	178.80
190.27	231.06	69.32	201.43	65.85	167.49	85	214.05	259.94	77.98	226.60	74.08	188.43
197.79	241.89	72.57	211.47	68.94	175.44	86	222.51	272.13	81.64	237.90	77.56	197.37
205.61	253.20	75.96	221.98	72.16	183.74	87	231.31	284.85	85.46	249.73	81.18	206.70
213.73	265.01	79.50	232.98	75.53	192.38	88	240.44	298.14	89.44	262.10	84.97	216.43
222.17	277.34	83.20	244.49	79.04	201.39	89	249.94	312.00	93.60	275.05	88.92	226.56
229.13	287.93	86.38	254.29	82.06	209.54	90	257.78	323.93	97.18	286.08	92.32	235.73
235.59	298.22	89.47	263.80	84.99	217.35	91	265.03	335.50	100.65	296.77	95.62	244.52
240.55	306.73	92.02	273.64	87.42	225.20	92	270.62	345.07	103.52	307.84	98.34	253.35
245.62	315.46	94.64	281.87	89.91	232.85	93	276.33	354.89	106.47	317.10	101.14	261.96
250.80	324.41	97.32	290.33	92.46	240.73	94	282.15	364.97	109.49	326.62	104.02	270.83
256.09	333.60	100.08	298.73	95.08	248.86	95	288.10	375.30	112.59	336.07	106.96	279.97
261.23	340.31	102.09	304.73	96.99	254.61	96	293.89	382.85	114.85	342.82	109.11	286.44
266.48	347.15	104.14	310.85	98.94	260.50	97	299.79	390.54	117.16	349.71	111.30	293.07
271.84	354.13	106.24	317.10	100.93	266.53	98	305.82	398.39	119.52	356.74	113.54	299.84
277.30	361.24	108.37	323.48	102.95	272.69	99	311.97	406.40	121.92	363.91	115.82	306.78

Note: These are the monthly base rates. Please refer to the "How to calculate the premium" instructions on page 2.

Illinois

ZIP codes: 600–608
Monthly base rates

Effective May 1, 2022

Female							Male					
Plan A	Plan F	Plan HdF	Plan G	Plan HdG	Plan N	Attained Age	Plan A	Plan F	Plan HdF	Plan G	Plan HdG	Plan N
308.50	401.88	120.57	359.87	114.54	303.37	Under 65	347.06	452.12	135.64	404.85	128.85	341.29
118.21	133.65	40.10	110.39	38.09	85.74	65-68	132.99	150.36	45.11	124.19	42.85	96.45
119.27	134.63	40.39	111.71	38.37	86.77	69	134.17	151.46	45.44	125.67	43.17	97.62
121.49	136.81	41.04	113.96	38.99	89.35	70	136.68	153.91	46.17	128.20	43.86	100.52
125.12	141.17	42.35	118.00	40.23	93.08	71	140.76	158.82	47.64	132.75	45.26	104.71
128.76	145.53	43.66	122.04	41.48	96.80	72	144.85	163.72	49.12	137.30	46.66	108.91
132.39	149.89	44.97	126.08	42.72	100.53	73	148.93	168.63	50.59	141.85	48.06	113.10
136.02	154.26	46.28	130.13	43.96	104.57	74	153.02	173.54	52.06	146.39	49.46	117.64
140.76	159.89	47.97	135.44	45.57	108.41	75	158.36	179.87	53.96	152.37	51.26	121.96
146.32	167.17	50.15	142.00	47.64	113.96	76	164.61	188.06	56.42	159.75	53.60	128.20
152.07	174.72	52.42	148.82	49.80	119.71	77	171.08	196.56	58.97	167.42	56.02	134.67
158.02	182.55	54.77	155.90	52.03	125.67	78	177.78	205.37	61.61	175.39	58.53	141.38
164.18	190.67	57.20	163.25	54.34	131.85	79	184.70	214.51	64.35	183.66	61.13	148.33
170.55	199.09	59.73	170.89	56.74	138.26	80	191.87	223.98	67.19	192.25	63.83	155.54
178.24	209.81	62.94	180.52	59.80	150.65	81	200.53	236.03	70.81	203.09	67.27	169.48
186.09	220.82	66.25	190.63	62.93	158.98	82	209.35	248.42	74.53	214.46	70.80	178.86
194.27	232.35	69.71	201.25	66.22	167.70	83	218.55	261.40	78.42	226.41	74.50	188.66
202.79	244.42	73.33	212.39	69.66	176.81	84	228.14	274.97	82.49	238.94	78.37	198.91
211.67	257.05	77.12	224.09	73.26	186.33	85	238.13	289.18	86.75	252.10	82.42	209.63
220.04	269.10	80.73	235.26	76.70	195.18	86	247.55	302.74	90.82	264.66	86.28	219.58
228.74	281.69	84.51	246.95	80.28	204.41	87	257.33	316.90	95.07	277.82	90.32	229.96
237.77	294.82	88.45	259.19	84.02	214.02	88	267.49	331.68	99.50	291.59	94.53	240.77
247.16	308.54	92.56	272.00	87.93	224.04	89	278.06	347.10	104.13	306.00	98.92	252.05
254.91	320.33	96.10	282.90	91.29	233.11	90	286.78	360.37	108.11	318.26	102.71	262.25
262.09	331.77	99.53	293.47	94.56	241.80	91	294.85	373.24	111.97	330.16	106.37	272.03
267.61	341.24	102.37	304.42	97.25	250.54	92	301.07	383.89	115.17	342.47	109.41	281.85
273.26	350.95	105.28	313.58	100.02	259.05	93	307.41	394.82	118.44	352.78	112.52	291.43
279.01	360.91	108.27	322.99	102.86	267.82	94	313.89	406.02	121.81	363.37	115.72	301.29
284.89	371.13	111.34	332.33	105.77	276.85	95	320.51	417.52	125.26	373.87	118.99	311.46
290.62	378.59	113.58	339.01	107.90	283.26	96	326.95	425.92	127.78	381.39	121.39	318.66
296.46	386.20	115.86	345.83	110.07	289.81	97	333.52	434.48	130.34	389.05	123.83	326.04
302.42	393.97	118.19	352.78	112.28	296.51	98	340.22	443.21	132.96	396.87	126.31	333.58
308.50	401.88	120.57	359.87	114.54	303.37	99	347.06	452.12	135.64	404.85	128.85	341.29

Note: These are the monthly base rates. Please refer to the "How to calculate the premium" instructions on page 2.

Illinois

All other ZIP codes
Monthly base rates

Effective May 1, 2022

Female							Male					
Plan A	Plan F	Plan HdF	Plan G	Plan HdG	Plan N	Attained Age	Plan A	Plan F	Plan HdF	Plan G	Plan HdG	Plan N
346.63	451.56	135.47	404.35	128.69	340.87	Under 65	389.96	508.00	152.40	454.89	144.78	383.47
132.82	150.17	45.05	124.04	42.80	96.33	65-68	149.43	168.94	50.68	139.54	48.15	108.38
134.01	151.27	45.38	125.52	43.11	97.50	69	150.76	170.18	51.06	141.21	48.50	109.69
136.51	153.72	46.12	128.04	43.81	100.40	70	153.57	172.93	51.88	144.05	49.29	112.95
140.59	158.62	47.59	132.58	45.21	104.58	71	158.16	178.44	53.53	149.16	50.86	117.66
144.67	163.52	49.06	137.13	46.60	108.77	72	162.75	183.96	55.19	154.27	52.43	122.37
148.75	168.42	50.53	141.67	48.00	112.95	73	167.34	189.47	56.84	159.38	54.00	127.07
152.83	173.32	52.00	146.21	49.40	117.49	74	171.93	194.99	58.50	164.49	55.57	132.18
158.16	179.65	53.89	152.18	51.20	121.81	75	177.93	202.10	60.63	171.21	57.60	137.04
164.41	187.83	56.35	159.55	53.53	128.05	76	184.96	211.31	63.39	179.50	60.22	144.05
170.87	196.32	58.89	167.21	55.95	134.51	77	192.23	220.85	66.26	188.11	62.94	151.32
177.55	205.12	61.53	175.17	58.46	141.21	78	199.75	230.76	69.23	197.06	65.77	158.86
184.47	214.24	64.27	183.43	61.06	148.15	79	207.53	241.02	72.31	206.36	68.69	166.67
191.63	223.70	67.11	192.01	63.76	155.34	80	215.59	251.66	75.50	216.01	71.72	174.76
200.28	235.74	70.72	202.83	67.19	169.27	81	225.31	265.21	79.56	228.19	75.58	190.43
209.09	248.12	74.43	214.20	70.71	178.63	82	235.23	279.13	83.74	240.97	79.55	200.96
218.28	261.07	78.32	226.12	74.41	188.43	83	245.56	293.70	88.11	254.39	83.71	211.98
227.85	274.63	82.39	238.64	78.27	198.66	84	256.34	308.96	92.69	268.47	88.05	223.50
237.83	288.82	86.65	251.78	82.31	209.36	85	267.56	324.93	97.48	283.25	92.60	235.54
247.24	302.37	90.71	264.33	86.17	219.31	86	278.14	340.16	102.05	297.38	96.95	246.72
257.01	316.50	94.95	277.47	90.20	229.67	87	289.13	356.07	106.82	312.16	101.48	258.38
267.16	331.26	99.38	291.22	94.41	240.47	88	300.56	372.67	111.80	327.63	106.21	270.53
277.71	346.67	104.00	305.61	98.80	251.73	89	312.42	390.00	117.00	343.82	111.15	283.20
286.42	359.92	107.98	317.86	102.58	261.93	90	322.22	404.91	121.47	357.60	115.40	294.67
294.48	372.78	111.83	329.75	106.24	271.69	91	331.29	419.38	125.81	370.96	119.52	305.65
300.69	383.41	115.02	342.05	109.27	281.50	92	338.28	431.34	129.40	384.80	122.93	316.69
307.03	394.32	118.30	352.34	112.38	291.06	93	345.41	443.61	133.08	396.38	126.43	327.45
313.50	405.52	121.66	362.91	115.57	300.92	94	352.69	456.21	136.86	408.28	130.02	338.53
320.11	417.00	125.10	373.41	118.85	311.07	95	360.12	469.13	140.74	420.08	133.70	349.96
326.54	425.39	127.62	380.91	121.24	318.27	96	367.36	478.56	143.57	428.53	136.39	358.05
333.10	433.94	130.18	388.57	123.67	325.63	97	374.74	488.18	146.45	437.14	139.13	366.33
339.80	442.66	132.80	396.38	126.16	333.16	98	382.27	497.99	149.40	445.93	141.93	374.81
346.63	451.56	135.47	404.35	128.69	340.87	99	389.96	508.00	152.40	454.89	144.78	383.47

Note: These are the monthly base rates. Please refer to the "How to calculate the premium" instructions on page 2.