MEDICO®
LIFE AND HEALTH INSURANCE COMPANY

Medico® Life and Health Medicare Supplement Insurance

ILLINOIS SALES KIT

PRODUCER INSTRUCTIONS

Submit applications electronically using MyEnroller:

MyEnroller
Electronic Application Submission Tool
Website: mic.GoMedico.com

If you need assistance, please call 800-547-2401, Option 3.

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LIFE AND HEALTH INSURANCE COMPANY

Medico Life and Health Insurance Company
601 Sixth Ave., Des Moines, IA 50309
P.O. Box 10386, Des Moines, IA 50306

www.GoMedico.com
Phone (toll-free): 800-228-6080

Application for Medicare Supplement Insurance

Requested effective date of new policy (optional)

_____
MM/DD/YYYY

Requested effective date must be after the application date. If no effective date is requested, the effective date will be the day the application is approved by the company.

Policy delivery

Upon approval of this application, the policy will be delivered to the applicant by mail.

Part A: Applicant information (please print)

Full name of applicant: *first, middle, last, suffix* | Date of birth (MM/DD/YYYY) | Age | Gender

Social Security number | Phone number | Email address

Residence address *(include Apt/Bldg/Unit Nbr if applicable)* | City | State | ZIP code

Mailing address *(if different than residence address)* | City | State | ZIP code

Have you used tobacco in any form, electronic cigarettes, or other nicotine products in the past 24 months? ❒ Yes ❒ No

Are you eligible for Open Enrollment? ❒ Yes ❒ No
If "Yes," skip Parts C and D.

Part B: Insurance information

If you lost other health insurance coverage and received a notice from your previous insurer that said you were eligible for guaranteed issue of a Medicare Supplement insurance policy or you had certain rights to buy such a policy, you may be guaranteed acceptance in one of Medico Life and Health's Medicare Supplement plans. Please include a copy of the notice from your previous insurer with your application.

Please answer the following questions to the best of your knowledge.

1. Please enter your Medicare claim number: _____
2. a. Are you within 6 months of your 65th birthday? ❒ Yes ❒ No
   b. Did you enroll in Medicare Part B in the last 6 months? ❒ Yes ❒ No
   c. What is your Part B effective date? _____
   d. What is your Part A effective date? _____
3. Are you covered for medical assistance through the state Medicaid program? (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 policy? ❒ Yes ❒ No
   b. Do you receive any benefits from Medicaid **other than** payments toward your Medicare Part B premium? ❒ Yes ❒ No
4. a. If you had coverage from any Medicare plan other than original Medicare within the past 63 days, such as Medicare Advantage, Medicare HMO, or Medicare PPO, provide your start and end dates. (If you are still covered under the policy, leave "End" blank.) Start: _____ End: _____
   b. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy? ❒ Yes ❒ No
   c. Was this your first time in this type of Medicare plan? ❒ Yes ❒ No
   d. Did you cancel a Medicare Supplement policy to enroll in this Medicare plan? ❒ Yes ❒ No

Part B: Insurance information (continued)

5. a. Do you have another Medicare Supplement policy in force? ❒ Yes ❒ No

   b. If "Yes," please provide the following information.

Company name Policy number Plan

   c. Do you intend to replace your current Medicare Supplement policy with this policy? ❒ Yes ❒ No

If you are replacing another Medicare or Medicare Supplement plan, please complete and submit the Notice to Applicant Regarding Replacement of Medicare Supplement Insurance or Medicare Advantage.

6. Are you eligible for guaranteed issue? ❒ Yes ❒ No

   If "Yes," please provide documentation and skip Parts C and D.

7. Have you had coverage under any other health insurance within the past 63 days (such as an employer, union, or individual plan)? ❒ Yes ❒ No

   a. If "Yes," please list the company and policy type.

Company name Policy type

   b. What are the dates of coverage under your other policy? (If you are still covered under the other policy, leave "End" blank.) Start: _____ End: _____

8. If you have lost or are losing other health insurance coverage, did you receive notice from that insurance company stating you were eligible for guaranteed issue of a Medicare Supplement insurance policy or that you had certain rights to buy a policy? (If you answered, "Yes," and you are unable to provide a termination notice, please complete all sections of this form.) ❒ Yes ❒ No

   If "No," please provide an explanation:

Part C: General health information

Note: These questions should not be answered if you apply during Open Enrollment or if you are eligible for guaranteed issue.

Please list your current height and weight. Height: _____ Weight: _____

Qualifying information

(If any answer to questions 1 through 4 is "Yes," you are not eligible for coverage.)

Please answer the following questions to the best of your knowledge.

1. Within the past 5 years, have you:
   a. Had, been treated for, or diagnosed with diabetes that required insulin, required three or more medications for control, or had complications? ❒ Yes ❒ No
   b. Had, been treated for, or advised to have a bone marrow or organ transplant? ❒ Yes ❒ No
   c. Had, been treated for, or diagnosed by a member of the medical profession with acquired immune deficiency syndrome (AIDS) or AIDS-related complex (ARC), or tested positive for human immunodeficiency virus (HIV)? ❒ Yes ❒ No
2. Within the past 24 months have you:
   a. Had, been treated for, or diagnosed with internal cancer, leukemia, melanoma, Hodgkin's disease, myeloma, or lymphoma? ❒ Yes ❒ No
   b. Had, been treated for, or diagnosed with amyotrophic lateral sclerosis (ALS), Parkinson's disease, or multiple or lateral sclerosis? ❒ Yes ❒ No
   c. Had, been treated for, or diagnosed with cirrhosis of the liver, Hepatitis B or C, chronic renal/kidney failure, or had dialysis? ❒ Yes ❒ No
   d. Had, been treated for, or diagnosed as having had a stroke or transient ischemic attack (TIA)? ❒ Yes ❒ No
   e. Had, been treated for, or diagnosed with peripheral vascular disease (poor circulation in your extremities), had angioplasty, stent placement of any vessel, bypass surgery, heart attack, heart surgery, or congestive heart failure? ❒ Yes ❒ No

Part C: General health information (continued)

f. Had, been treated for, or diagnosed with emphysema, chronic obstructive pulmonary disease (COPD), or other chronic pulmonary disease? ❒ Yes ❒ No

g. Had, been treated for, or diagnosed with a connective tissue disease (such as systemic lupus), degenerative bone disease, rheumatoid arthritis, or arthritis that is disabling? ❒ Yes ❒ No

h. Had any fractures due to osteoporosis or amputation due to disease? ❒ Yes ❒ No

i. Been or are you now bedridden or permanently confined to a wheelchair? ❒ Yes ❒ No

j. Had, been treated for, or diagnosed with schizophrenia or bipolar disease? ❒ Yes ❒ No

k. Been confined to a hospital for a mental or nervous condition? ❒ Yes ❒ No

l. Been treated for abuse of or diagnosed with addiction to alcohol, drugs, or opioids? ❒ Yes ❒ No

3. Do you have or have you been told by a medical professional that you have Alzheimer's disease, dementia, organic brain disorder, or a cognitive disorder? ❒ Yes ❒ No

4. Are you currently using oxygen? ❒ Yes ❒ No

Part D: Medical health information

Note: These questions should not be answered if you apply during Open Enrollment or if you are eligible for guaranteed issue.

If you answer "Yes" to any of the following questions, please provide details in the space allotted after question 4. If you need additional space, attach a separate page that you have signed and dated.

1. Do you require assistance or supervision to perform any of the following activities of daily living: dressing, eating, bathing, toileting (including use of a catheter), or walking (including use of a cane, walker, motorized scooter/mobility aid, or wheelchair)? ❒ Yes ❒ No
2. Has a member of the medical profession recommended that you have medical tests, treatment, therapy, or surgery, including cataract surgery or joint replacement, that has not yet been performed? ❒ Yes ❒ No
3. Have you been hospitalized within the last 60 days? Has a member of the medical profession recommended that you be hospitalized, confined to a nursing facility or assisted living facility, or received home health care within the last 60 days? Have you been hospitalized or in the emergency room three or more times within the past 24 months? ❒ Yes ❒ No
4. Have you had a seizure within the past 24 months? ❒ Yes ❒ No

Question details
(list 1, 2, 3, or 4)

Have you taken any medication in the last 12 months, including injections or infusions? ❒ Yes ❒ No

If "Yes," please provide the following information.

Medication name	Dosage	Quantity taken each time	Frequency taken	Diagnosis/Condition	Start date

Primary physician

Name of physician

Date of last visit (MM/DD/YYYY)

Office phone number

City and state

Part D: Medical health information (continued)

Specialists seen in the past 24 months

Name of physician	Specialty	Date of last visit (MM/DD/YYYY)
Name of physician	Specialty	Date of last visit (MM/DD/YYYY)

Part E: Benefit options

Choose your plan:

❒ Plan A ❒ Plan G ❒ High-deductible Plan G ❒ Plan N

If your Medicare Part A eligibility date is before Jan. 1, 2020, these additional plans are also available:

❒ Plan F ❒ High-deductible Plan F

Household Discount: Complete the following section to determine eligibility for the Household Discount. If you answer "No" to the question in this section, you are not eligible for the Household Discount. When the applicant lives in the same household with another person who is 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.

The Household Discount will be removed if the other person no longer resides with you, except in the event of the death of the other household member.

Do you live in the same household with another person who is age 50 or older? ❒ Yes ❒ No

Full name: *first, middle, last, suffix*

Method of payment:	**Frequency of payment:**			
❒ Automatic bank withdrawal	❒ Monthly	❒ Quarterly	❒ Semi-annually	❒ Annually
❒ Credit/Debit card	❒ Monthly	❒ Quarterly	❒ Semi-annually	❒ Annually

Part F: Notices

You do not need more than one Medicare Supplement policy.

If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

You may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy.

If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement policy 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 policy (or if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing Medicaid eligibility. If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but it will otherwise be substantially equivalent to your coverage before the date of the suspension.

If you are eligible for, and have enrolled in, a Medicare Supplement policy 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 policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare Supplement policy under these circumstances and later lose your employer or union-based group health plan, your suspended Medicare Supplement policy (or if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but it will otherwise be substantially equivalent to your coverage before the date of the suspension.

Counseling services may be available in your state to provide advice concerning your purchase of Medicare Supplement insurance 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).

Part G: Application agreement

I hereby apply to Medico Life and Health Insurance Company (the Company) for a **Medicare Supplement insurance policy** to be issued solely and entirely in reliance on my answers to the questions. This application will become a part of any policy to which this form is attached. If I am not applying during Open Enrollment or not eligible for guaranteed issue, I do not have a right to have this policy issued to me if I have answered "Yes" to any of questions 1 through 4 in the "General health information" part or have answered "Yes" to any of questions 1 through 4 in the "Medical health information" part. I have read, or had read to me, the complete application.

I have read and agree:

- **No insurance exists unless and until coverage is approved by the Company, the first premium is paid, and a policy is delivered.**
- The information furnished is complete, true, and correctly recorded to the best of my knowledge.
- If requested, I will complete a recorded telephone call with a Company representative as part of the underwriting process.
- No portion of the premium will be paid, during the period the policy is in force, by or on behalf of a third party (not to include an immediate family member), either directly, through wage adjustments, or other means of reimbursement.

I have received the Notice of Privacy Practices and the Outline of Coverage for the policy.

I have received a link to the Medicare Supplement Buyers Guide, "A Guide to Health Insurance for People With Medicare," on the Company website at www.GoMedico.com/products.

CAUTION: If your answers on this application are incorrect or untrue, the Company may have the right to deny benefits or rescind your policy if the misrepresentation was material to our acceptance of the risk.

NOTICE: The Company may have the right to deny benefits or rescind your policy for fraud or intentional misrepresentation of material fact on your application.

I acknowledge that in states where it is required, the producer made the necessary inquiries concerning my insurance needs and proposed a program of insurance that is suitable for my needs. I am applying for this Medicare Supplement insurance policy.

X _____

Applicant's signature Date (MM/DD/YYYY)

Part H: Producer's section

Have you personally sold any other health insurance policies to the proposed insured that are still in force OR sold any policies no longer in force in the past 5 years? ❒ Yes ❒ No

If "Yes," please list policies:

Policy type and number	In force?
	❒ Yes ❒ No
	❒ Yes ❒ No

Is the insurance applied for intended to replace any medical or health insurance coverage? ❒ Yes ❒ No

Producer's certification: I certify the information in this application was provided by the applicant and correctly recorded. I have no information to add that could affect the acceptance or rejection of the risk. Any intention to replace coverage is reflected in the application. I have provided the applicant a link to the Medicare Supplement Buyers Guide at www.GoMedico.com/products.

Producer's printed name Producer's number

X _____

Producer's signature Date (MM/DD/YYYY)

HIPAA Authorization

I authorize any physician, hospital, pharmacy, pharmacy benefit manager, health insurance plan, or any other entity that possesses any diagnosis, treatment, prescription, or other medical information about me to furnish such health information to Medico Insurance Company, Medico Corp Life Insurance Company, and/or Medico Life and Health Insurance Company and the entities with which it contracts to administer insurance applications (collectively the "Company"), and their agents and representatives, for the purpose of evaluating my eligibility for insurance. This medical or health information may include information on the diagnosis and treatment of mental illness, alcohol, and drug use. This also includes information on the diagnosis, treatment, and testing results related to HIV, AIDS, and sexually transmitted diseases, unless otherwise restricted by state law. This authorization overrides any restrictions that I may have in place with any entity regarding the release of my medical information. Health information obtained will not be re-disclosed without my authorization unless permitted by law, in which case it may not be protected under federal privacy rules. This authorization shall be valid for two years from this date and may be revoked by sending written notice to the Company.

Non-health information is all other information. It may be about employment, other insurance owned, or motor vehicle, consumer, or credit reports. It may also be information used to confirm questions and answers on the application for insurance.

I authorize disclosure of this information to the Company by any of the following sources: doctors, medical practitioners, hospitals, clinics, or other medical or medically related facilities or professionals; the Company's legal representatives or agents; insurers or reinsurers; health plans; consumer reporting agencies; public records; employers; Pharmacy Benefit Manager (PBM); or the Medical Information Bureau (MIB).

I authorize the Company or it's reinsurers to make a brief report of my personal health information to the MIB.

I understand:

- I can refuse to sign this Authorization. If I refuse, the Company will not be able to consider my application(s).
- I can revoke this Authorization at any time, except to the extent that the Company has acted in reliance upon it or other law that gives the Company the right to contest a claim under the policy/certificate or the policy/certificate itself.
- Revoking this Authorization means the Company will not be able to consider my application(s). Requests to revoke must be in writing and sent to: Medico Insurance Company and/or Medico Life and Health Insurance Company, P.O. Box 10386, Des Moines, Iowa 50306-0386 and/or Medico Corp Life Insurance Company, P.O. Box 10482, Des Moines, Iowa 50306-0482.
- Subject to state and federal laws, information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and may no longer be protected.
- I (or my authorized personal representative) am entitled to and will be sent a copy of this Authorization.
- This Authorization expires 24 months from the date I sign it.
- I may request to be interviewed in connection with the preparation of a consumer report and, upon written request, receive a copy of the report.

I agree that a copy of this Authorization is as valid as the original.

Your name (Please print) Date

X

Your signature

Spouse's name (If applying, please print) Date

X

Your signature

Authorization to Disclose Information (MIB)

I authorize Medico Insurance Company, Medico Corp Life Insurance Company, and/or Medico Life and Health Insurance Company (the "Company") to disclose health and non-health information that they may obtain about me to the Medical Information Bureau (MIB). The purpose of the disclosure is fraud prevention.

I understand that I do not have to authorize this disclosure to MIB. Issuance of coverage will not be conditioned on me signing this authorization. ❒ **Yes** ❒ **No**

I understand that, subject to state and Federal laws, information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected.

I understand that I have the right to revoke this authorization at any time except to the extent that the Company has acted upon this authorization. I further understand that if I revoke this authorization I must do so in writing and must send my written request to: Medico Insurance Company and/or Medico Life and Health Insurance Company, P.O. Box 10386, Des Moines, Iowa 50306-0386 and/or Medico Corp Life Insurance Company, P.O. Box 10482, Des Moines, Iowa 50306-0482.

I understand that this authorization will expire 24 months from the date I sign it.

I acknowledge that I, or my authorized personal representative, am entitled to and have received a copy of this form.

Your name (Please print) Date

X

Your signature

Spouse's name (If applying, please print) Date

X

Your signature

If you are signing as a personal representative for an individual to be insured, read and sign below

I hereby certify and attest that I am the duly authorized personal representative of these persons to be insured.

Personal representative (Please print)

X

Personal representative signature

Person(s) to be insured (Please print):

1.

2.

My relationship to applicant(s) (Please print):

1.

2.

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Notice to Applicant Regarding Replacement of Medicare Supplement or Medicare Advantage

Save this notice! It may be important to you in the future.

According to your application or information you have furnished, you intend to terminate existing Medicare Supplement or Medicare Advantage insurance and replace it with a policy to be issued by Medico Life and Health Insurance Company. Your new policy will provide 30 days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that the purchase of this Medicare Supplement coverage is a wise decision, you should terminate your present Medicare Supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY ISSUER OR PRODUCER:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare Supplement policy will not duplicate your existing Medicare Supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare Supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason. (check one):

❒ Additional benefits.
❒ No change in benefits, but lower premiums.
❒ Fewer benefits and lower premiums.
❒ My plan has outpatient prescription drug coverage, and I am enrolling in Part D.
❒ Disenrollment from a Medicare Advantage plan. (please explain reason for disenrollment)

_____

❒ Other (please specify)

_____

_____

_____

If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

Signature of producer	Typed name and address of issuer or producer
Applicant's signature	Date

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Medicare Supplement Policy Checklist

Applicant's Name _____ Existing Policy Number _____

Name of Existing Insurer _____

Expiration Date of Existing Insurance _____

Medicare Supplement Plans
Important

*You **must** indicate your choice of coverage.*

Mark only one box, please.

❒ Plan A ❒ Plan F* ❒ High-deductible Plan F* ❒ Plan G ❒ High-deductible Plan G ❒ Plan N

* Plan F and High-Deductible Plan F are only available if your Medicare Part A eligibility date is before Jan. 1, 2020

SERVICE	BENEFIT	MEDICARE PAYS	EXISTING COVERAGE PAYS	SUPPLEMENT COVERS	YOU PAY*
INPATIENT HOSPITAL BENEFITS	First 60 Days	All but $1,600		❒ Nothing (Plan A) **or**	❒ $1,600 Part A deductible (Plan A) **or**
				❒ $1,600 Part A deductible (Plans F, HdF, G, HdG, & N)	❒ Nothing (Plans F, HdF, G, HdG & N)
	61st to 90th day	All but $400 a day		$400 a day	Nothing
	91st to 150th day	All but $800 a day		$800 a day	Nothing
	Beyond 150 days for up to 365 lifetime days	Nothing		100% of Medicare eligible expenses	Nothing
SKILLED NURSING HOME CARE BENEFITS	First 20 days	100% of cost		Nothing	Nothing
	21st to 100th day	All but $200 a day		❒ Nothing (Plan A) **or**	❒ $200 a day (Plan A) **or**
				❒ $200 a day (Plans F, HdF, G, HdG & N)	❒ Nothing (Plans F, HdF, G, HdG & N)
	After 100 days	Nothing		Nothing	All costs

*Plan F and Plan G also have a high deductible option. The high deductible plan pays the same benefits as Plan F or Plan G after one has paid a calendar year $2,700 deductible. Benefits from the high deductible plan 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 Parts A and Parts B, but does not include the plan's separate foreign travel emergency deductible.

over

MEDICAL EXPENSE BENEFITS	Physician's services in hospital, office or home; inpatient and outpatient medical services and supplies at a hospital; physical and speech therapy; and ambulance	80% of Medicare determined allowable charges after $226 deductible		For charges covered under Part B Medicare: ☐ 20% of Medicare determined allowable charges (Plans A, F, HdF, G & HdG) ☐ After $226 deductible, Plan N pays the balance, other than up to $20 per office visit and up to $50 per emergency room visit. The $50 copayment is waived if you are admitted to any hospital and the emergency visit is covered as a Medicare Part A expense ☐ $226 Part B deductible (Plan F & HdF) ☐ 100% of excess charges above Medicare determined allowable charges (Plan F, HdF, G & HdG)	☐ Nothing (Plan F & HdF) ☐ After $226 deductible, you are responsible for up to $20 per office visit and up to $50 per emergency room visit. The $50 copayment is waived if you are admitted to any hospital and the emergency visit is covered as a Medicare Part A expense (Plan N) ☐ $226 Part B deductible (Plans A, G, HdG & N) ☐ Part B Excess Charges for (Plans A & N)
PRESCRIPTION DRUGS	Inpatient prescription drugs (immunosup-pressive drugs during the first year following a covered transplant)	80% of Medicare determined allowable charges after $226 deductible		☐ 20% of Medicare determined allowable charges (Plans A, F, HdF, G & HdG) ☐ $226 deductible (Plans F & HdF)	☐ $226 deductible and excess charges above Medicare determined allowable charges (Plans A, G & HdG) ☐ Nothing (Plans F & HdF)

The MLHMS2021 series policies do comply with the minimum standards set forth in Section 363 of the Illinois Insurance Code.

Applicant's Signature _____ Date _____

Producer's Signature _____ Date _____

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Medicare Supplement Policy Checklist

Applicant's Name _____ Existing Policy Number _____

Name of Existing Insurer _____

Expiration Date of Existing Insurance _____

Medicare Supplement Plans
Important

*You **must** indicate your choice of coverage.*

Mark only one box, please.

❒ Plan A ❒ Plan F* ❒ High-deductible Plan F* ❒ Plan G ❒ High-deductible Plan G ❒ Plan N

* Plan F and High-Deductible Plan F are only available if your Medicare Part A eligibility date is before Jan. 1, 2020

SERVICE	BENEFIT	MEDICARE PAYS	EXISTING COVERAGE PAYS	SUPPLEMENT COVERS	YOU PAY*
INPATIENT HOSPITAL BENEFITS	First 60 Days	All but $1,600		❒ Nothing (Plan A) **or**	❒ $1,600 Part A deductible (Plan A) **or**
				❒ $1,600 Part A deductible (Plans F, HdF, G, HdG, & N)	❒ Nothing (Plans F, HdF, G, HdG & N)
	61st to 90th day	All but $400 a day		$400 a day	Nothing
	91st to 150th day	All but $800 a day		$800 a day	Nothing
	Beyond 150 days for up to 365 lifetime days	Nothing		100% of Medicare eligible expenses	Nothing
SKILLED NURSING HOME CARE BENEFITS	First 20 days	100% of cost		Nothing	Nothing
	21st to 100th day	All but $200 a day		❒ Nothing (Plan A) **or**	❒ $200 a day (Plan A) **or**
				❒ $200 a day (Plans F, HdF, G, HdG & N)	❒ Nothing (Plans F, HdF, G, HdG & N)
	After 100 days	Nothing		Nothing	All costs

*Plan F and Plan G also have a high deductible option. The high deductible plan pays the same benefits as Plan F or Plan G after one has paid a calendar year $2,700 deductible. Benefits from the high deductible plan 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 Parts A and Parts B, but does not include the plan's separate foreign travel emergency deductible.

over

MEDICAL EXPENSE BENEFITS	Physician's services in hospital, office or home; inpatient and outpatient medical services and supplies at a hospital; physical and speech therapy; and ambulance	80% of Medicare determined allowable charges after $226 deductible		For charges covered under Part B Medicare: ☐ 20% of Medicare determined allowable charges (Plans A, F, HdF, G & HdG) ☐ After $226 deductible, Plan N pays the balance, other than up to $20 per office visit and up to $50 per emergency room visit. The $50 copayment is waived if you are admitted to any hospital and the emergency visit is covered as a Medicare Part A expense ☐ $226 Part B deductible (Plan F & HdF) ☐ 100% of excess charges above Medicare determined allowable charges (Plan F, HdF, G & HdG)	☐ Nothing (Plan F & HdF) ☐ After $226 deductible, you are responsible for up to $20 per office visit and up to $50 per emergency room visit. The $50 copayment is waived if you are admitted to any hospital and the emergency visit is covered as a Medicare Part A expense (Plan N) ☐ $226 Part B deductible (Plans A, G, HdG & N) ☐ Part B Excess Charges for (Plans A & N)
PRESCRIPTION DRUGS	Inpatient prescription drugs (immunosup-pressive drugs during the first year following a covered transplant)	80% of Medicare determined allowable charges after $226 deductible		☐ 20% of Medicare determined allowable charges (Plans A, F, HdF, G & HdG) ☐ $226 deductible (Plans F & HdF)	☐ $226 deductible and excess charges above Medicare determined allowable charges (Plans A, G & HdG) ☐ Nothing (Plans F & HdF)

The MLHMS2021 series policies do comply with the minimum standards set forth in Section 363 of the Illinois Insurance Code.

Applicant's Signature _____ Date _____

Producer's Signature _____ Date _____

MEDICO®
LIFE AND HEALTH INSURANCE COMPANY

IMPORTANT NOTICE

Illinois recently passed the Illinois Religious Freedom Protection and Civil Union Act recognizing civil unions. Effective June 1, 2011, an individual that enters into a civil union is treated the same under Illinois law as if he or she were married.

Therefore, where the term "spouse" or "marriage" appears in any application, policy or other form issued by Medico Life and Health Insurance Company, the term should be understood to include a civil union spouse and a civil union, respectively. Medico Life and Health will administer the policy for spouses in a civil union exactly as we would spouses in a marriage.

It is important to note that federal law does not recognize civil unions. This Act does not affect any rights and responsibilities provided under federal law.

CURRENT POLICYHOLDERS: As of June 1, 2011, your policy is considered amended by operation of law to conform to the Act. For spouses in a civil union, this Act may change the eligibility requirements and/or benefits under the policy for you or your civil union spouse. For example, parties to a civil union may now elect coverage for his or her civil union spouse and/or dependent child(ren) if such coverage is provided to spouses and dependents under the terms of your policy.

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Illinois Birthday Rule

If you have a Medicare Supplement policy with Medico Life and Health Insurance Company, you have 45 days of open enrollment following your birthday each year to buy a different Medicare Supplement plan with us that has the same or lesser benefits as your current plan. You must be at least 65 years of age but no more than 75 years of age to exercise this privilege.

Medico Life and Health Insurance Company
601 Sixth Ave., Des Moines, IA 50309
P.O. Box 10386, Des Moines, IA 50306

www.GoMedico.com
Phone (toll-free): 800-228-6080

Medicare Supplement Application Receipt

An application for Medicare Supplement insurance with the following plan:

- ❒ Plan A
- ❒ Plan F
- ❒ High-deductible Plan F
- ❒ Plan G
- ❒ High-deductible Plan G
- ❒ Plan N

was received from_____
First Name MI Last Name Suffix

on _____.
Date

The premium payments for this coverage will be collected by:

❒ Automatic bank withdrawal ❒ Credit/Debit card

on the following frequency:

❒ Monthly ❒ Quarterly ❒ Semi-annually ❒ Annually

The premium amount will be $_____.

This insurance will not be in force until the first premium is paid.

We will notify you if your application cannot be approved. If you do not receive your contract within 30 days, please contact us by one of the following methods:

Write to: Medico Life and Health Insurance Company
P.O. Box 10386
Des Moines, IA 50306-0386

Call: Customer Care at 800-228-6080

E-mail: customerservice@GoMedico.com

X _____ _____
Producer's signature Date (MM/DD/YYYY)

_____
Producer's printed name

The Medicare Buyers Guide, "Choosing a Medigap Policy: A Guide to Health Insurance for People With Medicare," can be found on our website at www.GoMedico.com/products.

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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.

Disclosures

Notice of Privacy Practices for American Enterprise Group Affiliated Covered Entity

MEDICAL

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices covers an affiliated covered entity. When the notice refers to "we," "our," or "us," it is referring to the following affiliated entities: American Republic Insurance Company, Medico Insurance Company, Medico Life and Health Insurance Company, American Republic Corp Insurance Company, and Medico Corp Life Insurance Company. For purposes of complying with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as amended by the Health Information Technology for Economic and Clinical Health Act (HITECH), the combined companies listed are designated as a single covered entity. The single covered entity shall be known as the "American Enterprise Group ACE." This designation may be amended from time to time to add new covered entities that are under common control and ownership with the American Enterprise Group ACE.

We respect the confidentiality of your health information and will protect your information in a responsible and professional manner. We are required by law to maintain the privacy of your health information and to send you this notice. This notice explains how we use information about you and when we can share that information with others. It also informs you of your rights with respect to your health information and how you can exercise those rights.

When we talk about "information" or "health information" in this notice we mean individually identifiable health information, as defined by HIPAA. Individually identifiable health information is health information that:

- Is created or received by the American Enterprise Group ACE's designated health care components;
- Relates to the past, present, or future physical or mental health condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual; and
- Identifies the individual, or with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

How We Use or Share Information

Subject to state and federal laws, we are permitted to use and/or share your information without your authorization in certain circumstances, such as:

- To use or disclose the information for payment purposes. For example, we may use the information to help pay medical bills that have been submitted to us by doctors and hospitals for payment or to contact your doctor to obtain medical records in order to make claim payment decisions.
- To use or disclose the information to perform health care operations. For example, we may use the information for activities relating to underwriting; customer service; legal services; and auditing functions, including fraud and abuse detection and compliance programs. We will not use or disclose genetic information, including family history, for underwriting purposes.
- To use or disclose your information to provide you with information about health related benefits and services that you may be interested in. We will not share your information with or sell it to telemarketing agencies or other agencies that market products other than those products provided or administered by the American Enterprise Group ACE or its business associates without your authorization.
- If you are available and do not object, we may disclose information to a member of your family, a friend, or other person you identify who is involved in your health care or the payment of a claim. If you are unavailable, incapacitated, or facing an emergency medical situation, and we determine that a limited disclosure is in your best interest, we may share limited information with such persons.
- To disclose information to a disaster relief organization in order for the organization to communicate with a family member or other person involved in your care.

State and federal laws may require or permit us to release your information to others without your authorization, such as:

- To use and disclose information to the extent required to comply with the law.
- To report information to state and federal agencies that regulate us, such as the U.S. Department of Health and Human Services and the Iowa Insurance Division.
- To share information for public health activities.
- To use or disclose information to avert a serious health or safety threat.
- To share information with a health oversight agency for certain oversight activities authorized by law such as audits, inspections, licensure, and disciplinary actions.
- To disclose information in the course of a judicial or administrative proceeding, such as pursuant to a subpoena.
- To report information for law enforcement purposes.
- To report information to a government authority regarding child abuse, neglect, or domestic violence.
- To share information with a coroner or medical examiner to identify a deceased person, determine a cause of death, or as
- To use or disclose information for research purposes, but only as permitted by law.
- To share information for specialized government functions, such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others.
- To report information on job-related injuries because of requirements of your state workers' compensation laws.

NOTICE OF PRIVACY PRACTICES—MEDICAL (continued)

In the event that an applicable law prohibits or materially limits one of the uses or disclosures of information described above, we will restrict the use or disclosure in accordance with the more stringent law. If one of the above reasons for a use or disclosure does not apply, **we must get your written permission, in the form of an authorization, to use or disclose your information.** In any case, we must obtain authorization for the use and disclosure of psychotherapy notes. If you give us written permission and change your mind you may revoke your authorization at any time except to the extent that we have taken action in reliance on the authorization or, if the authorization was obtained as a condition of obtaining insurance coverage, other law provides us with the right to contest a claim under the policy or the policy itself.

What Are Your Rights?

The following are your rights with respect to your information. If you would like to exercise the following rights, please contact our Customer Care Center. Contact information for our Customer Care Center is located at the end of this Notice.

- **You have the right to be notified** in the event there is a breach of your health information.
- **You have the right to ask us to restrict:** (a) how we use or disclose your information for payment or health care operations; (b) information that we have been asked to give to family members or to others who are involved in your health care or payment for your health care; and (c) uses and disclosures for disaster relief purposes. Please note that while we will try to accommodate reasonable requests, we are not required to agree to these restrictions.
- **You have the right to request confidential communications of information.** For example, if you believe that you would be harmed if we send your information to your current mailing address (for example, in situations involving domestic disputes or violence), you can ask us to send the information by alternative means (for example, by fax) or to an alternative address. We will accommodate your reasonable requests as explained above.
- **You have the right to copy and inspect certain components of your information that we maintain.** All requests for access must be made in writing and signed by you or your representative. Access request forms are available from our Customer Care Center at the address below. We may charge you a fee for copying and postage.
- **You have the right to request that certain components of your information be amended to correct an error or omission.** We are not obligated to make all requested amendments but will give each request careful consideration. All amendment requests must be in writing, signed by you or your representative, and must state the reasons for the requested amendment. Amendment request forms are available from our Customer Care Center.
- **You have the right to receive an accounting** of certain disclosures of your information. Accounting request forms are available from our Customer Care Center at the address below. The first accounting in any 12-month period is free; however, we may charge you a fee for each subsequent accounting you request in the same 12-month period. Please note that we are not required to release:
    - Any information collected prior to April 14, 2003.
    - Information disclosed or used for treatment, payment, and/or health care operations purposes.
    - Information disclosed to you or pursuant to your authorization.
    - Information that is incidental to a use or disclosure otherwise permitted.
    - Information disclosed for a facility's directory or to person involved in your care or other notification purposes.
    - Information disclosed for national security or intelligence purposes.
    - Information disclosed to correctional institutions, law enforcement officials, or health oversight agencies.
    - Information that was disclosed or used as part of a limited data set for research, public health, or health care operations purposes.

Exercising Your Rights

You have a right to receive a copy of this notice upon request at any time. We are required to abide by the terms of this notice. Should any of our privacy practices change, we reserve the right to change the terms of this notice and to make the new notice effective for all protected health information we maintain. Once revised, we will provide the new notice to you by mail. If you believe your privacy rights have been violated, you may file a complaint with us by contacting our Customer Care Center. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. **We will not take any action against you for filing a complaint.**

Contact Information

If you have any questions or complaints, please contact us at:

Notice of Privacy Practices
American Enterprise Group
P.O. Box 1
Des Moines, IA 50306-0001

You can call us at **800-247-2190** or visit **www.americanenterprise.com**.

Notice of Privacy Practices for American Enterprise Group Companies

FINANCIAL

THIS NOTICE APPLIES TO ALL PROSPECTS, APPLICANTS, CUSTOMERS AND FORMER CUSTOMERS WHO HAVE INQUIRED ABOUT OR PURCHASED INSURANCE PRODUCTS USED PRIMARILY FOR PERSONAL, FAMILY OR HOUSEHOLD PURPOSES.

At AmericanEnterprise Group Companies, including but not limited to American Republic Insurance Company, American Republic Corp Insurance Company, Medico Insurance Company, Medico Life and Health Insurance Company, and Medico Corp Life Insurance Company, ("Company") we keep your personal information confidential and share it only in a responsible manner as necessary to provide and service the products you purchase from us or to offer you additional products.

What Information Do We Collect?

To provide and administer products and services, we must refer to relevant personal information that can be identified to you or your household and that may not be available in public records ("nonpublic personal information"). We collect only the following information required to conduct business:

- Identity information received from your application, such as name, address, social security number, and age.
- Information about your transactions with us, including your identification and policy number(s), the type of products you buy, the premiums you pay, and how you purchased your coverage.
- Information received from a consumer reporting or credit agency or from public records (such as your driving record) as needed by our insurance underwriting practices.
- Information received from a third-party agency, such as consumer purchasing or census data.
- Information received from service providers regarding treatment of health conditions and payment for that treatment.

What Information Do We Share With Others?

To help us provide you with the best possible products and services, we maintain strong relationships with business associates. In the course of conducting business and as permitted or required by law, we may share any of the listed nonpublic personal information with our business associates for the following purposes:

- To process your application and issue your policy.
- To pay your claims.
- To make any policy changes you may request.
- To offer you additional opportunities to improve your financial security.

We may also disclose relevant portions of the information we collect, as described above, to companies that perform services on our behalf or with whom we have joint marketing agreements. We will not, however, disclose your health information for marketing purposes.

Other than the disclosures listed above, we do not release your information to nonaffiliated third parties. We will not for any reason share your information with or sell it to telemarketing agencies or other agencies that market products other than those products provided or administered by the Company or its business associates. Our business associates are bound by the same restrictions on the release and use of such information as the Company. Any future alliances with business associates which include personal information sharing will follow the same policy.

Fair Credit Reporting Act

We do not disclose information subject to the Fair Credit Reporting Act except as permitted or required by law. To the extent that we decide in the future to make any disclosures of your nonpublic personal financial information that are subject to the Act, we will follow the necessary requirements of the Act including providing you with the opportunity to restrict our ability to disclose information.

How Do We Protect Your Information?

We maintain appropriate physical, electronic and procedural safeguards to ensure the confidentiality of your nonpublic personal information. We follow security standards and procedures to help prevent unauthorized access to personal information. Only employees who need the information we collect from or about you to provide products or services to you may access that information. Employees are required to comply with our established policies.

What About Former Customers?

We do not disclose information about former customers unless permitted or required by law.

How Can You Correct Inaccurate Information?

We want to keep our records of your information accurate. If you discover inaccuracies in any communications from us, please call customer service at the number listed on your policy or certificate materials. We will respond promptly when we learn corrections are needed.

Questions?

If you have any questions, you can call us at **800-247-2190** or visit **www.americanenterprise.com**.