## Medico® Insurance Company
## A Wellabe® Company

# Medicare Supplement Insurance

## WISCONSIN SALES KIT

**PRODUCER INSTRUCTIONS**

Submit applications electronically using MyEnroller:

**MyEnroller**
**Electronic Application Submission Tool**
**Website: wellabe.com/signin**

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

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**Medico® Insurance Company**
***A Wellabe® Company***
601 Sixth Ave., Des Moines, IA 50309
P.O. Box 10386, Des Moines, IA 50306
**www.wellabe.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

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'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: _____

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

**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)? (Disclose only FDA-licensed test results and not anonymous counseling & testing site or home test kit results.) ❒ 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

## Part C: General health information (continued)

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

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 |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

## Part D: Medical health information (continued)

**Primary physician**

| Name of physician | Date of last visit (MM/DD/YYYY) |
|---|---|
| Office phone number | City and state |

**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:**

- ❒ Basic Medicare Supplement coverage
- ❒ Part A Deductible rider
- ❒ Additional Home Health Care rider
- ❒ Part B Deductible rider*****
- ❒ Part B Copayment or Coinsurance rider
- ❒ Part B Excess Charge rider
- ❒ Foreign Travel rider

***** The Part B Deductible rider is only available if your Medicare Part A eligibility date is before Jan. 1, 2020.

You cannot purchase the Medicare Part B Deductible rider and the Medicare Part B Copayment or Coinsurance rider for the same period of coverage.

**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 Insurance Company, a discount is applied to the premium rates.

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

## Part F: Notices (continued)

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 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 wellabe.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: Any person who knowingly and with intent to defraud or damage files a claim containing false, incomplete, or misleading information may be in violation of state law. Use of the mail to defraud is a violation of federal law.**

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 |

## Part H: Producer's section (continued)

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 wellabe.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 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)

_____

_____

_____

1. Health conditions that you may presently have (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. State law provides that your replacement policy or certificate may not contain new preexisting condition waiting periods. The issurer will waive any time periods applicable to preexisting conditions waiting periods in the new policy (or coverage) for similar benefits to the extent such time was satisfied under the Medicare supplement policy.
3. 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 |

# Medico Insurance Company

P. O. Box 10386, Des Moines, Iowa 50306-0386

## Outline of Medicare Supplement Coverage
## (Policy Form MMS21W)

## MEDICARE SUPPLEMENT INSURANCE

**The Wisconsin Insurance Commissioner has set standards for Medicare Supplement Insurance. This plan meets these standards. It, along with Medicare, may not cover all of your medical costs. You should review carefully all plan limitations. For an explanation of these standards and other important information, see "Wisconsin Guide to Health Insurance for People with Medicare" given to you when you received your coverage. Do not buy this coverage if you did not get this guide.**

**Premium Information**
We, Medico Insurance Company, can only raise your premium if we raise the premium for all plans like yours in this state. Premiums for coverage issued to persons under the age of 65 may change because of a change in residence or as Medicare benefits change. At age 65, a new open enrollment period is open to an individual and premiums may be lower by applying for new coverage at that time. At issue age 65 and above, premium is based on attained age and may go up because a covered person is 1 year older, or because of a change in residence or as Medicare benefits change.

**Disclosures**
Use this outline to compare benefits and premiums among plans.

**Grievance**
"Grievance" means any dissatisfaction that an insured or someone on the insured's behalf, expresses in writing to the insurer. The dissatisfaction is related to the provision of services or claims practices of an insurer offering a health benefit plan or administration of a health benefit plan by the insurer.

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

**Right to Return Policy**
If you find that you are not satisfied with your coverage, you may return it to P. O. Box 10386, Des Moines, Iowa 50306-0386. 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 directly to the person who paid the premium.

**Medicare Supplement Replacement**
If you are replacing another health insurance policy, do not cancel your other health insurance policy until you have actually received your new policy and you are sure you want to keep it.

**Notice** – This Medicare Supplement coverage may not fully cover all of your medical costs. Benefits provided based on the Usual and Customary Charge may be less than the provider's actual billed charge.

# Neither Medico Insurance Company nor its agents are connected with Medicare.

* These are optional riders. You purchased this benefit if the box is checked and you paid the premium.

** 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 nursing 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 as provided in the policy's "Core Benefits".

## Checklist of Benefits

| Medicare Part A - Hospital Services | Per Benefit Period | Medicare Pays | This Policy Pays | You Pay |
|---|---|---|---|---|
| **HOSPITALIZATION**** Semiprivate room and board, general nursing and miscellaneous hospital services and supplies. | First 60 days | All but $1,632 Medicare Part A Deductible | $0 **OR** ☐ **Optional Part A Deductible Rider*** | $1,632 Deductible **OR** $0 |
| | 61st to 90 days | All but $408 per day | $408 per day | All costs that are not eligible expenses |
| | 91st day and after while using 60 lifetime reserve days | All but $816 per day | $816 per day | |
| | Once lifetime reserve days are used: Additional 365 days | $0 | 100% of Medicare eligible expenses*** | |
| | Beyond the additional 365 days | $0 | $0 | All costs |
| **SKILLED NURSING FACILITY CARE** You must meet Medicare's minimum 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 | 100% of all approved amounts | $0 | $0 |
| | 21st through 100th day | All but $204 per day | Up to $204 a day | |
| | 101st day and after | $0 | $0 | All costs |
| **INPATIENT PSYCHIATRIC CARE** Inpatient Psychiatric Care in a Participating Hospital | | 190 days per lifetime | 175 additional days per lifetime | All costs over the lifetime maximum |
| **BLOOD** | First 3 pints | $0 | First 3 pints | $0 |
| | Additional amounts | 100% | $0 | $0 |
| **HOSPICE CARE** Available as long as your doctor certifies you are terminally ill and you elect to receive these services. | | All but very limited coinsurance/ copayment for outpatient drugs and inpatient respite care | 100% of coinsurance or copayments | $0 |

* These are optional riders. You purchased this benefit if the box is checked and you paid the premium.

** Once you have been billed $240 of Medicare-approved amounts for covered services, your Part B Deductible will have been met for the calendar year.

*** This is an optional rider. You purchased this benefit if the box is checked and you paid the premium. Only applicants first eligible for Medicare before January 1, 2020, may purchase the Part B Deductible rider.

THIS OUTLINE OF COVERAGE DOES NOT GIVE ALL THE DETAILS OF YOUR COVERAGE. CONTACT YOUR LOCAL SOCIAL SECURITY OFFICE OR CONSULT "MEDICARE & YOU" FOR MORE DETAILS.

| Medicare Part B Benefits | Per Calendar Year | Medicare Pays | This Policy Pays | You Pay |
|---|---|---|---|---|
| **MEDICAL EXPENSES**** Eligible expense for physician's services, inpatient and out-patient medical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment | First $240 of Medicare approved amounts | $0 | $0 **OR** ❒ **Optional Part B Deductible Rider***** **OR** ❒ **Optional Part B Copayment or Coinsurance Rider*** provides the lesser of $20 or Medicare Part B coinsurance for each covered office visit and the lesser of $50 or the Medicare Part B coinsurance for each covered emergency room visit | The $240 annual deductible **OR** $0 **OR** Up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense |
| | Remainder of Medicare approved amounts | Generally 80% | Generally 20% **OR** ❒ **Optional Medicare Part B Excess Charges Rider*** **OR** ❒ **Optional Foreign Travel Emergency Rider*** | |
| **BLOOD**** | First 3 pints | $0 | All costs | $0 |
| | Next $240 of Medicare approved amounts | $0 | $0 **OR** ❒ **Optional Part B Deductible Rider***** | $240 **OR** $0 |
| | Remainder of Medicare approved amounts | 80% | 20% | $0 |
| **CLINICAL LABORATORY SERVICES** Tests for Diagnostic Services | | 100% | $0 | $0 |
| **HOME HEALTH CARE** | | 100% of charges for visits considered medically necessary by Medicare | 40 visits **OR** ❒ **Optional Additional Home Health Care Rider*** | All costs that are not eligible expenses |
| **PREVENTIVE MEDICAL CARE BENEFIT - NOT COVERED BY MEDICARE** Some annual physical and preventive tests and services administered or ordered by your doctor when not covered by Medicare. | First $1,000 each calendar year | $0 | $1,000 | $0 |
| | Additional charges | $0 | $0 | All costs |

**Additional Benefits**

1. **Preventive Health Care Services Benefit**
   For the following preventive health services, we will pay the actual charge up to the 100% of the Medicare approved amount, for each service, as if Medicare covered the service as identified by the American Medical Association Current Procedural Terminology (AM CPT):
   a. An annual clinical preventive medical history and physical examination that may include tests and services described below and patient education to address preventive health care measures; and
   b. Preventive screening tests or preventive services, the selection and frequency of which is determined to be medically appropriate by your Physician.

   This benefit shall not include payment of any procedure covered by Medicare. This benefit is limited to a Calendar Year maximum of $1,000.

2. **Skilled Nursing Facility Care Confinement Benefit**
   When you are confined in a Wisconsin licensed Skilled Nursing Facility for a skilled nursing stay not approved by Medicare, we will pay the maximum daily rate set for licensed skilled nursing facilities by the Wisconsin Department of Health and Social Services for services, supplies or treatments. During a Benefit Period, we will pay for up to 30 days of such confinement for skilled nursing care. A new confinement does not begin until you have not received care in either a hospital or nursing facility for at least 60 consecutive days. At least once every 7 days, the attending physician must certify that the confinement is Medically Necessary as a result of the continuing treatment for the same condition. We will not pay for care that is primarily domiciliary or custodial.

3. **Inpatient Psychiatric Benefit**
   Coverage for 175 days per lifetime for inpatient psychiatric hospital care upon exhaustion of Medicare hospital inpatient psychiatric coverage. The benefit we will pay will be the Medicare Eligible Expense for hospital care in a Medicare participating psychiatric hospital.

4. **Chiropractic Services Benefit**
   When Medicare Part B medical benefits do not pay for Medically Necessary services received from a chiropractor, we will provide payment in full for all Usual and Customary Charges for chiropractic services. Benefits are not payable for any charges paid by Medicare.

5. **Home Health Care Benefi**t
   We will pay the Usual and Customary Charges for Home Health Care that you receive in lieu of hospitalization for an Injury or Sickness. Four consecutive hours of Home Health Care in a 24-hour period or each visit by a member of a Home Health Care team will be considered one Home Health Care visit. This benefit is limited to a maximum of 40 home health care visits in a 12-month period.
   Home Health Care is covered under this policy only is the attending Physician certifies that:
   a. Hospitalization or confinement is a Skilled Nursing Facility would otherwise be required is Home Health Care was not provided;
   b. Necessary care and treatment are not available for members of your Immediate Relative or other persons residing with you without causing undue hardship; and
   c. The Home Health Care services will be provided or coordinated by a state-licensed or Medicare-certified home health agency, or certified rehabilitation agency.

   If you are hospitalized immediately prior to the commencement of Home Health Care, the Home Health Care plan also must initially be approved by the Physician who was the primary provider of services during you hospitalization.

   The maximum weekly benefit for Home Health Care will not exceed the Usual and Customary weekly cost for care in a Skilled Nursing Facility.

6. **Kidney Disease Treatment Benefit**
   We will pay the Usual and Customary Charges which are not payable under Medicare that you incur for necessary Hospital inpatient and outpatient treatment of kidney disease, including dialysis, transplantation, and donor-related services. Benefits are not payable for that portion of expenses that is paid under any other part of this policy. Benefits will be reduced by like benefits payable under any other policy you have with us. Benefits are limited to $30,000 per Calendar Year.

7. **Diabetes Treatment Benefit**
   We will pay the Usual and Customary Charges which were not payable under Medicare for expenses you incur for the following services or supplies for the treatment of diabetes:

a. The installation and use of an insulin infusion pump, limited to one pump every year which is used for at least 30 days before purchase;
b. Other equipment and supplies for the treatment of diabetes that are not covered by Medicare Part D; and
c. Diabetic self-management education programs.

This benefit does not include insulin and other prescription medication used in the treatment of diabetes. We will not pay for diabetic supplies and insulin covered under Medicare Part D.

8. **Hospital and Ambulatory Surgery Center Charges and Anesthetics for Dental Care Benefit:**
We will pay the Usual and Customary Charges which are not payable under Medicare for Hospital and ambulatory surgery center charges incurred and for anesthetics provided in conjunction with dental care, if any of the following apply:
   a. You have a chronic disability; or
   b. You have a medical condition that requires hospitalization or general anesthesia for dental care.

9. **Breast Reconstruction Benefit**
We will pay the Usual and Customary Charges which are not payable under Medicare that you incur for breast reconstruction incident to a mastectomy.

**Renewability**
We guarantee to renew your policy as long as you live if you pay your premiums when due.

We may change the premiums on your policy from time to time. We will not change the premiums unless we do so on all policies of this form issued to persons of your class. Premiums may change because of an increase in age, change of residence, or as Medicare benefits change. We will only raise your premium if we raise the premium for all policies like yours in this state. We will notify you of the new premium at least 60 days before the next due date. Premiums are based on your attained age.

**Benefit Appeal and Grievance Processes**
You (or your representative) have the right to request a review of any claim for benefits that has been denied. The request must be made by writing to us at Medico Insurance Company, P. O. Box 10386, Des Moines, Iowa 50306-0386. We will acknowledge receipt of your grievance within 5 business days of receiving it. Within 7 calendar days before the review panel meeting, we will provide you with written notification of the time and place of this meeting. We will provide a written resolution of the grievance within 30 calendar days of receiving your grievance. You, as a Covered Person under this coverage, have the option to file a grievance regarding any decision made by us that affects you. Please see endorsement M1543 for details.

**Medicare Changes**
The benefits of your policy change when the Medicare deductibles or copayment amounts you are required to pay are changed. We may also change the premiums (with state insurance department approval) when the benefits change.

We will not pay benefits for: 1) services for which a charge is normally not made when there is no insurance; 2) expenses incurred before the Policy Date; or 3) that portion of expense incurred which is paid for by Medicare.

**Limitations and Exclusions**
We will not pay for:

(A) Nursing home care costs beyond what is covered by Medicare, the policy and the 30-day skilled nursing mandate.
(B) Home health care above the number of visits covered by Medicare, the policy, and the 40-day home health care mandate and, if you elect the optional Home Health Care rider, 365 days.
(C) Physician charges above Medicare's approved charge, unless you elect the Part B excess charges rider.
(D) Outpatient prescription drugs, except as provided in the policy.
(E) Most care received outside of U.S.A., unless you elect the foreign travel benefit rider.
(F) Dental care, dentures, checkups, routine immunizations, cosmetic surgery, routine foot care, examinations for the cost of eyeglasses or hearing aids, unless eligible under Medicare, except as specifically provided.
(G) Expenses above the usual and customary charges for Wisconsin mandated benefits. Usual and customary charges are those charges usually made for a service, supply or treatment by other providers in the same locality (as determined by the company) and may not equal the actual charge.

**In addition to this outline of coverage, Medico Insurance Company will send an annual notice to you 30 days prior to the effective date of Medicare changes which will describe these changes and the changes in your Medicare supplement coverage.**

***Note: The Medicare Part B Deductible Rider and the Medicare Part B Copayment and Coinsurance Rider cannot be purchased for the same period of coverage.**

# Medicare Supplement Premium Information

## 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 for the basic coverage and any selected optional benefit riders on the following tables based on the applicant's age, gender, and ZIP code.

Write the premium amounts on the lines below then add to determine the monthly base premium amount.

Copy the total monthly base premium amount to line 1 below.

| Basic Medicare Supplement coverage | Part A Deductible rider | Additional Home Health Care rider | Part B Deductible rider * | Part B Copayment or Coinsurance rider | Part B Excess Charges rider | Foreign Travel rider | Total monthly base premium |
|---|---|---|---|---|---|---|---|
| $_____ | + $_____ | + $_____ | + $_____ | + $_____ | + $_____ | + $_____ | = $_____ |

* The Part B Deductible rider is only available to applicants who were first eligible for Medicare Part A before Jan. 1, 2020.

**Step 2: Determine the rate class**
Write 1 on line 2 below for all applicants in an open enrollment or guaranteed issue period.

Write 1.25 on line 2 below for all other applicants who 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 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 |

## Wisconsin

**ZIP codes: 535, 537, 542–544, 549**

**Monthly base rates**

**Female**

**Effective February 1, 2024**

| Attained Age | Basic coverage | Part A Deductible rider | Additional Home Health Care rider | Part B Deductible rider | Part B Copayment or Coinsurance rider | Part B Excess Charges rider | Foreign Travel rider |
|---|---|---|---|---|---|---|---|
| 0–64 | 492.32 | 74.58 | 2.58 | 14.82 | -149.77 | 3.80 | 2.49 |
| 65–66 | 109.40 | 16.57 | 0.57 | 14.82 | -33.28 | 0.84 | 0.55 |
| 67 | 109.40 | 16.57 | 0.57 | 14.82 | -35.79 | 0.84 | 0.55 |
| 68 | 109.28 | 16.69 | 0.57 | 14.82 | -34.25 | 0.85 | 0.55 |
| 69 | 109.92 | 17.05 | 0.58 | 14.82 | -33.80 | 0.86 | 0.56 |
| 70 | 111.98 | 17.29 | 0.60 | 14.82 | -33.36 | 0.88 | 0.57 |
| 71 | 115.75 | 18.12 | 0.61 | 14.82 | -33.85 | 0.90 | 0.59 |
| 72 | 119.53 | 18.95 | 0.63 | 14.82 | -34.34 | 0.93 | 0.61 |
| 73 | 123.30 | 19.79 | 0.65 | 14.82 | -35.00 | 0.96 | 0.63 |
| 74 | 127.05 | 20.64 | 0.67 | 14.82 | -35.53 | 0.99 | 0.65 |
| 75 | 131.97 | 21.67 | 0.70 | 14.82 | -36.36 | 1.03 | 0.67 |
| 76 | 138.23 | 23.10 | 0.73 | 14.82 | -37.34 | 1.07 | 0.70 |
| 77 | 144.70 | 24.59 | 0.76 | 14.82 | -38.50 | 1.12 | 0.73 |
| 78 | 151.42 | 26.14 | 0.79 | 14.82 | -39.66 | 1.17 | 0.77 |
| 79 | 158.36 | 27.76 | 0.83 | 14.82 | -40.77 | 1.22 | 0.80 |
| 80 | 165.55 | 29.45 | 0.87 | 14.82 | -41.88 | 1.28 | 0.84 |
| 81 | 174.88 | 31.46 | 0.91 | 14.82 | -43.45 | 1.34 | 0.88 |
| 82 | 184.43 | 33.56 | 0.95 | 14.82 | -45.02 | 1.40 | 0.92 |
| 83 | 194.42 | 35.76 | 1.00 | 14.82 | -46.66 | 1.47 | 0.96 |
| 84 | 204.87 | 38.08 | 1.04 | 14.82 | -48.35 | 1.54 | 1.01 |
| 85 | 215.79 | 40.52 | 1.09 | 14.82 | -50.11 | 1.61 | 1.05 |
| 86 | 226.42 | 42.65 | 1.14 | 14.82 | -51.94 | 1.68 | 1.10 |
| 87 | 237.51 | 44.87 | 1.19 | 14.82 | -53.83 | 1.75 | 1.15 |
| 88 | 249.08 | 47.21 | 1.24 | 14.82 | -55.80 | 1.83 | 1.20 |
| 89 | 261.15 | 49.65 | 1.30 | 14.82 | -57.83 | 1.91 | 1.25 |
| 90 | 271.49 | 51.79 | 1.34 | 14.82 | -59.45 | 1.97 | 1.29 |
| 91 | 281.64 | 53.78 | 1.38 | 14.82 | -61.12 | 2.03 | 1.33 |
| 92 | 290.00 | 55.46 | 1.41 | 14.82 | -62.40 | 2.07 | 1.36 |
| 93 | 298.60 | 57.18 | 1.44 | 14.82 | -63.69 | 2.12 | 1.39 |
| 94 | 307.42 | 58.94 | 1.47 | 14.82 | -65.01 | 2.16 | 1.42 |
| 95 | 316.47 | 60.74 | 1.50 | 14.82 | -66.35 | 2.21 | 1.45 |
| 96 | 323.10 | 62.01 | 1.53 | 14.82 | -67.73 | 2.26 | 1.48 |
| 97 | 329.85 | 63.30 | 1.57 | 14.82 | -69.14 | 2.30 | 1.51 |
| 98 | 336.75 | 64.62 | 1.60 | 14.82 | -70.58 | 2.35 | 1.54 |
| 99 | 343.79 | 65.96 | 1.63 | 14.82 | -72.05 | 2.40 | 1.57 |

## Wisconsin

**ZIP codes: 535, 537, 542–544, 549**

**Monthly base rates**

**Male**

**Effective February 1, 2024**

| Attained Age | Basic coverage | Part A Deductible rider | Additional Home Health Care rider | Part B Deductible rider | Part B Copayment or Coinsurance rider | Part B Excess Charges rider | Foreign Travel rider |
|---|---|---|---|---|---|---|---|
| 0–64 | 553.86 | 83.90 | 2.91 | 14.82 | -168.50 | 4.28 | 2.80 |
| 65–66 | 123.08 | 18.64 | 0.65 | 14.82 | -37.44 | 0.95 | 0.62 |
| 67 | 123.08 | 18.64 | 0.65 | 14.82 | -40.26 | 0.95 | 0.62 |
| 68 | 122.94 | 18.77 | 0.65 | 14.82 | -38.53 | 0.95 | 0.62 |
| 69 | 123.66 | 19.18 | 0.66 | 14.82 | -38.02 | 0.97 | 0.63 |
| 70 | 125.98 | 19.45 | 0.67 | 14.82 | -37.53 | 0.99 | 0.65 |
| 71 | 130.22 | 20.39 | 0.69 | 14.82 | -38.08 | 1.02 | 0.67 |
| 72 | 134.47 | 21.32 | 0.71 | 14.82 | -38.63 | 1.05 | 0.69 |
| 73 | 138.71 | 22.26 | 0.73 | 14.82 | -39.38 | 1.08 | 0.71 |
| 74 | 142.94 | 23.22 | 0.75 | 14.82 | -39.97 | 1.11 | 0.73 |
| 75 | 148.47 | 24.38 | 0.78 | 14.82 | -40.90 | 1.15 | 0.76 |
| 76 | 155.50 | 25.98 | 0.82 | 14.82 | -42.01 | 1.21 | 0.79 |
| 77 | 162.79 | 27.66 | 0.86 | 14.82 | -43.31 | 1.26 | 0.83 |
| 78 | 170.34 | 29.41 | 0.89 | 14.82 | -44.62 | 1.32 | 0.86 |
| 79 | 178.16 | 31.23 | 0.93 | 14.82 | -45.87 | 1.38 | 0.90 |
| 80 | 186.25 | 33.13 | 0.98 | 14.82 | -47.11 | 1.44 | 0.94 |
| 81 | 196.74 | 35.39 | 1.02 | 14.82 | -48.88 | 1.51 | 0.99 |
| 82 | 207.48 | 37.75 | 1.07 | 14.82 | -50.65 | 1.58 | 1.03 |
| 83 | 218.72 | 40.23 | 1.12 | 14.82 | -52.49 | 1.65 | 1.08 |
| 84 | 230.48 | 42.84 | 1.17 | 14.82 | -54.40 | 1.73 | 1.13 |
| 85 | 242.76 | 45.58 | 1.23 | 14.82 | -56.37 | 1.81 | 1.18 |
| 86 | 254.72 | 47.98 | 1.28 | 14.82 | -58.43 | 1.89 | 1.24 |
| 87 | 267.19 | 50.48 | 1.34 | 14.82 | -60.56 | 1.97 | 1.29 |
| 88 | 280.21 | 53.11 | 1.40 | 14.82 | -62.77 | 2.06 | 1.35 |
| 89 | 293.79 | 55.86 | 1.46 | 14.82 | -65.06 | 2.15 | 1.40 |
| 90 | 305.42 | 58.26 | 1.51 | 14.82 | -66.88 | 2.22 | 1.45 |
| 91 | 316.84 | 60.51 | 1.55 | 14.82 | -68.76 | 2.28 | 1.50 |
| 92 | 326.25 | 62.40 | 1.59 | 14.82 | -70.20 | 2.33 | 1.53 |
| 93 | 335.92 | 64.33 | 1.62 | 14.82 | -71.65 | 2.38 | 1.56 |
| 94 | 345.85 | 66.31 | 1.65 | 14.82 | -73.13 | 2.43 | 1.60 |
| 95 | 356.03 | 68.33 | 1.69 | 14.82 | -74.64 | 2.49 | 1.63 |
| 96 | 363.48 | 69.76 | 1.72 | 14.82 | -76.20 | 2.54 | 1.66 |
| 97 | 371.09 | 71.22 | 1.76 | 14.82 | -77.79 | 2.59 | 1.70 |
| 98 | 378.84 | 72.70 | 1.80 | 14.82 | -79.41 | 2.65 | 1.73 |
| 99 | 386.76 | 74.21 | 1.83 | 14.82 | -81.05 | 2.70 | 1.77 |

## Wisconsin

**ZIP codes: 530–531**

**Monthly base rates**

**Female**

**Effective February 1, 2024**

| Attained Age | Basic coverage | Part A Deductible rider | Additional Home Health Care rider | Part B Deductible rider | Part B Copayment or Coinsurance rider | Part B Excess Charges rider | Foreign Travel rider |
|---|---|---|---|---|---|---|---|
| 0–64 | 537.07 | 81.36 | 2.82 | 16.17 | -163.39 | 4.15 | 2.72 |
| 65–66 | 119.35 | 18.08 | 0.63 | 16.17 | -36.31 | 0.92 | 0.60 |
| 67 | 119.35 | 18.08 | 0.63 | 16.17 | -39.04 | 0.92 | 0.60 |
| 68 | 119.21 | 18.20 | 0.63 | 16.17 | -37.36 | 0.92 | 0.60 |
| 69 | 119.91 | 18.60 | 0.64 | 16.17 | -36.87 | 0.94 | 0.61 |
| 70 | 122.16 | 18.86 | 0.65 | 16.17 | -36.39 | 0.96 | 0.63 |
| 71 | 126.28 | 19.77 | 0.67 | 16.17 | -36.92 | 0.99 | 0.65 |
| 72 | 130.39 | 20.68 | 0.69 | 16.17 | -37.46 | 1.02 | 0.67 |
| 73 | 134.51 | 21.59 | 0.71 | 16.17 | -38.19 | 1.05 | 0.69 |
| 74 | 138.60 | 22.51 | 0.73 | 16.17 | -38.76 | 1.08 | 0.71 |
| 75 | 143.97 | 23.64 | 0.76 | 16.17 | -39.66 | 1.12 | 0.73 |
| 76 | 150.79 | 25.20 | 0.79 | 16.17 | -40.73 | 1.17 | 0.77 |
| 77 | 157.86 | 26.82 | 0.83 | 16.17 | -42.00 | 1.22 | 0.80 |
| 78 | 165.18 | 28.51 | 0.87 | 16.17 | -43.26 | 1.28 | 0.84 |
| 79 | 172.76 | 30.28 | 0.91 | 16.17 | -44.48 | 1.34 | 0.87 |
| 80 | 180.60 | 32.13 | 0.95 | 16.17 | -45.69 | 1.39 | 0.91 |
| 81 | 190.78 | 34.32 | 0.99 | 16.17 | -47.40 | 1.46 | 0.96 |
| 82 | 201.19 | 36.61 | 1.04 | 16.17 | -49.12 | 1.53 | 1.00 |
| 83 | 212.10 | 39.01 | 1.09 | 16.17 | -50.90 | 1.60 | 1.05 |
| 84 | 223.49 | 41.54 | 1.14 | 16.17 | -52.75 | 1.68 | 1.10 |
| 85 | 235.41 | 44.20 | 1.19 | 16.17 | -54.66 | 1.75 | 1.15 |
| 86 | 247.00 | 46.52 | 1.24 | 16.17 | -56.66 | 1.83 | 1.20 |
| 87 | 259.10 | 48.95 | 1.30 | 16.17 | -58.73 | 1.91 | 1.25 |
| 88 | 271.72 | 51.50 | 1.35 | 16.17 | -60.87 | 1.99 | 1.31 |
| 89 | 284.89 | 54.16 | 1.41 | 16.17 | -63.09 | 2.08 | 1.36 |
| 90 | 296.17 | 56.50 | 1.46 | 16.17 | -64.86 | 2.15 | 1.41 |
| 91 | 307.24 | 58.67 | 1.50 | 16.17 | -66.68 | 2.22 | 1.45 |
| 92 | 316.36 | 60.51 | 1.54 | 16.17 | -68.07 | 2.26 | 1.48 |
| 93 | 325.74 | 62.38 | 1.57 | 16.17 | -69.48 | 2.31 | 1.51 |
| 94 | 335.37 | 64.30 | 1.60 | 16.17 | -70.92 | 2.36 | 1.55 |
| 95 | 345.24 | 66.26 | 1.64 | 16.17 | -72.38 | 2.41 | 1.58 |
| 96 | 352.47 | 67.65 | 1.67 | 16.17 | -73.89 | 2.46 | 1.61 |
| 97 | 359.84 | 69.06 | 1.71 | 16.17 | -75.43 | 2.51 | 1.65 |
| 98 | 367.36 | 70.49 | 1.74 | 16.17 | -77.00 | 2.57 | 1.68 |
| 99 | 375.04 | 71.96 | 1.78 | 16.17 | -78.60 | 2.62 | 1.72 |

## Wisconsin

**ZIP codes: 530–531**

**Monthly base rates**

**Male**

**Effective February 1, 2024**

| Attained Age | Basic coverage | Part A Deductible rider | Additional Home Health Care rider | Part B Deductible rider | Part B Copayment or Coinsurance rider | Part B Excess Charges rider | Foreign Travel rider |
|---|---|---|---|---|---|---|---|
| 0–64 | 604.21 | 91.53 | 3.17 | 16.17 | -183.81 | 4.67 | 3.06 |
| 65–66 | 134.27 | 20.34 | 0.70 | 16.17 | -40.85 | 1.04 | 0.68 |
| 67 | 134.27 | 20.34 | 0.70 | 16.17 | -43.92 | 1.04 | 0.68 |
| 68 | 134.11 | 20.48 | 0.71 | 16.17 | -42.03 | 1.04 | 0.68 |
| 69 | 134.90 | 20.93 | 0.72 | 16.17 | -41.48 | 1.05 | 0.69 |
| 70 | 137.43 | 21.22 | 0.73 | 16.17 | -40.94 | 1.08 | 0.71 |
| 71 | 142.06 | 22.24 | 0.75 | 16.17 | -41.54 | 1.11 | 0.73 |
| 72 | 146.69 | 23.26 | 0.78 | 16.17 | -42.14 | 1.14 | 0.75 |
| 73 | 151.32 | 24.28 | 0.80 | 16.17 | -42.96 | 1.18 | 0.77 |
| 74 | 155.93 | 25.33 | 0.82 | 16.17 | -43.60 | 1.21 | 0.79 |
| 75 | 161.96 | 26.59 | 0.85 | 16.17 | -44.62 | 1.26 | 0.82 |
| 76 | 169.64 | 28.35 | 0.89 | 16.17 | -45.83 | 1.32 | 0.86 |
| 77 | 177.59 | 30.17 | 0.93 | 16.17 | -47.25 | 1.38 | 0.90 |
| 78 | 185.83 | 32.08 | 0.98 | 16.17 | -48.67 | 1.44 | 0.94 |
| 79 | 194.35 | 34.07 | 1.02 | 16.17 | -50.04 | 1.50 | 0.98 |
| 80 | 203.18 | 36.14 | 1.06 | 16.17 | -51.40 | 1.57 | 1.03 |
| 81 | 214.63 | 38.61 | 1.12 | 16.17 | -53.32 | 1.64 | 1.08 |
| 82 | 226.34 | 41.18 | 1.17 | 16.17 | -55.26 | 1.72 | 1.13 |
| 83 | 238.61 | 43.89 | 1.22 | 16.17 | -57.26 | 1.80 | 1.18 |
| 84 | 251.43 | 46.73 | 1.28 | 16.17 | -59.34 | 1.88 | 1.23 |
| 85 | 264.83 | 49.72 | 1.34 | 16.17 | -61.50 | 1.97 | 1.29 |
| 86 | 277.88 | 52.34 | 1.40 | 16.17 | -63.74 | 2.06 | 1.35 |
| 87 | 291.48 | 55.07 | 1.46 | 16.17 | -66.07 | 2.15 | 1.41 |
| 88 | 305.68 | 57.94 | 1.52 | 16.17 | -68.48 | 2.24 | 1.47 |
| 89 | 320.50 | 60.93 | 1.59 | 16.17 | -70.97 | 2.34 | 1.53 |
| 90 | 333.19 | 63.56 | 1.65 | 16.17 | -72.96 | 2.42 | 1.59 |
| 91 | 345.64 | 66.01 | 1.69 | 16.17 | -75.01 | 2.49 | 1.63 |
| 92 | 355.91 | 68.07 | 1.73 | 16.17 | -76.58 | 2.55 | 1.67 |
| 93 | 366.46 | 70.17 | 1.77 | 16.17 | -78.17 | 2.60 | 1.70 |
| 94 | 377.29 | 72.33 | 1.81 | 16.17 | -79.78 | 2.66 | 1.74 |
| 95 | 388.40 | 74.55 | 1.84 | 16.17 | -81.42 | 2.71 | 1.78 |
| 96 | 396.53 | 76.10 | 1.88 | 16.17 | -83.13 | 2.77 | 1.82 |
| 97 | 404.82 | 77.69 | 1.92 | 16.17 | -84.86 | 2.83 | 1.85 |
| 98 | 413.28 | 79.31 | 1.96 | 16.17 | -86.63 | 2.89 | 1.89 |
| 99 | 370.35 | 76.98 | 2.00 | 15.23 | -88.42 | 2.95 | 1.93 |

## Wisconsin

**ZIP codes: 532, 534**

**Monthly base rates**

**Female**

**Effective February 1, 2024**

| Attained Age | Basic coverage | Part A Deductible rider | Additional Home Health Care rider | Part B Deductible rider | Part B Copayment or Coinsurance rider | Part B Excess Charges rider | Foreign Travel rider |
|---|---|---|---|---|---|---|---|
| 0–64 | 581.83 | 88.14 | 3.05 | 17.52 | -177.00 | 4.49 | 2.95 |
| 65–66 | 129.30 | 19.59 | 0.68 | 17.52 | -39.33 | 1.00 | 0.65 |
| 67 | 129.30 | 19.59 | 0.68 | 17.52 | -42.29 | 1.00 | 0.65 |
| 68 | 129.15 | 19.72 | 0.68 | 17.52 | -40.48 | 1.00 | 0.65 |
| 69 | 129.91 | 20.15 | 0.69 | 17.52 | -39.94 | 1.01 | 0.67 |
| 70 | 132.34 | 20.43 | 0.70 | 17.52 | -39.42 | 1.04 | 0.68 |
| 71 | 136.80 | 21.42 | 0.73 | 17.52 | -40.00 | 1.07 | 0.70 |
| 72 | 141.26 | 22.40 | 0.75 | 17.52 | -40.58 | 1.10 | 0.72 |
| 73 | 145.72 | 23.39 | 0.77 | 17.52 | -41.37 | 1.13 | 0.74 |
| 74 | 150.15 | 24.39 | 0.79 | 17.52 | -41.99 | 1.17 | 0.76 |
| 75 | 155.96 | 25.61 | 0.82 | 17.52 | -42.97 | 1.21 | 0.79 |
| 76 | 163.36 | 27.30 | 0.86 | 17.52 | -44.13 | 1.27 | 0.83 |
| 77 | 171.01 | 29.06 | 0.90 | 17.52 | -45.50 | 1.32 | 0.87 |
| 78 | 178.95 | 30.89 | 0.94 | 17.52 | -46.87 | 1.38 | 0.91 |
| 79 | 187.16 | 32.81 | 0.98 | 17.52 | -48.19 | 1.45 | 0.95 |
| 80 | 195.65 | 34.80 | 1.03 | 17.52 | -49.49 | 1.51 | 0.99 |
| 81 | 206.68 | 37.18 | 1.07 | 17.52 | -51.35 | 1.58 | 1.04 |
| 82 | 217.96 | 39.66 | 1.13 | 17.52 | -53.21 | 1.66 | 1.08 |
| 83 | 229.77 | 42.26 | 1.18 | 17.52 | -55.14 | 1.73 | 1.14 |
| 84 | 242.12 | 45.00 | 1.23 | 17.52 | -57.14 | 1.82 | 1.19 |
| 85 | 255.02 | 47.88 | 1.29 | 17.52 | -59.22 | 1.90 | 1.24 |
| 86 | 267.58 | 50.40 | 1.35 | 17.52 | -61.38 | 1.98 | 1.30 |
| 87 | 280.69 | 53.03 | 1.40 | 17.52 | -63.62 | 2.07 | 1.36 |
| 88 | 294.36 | 55.79 | 1.47 | 17.52 | -65.94 | 2.16 | 1.41 |
| 89 | 308.63 | 58.68 | 1.53 | 17.52 | -68.34 | 2.25 | 1.48 |
| 90 | 320.85 | 61.20 | 1.58 | 17.52 | -70.26 | 2.33 | 1.53 |
| 91 | 332.84 | 63.56 | 1.63 | 17.52 | -72.23 | 2.40 | 1.57 |
| 92 | 342.73 | 65.55 | 1.67 | 17.52 | -73.74 | 2.45 | 1.61 |
| 93 | 352.89 | 67.58 | 1.70 | 17.52 | -75.27 | 2.50 | 1.64 |
| 94 | 363.31 | 69.65 | 1.74 | 17.52 | -76.83 | 2.56 | 1.68 |
| 95 | 374.01 | 71.78 | 1.77 | 17.52 | -78.41 | 2.61 | 1.71 |
| 96 | 381.84 | 73.28 | 1.81 | 17.52 | -80.05 | 2.67 | 1.75 |
| 97 | 389.83 | 74.81 | 1.85 | 17.52 | -81.72 | 2.72 | 1.78 |
| 98 | 397.98 | 76.37 | 1.89 | 17.52 | -83.42 | 2.78 | 1.82 |
| 99 | 406.30 | 77.95 | 1.93 | 17.52 | -85.15 | 2.84 | 1.86 |

## Wisconsin

**ZIP codes: 532, 534**

**Monthly base rates**

**Male**

**Effective February 1, 2024**

| Attained Age | Basic coverage | Part A Deductible rider | Additional Home Health Care rider | Part B Deductible rider | Part B Copayment or Coinsurance rider | Part B Excess Charges rider | Foreign Travel rider |
|---|---|---|---|---|---|---|---|
| 0–64 | 654.56 | 99.16 | 3.43 | 17.52 | -199.13 | 5.06 | 3.31 |
| 65–66 | 145.46 | 22.03 | 0.76 | 17.52 | -44.25 | 1.12 | 0.74 |
| 67 | 145.46 | 22.03 | 0.76 | 17.52 | -47.58 | 1.12 | 0.74 |
| 68 | 145.29 | 22.18 | 0.76 | 17.52 | -45.54 | 1.13 | 0.74 |
| 69 | 146.14 | 22.67 | 0.78 | 17.52 | -44.94 | 1.14 | 0.75 |
| 70 | 148.88 | 22.99 | 0.79 | 17.52 | -44.35 | 1.17 | 0.76 |
| 71 | 153.90 | 24.09 | 0.82 | 17.52 | -45.00 | 1.20 | 0.79 |
| 72 | 158.92 | 25.20 | 0.84 | 17.52 | -45.65 | 1.24 | 0.81 |
| 73 | 163.93 | 26.31 | 0.87 | 17.52 | -46.54 | 1.28 | 0.84 |
| 74 | 168.92 | 27.44 | 0.89 | 17.52 | -47.24 | 1.31 | 0.86 |
| 75 | 175.46 | 28.81 | 0.93 | 17.52 | -48.34 | 1.36 | 0.89 |
| 76 | 183.78 | 30.71 | 0.97 | 17.52 | -49.65 | 1.43 | 0.93 |
| 77 | 192.39 | 32.69 | 1.01 | 17.52 | -51.19 | 1.49 | 0.98 |
| 78 | 201.32 | 34.75 | 1.06 | 17.52 | -52.73 | 1.56 | 1.02 |
| 79 | 210.55 | 36.91 | 1.10 | 17.52 | -54.21 | 1.63 | 1.07 |
| 80 | 220.11 | 39.15 | 1.15 | 17.52 | -55.68 | 1.70 | 1.11 |
| 81 | 232.51 | 41.82 | 1.21 | 17.52 | -57.76 | 1.78 | 1.17 |
| 82 | 245.21 | 44.62 | 1.27 | 17.52 | -59.86 | 1.86 | 1.22 |
| 83 | 258.49 | 47.55 | 1.32 | 17.52 | -62.04 | 1.95 | 1.28 |
| 84 | 272.38 | 50.63 | 1.39 | 17.52 | -64.29 | 2.04 | 1.34 |
| 85 | 286.90 | 53.87 | 1.45 | 17.52 | -66.62 | 2.14 | 1.40 |
| 86 | 301.03 | 56.70 | 1.51 | 17.52 | -69.05 | 2.23 | 1.46 |
| 87 | 315.77 | 59.66 | 1.58 | 17.52 | -71.57 | 2.33 | 1.52 |
| 88 | 331.16 | 62.76 | 1.65 | 17.52 | -74.18 | 2.43 | 1.59 |
| 89 | 347.20 | 66.01 | 1.72 | 17.52 | -76.89 | 2.54 | 1.66 |
| 90 | 360.96 | 68.85 | 1.78 | 17.52 | -79.04 | 2.62 | 1.72 |
| 91 | 374.45 | 71.51 | 1.83 | 17.52 | -81.26 | 2.70 | 1.77 |
| 92 | 385.57 | 73.74 | 1.87 | 17.52 | -82.96 | 2.76 | 1.81 |
| 93 | 397.00 | 76.02 | 1.91 | 17.52 | -84.68 | 2.82 | 1.85 |
| 94 | 408.73 | 78.36 | 1.96 | 17.52 | -86.43 | 2.88 | 1.89 |
| 95 | 420.77 | 80.76 | 2.00 | 17.52 | -88.21 | 2.94 | 1.93 |
| 96 | 429.57 | 82.45 | 2.04 | 17.52 | -90.05 | 3.00 | 1.97 |
| 97 | 438.56 | 84.16 | 2.08 | 17.52 | -91.93 | 3.06 | 2.01 |
| 98 | 447.72 | 85.92 | 2.12 | 17.52 | -93.84 | 3.13 | 2.05 |
| 99 | 457.09 | 87.70 | 2.17 | 17.52 | -95.79 | 3.19 | 2.09 |

## Wisconsin

**All other ZIP codes**

**Monthly base rates**

**Female**

**Effective February 1, 2024**

| Attained Age | Basic coverage | Part A Deductible rider | Additional Home Health Care rider | Part B Deductible rider | Part B Copayment or Coinsurance rider | Part B Excess Charges rider | Foreign Travel rider |
|---|---|---|---|---|---|---|---|
| 0–64 | 656.42 | 99.44 | 3.44 | 19.76 | -199.70 | 5.07 | 3.32 |
| 65–66 | 145.87 | 22.10 | 0.77 | 19.76 | -44.38 | 1.13 | 0.74 |
| 67 | 145.87 | 22.10 | 0.77 | 19.76 | -47.72 | 1.13 | 0.74 |
| 68 | 145.70 | 22.25 | 0.77 | 19.76 | -45.67 | 1.13 | 0.74 |
| 69 | 146.56 | 22.73 | 0.78 | 19.76 | -45.07 | 1.14 | 0.75 |
| 70 | 149.31 | 23.05 | 0.79 | 19.76 | -44.47 | 1.17 | 0.77 |
| 71 | 154.34 | 24.16 | 0.82 | 19.76 | -45.13 | 1.21 | 0.79 |
| 72 | 159.37 | 25.27 | 0.84 | 19.76 | -45.78 | 1.24 | 0.81 |
| 73 | 164.40 | 26.38 | 0.87 | 19.76 | -46.67 | 1.28 | 0.84 |
| 74 | 169.41 | 27.52 | 0.89 | 19.76 | -47.37 | 1.32 | 0.86 |
| 75 | 175.96 | 28.89 | 0.93 | 19.76 | -48.48 | 1.37 | 0.90 |
| 76 | 184.30 | 30.79 | 0.97 | 19.76 | -49.79 | 1.43 | 0.94 |
| 77 | 192.94 | 32.78 | 1.01 | 19.76 | -51.33 | 1.49 | 0.98 |
| 78 | 201.89 | 34.85 | 1.06 | 19.76 | -52.88 | 1.56 | 1.02 |
| 79 | 211.15 | 37.01 | 1.11 | 19.76 | -54.37 | 1.63 | 1.07 |
| 80 | 220.74 | 39.27 | 1.16 | 19.76 | -55.84 | 1.70 | 1.12 |
| 81 | 233.17 | 41.94 | 1.21 | 19.76 | -57.93 | 1.79 | 1.17 |
| 82 | 245.90 | 44.74 | 1.27 | 19.76 | -60.03 | 1.87 | 1.22 |
| 83 | 259.23 | 47.68 | 1.33 | 19.76 | -62.21 | 1.96 | 1.28 |
| 84 | 273.16 | 50.77 | 1.39 | 19.76 | -64.47 | 2.05 | 1.34 |
| 85 | 287.72 | 54.02 | 1.45 | 19.76 | -66.81 | 2.14 | 1.40 |
| 86 | 301.89 | 56.86 | 1.52 | 19.76 | -69.25 | 2.24 | 1.46 |
| 87 | 316.68 | 59.83 | 1.58 | 19.76 | -71.78 | 2.33 | 1.53 |
| 88 | 332.10 | 62.94 | 1.65 | 19.76 | -74.39 | 2.44 | 1.60 |
| 89 | 348.19 | 66.20 | 1.73 | 19.76 | -77.10 | 2.54 | 1.66 |
| 90 | 361.98 | 69.05 | 1.79 | 19.76 | -79.27 | 2.63 | 1.72 |
| 91 | 375.51 | 71.71 | 1.84 | 19.76 | -81.49 | 2.71 | 1.77 |
| 92 | 386.67 | 73.95 | 1.88 | 19.76 | -83.20 | 2.77 | 1.81 |
| 93 | 398.13 | 76.24 | 1.92 | 19.76 | -84.92 | 2.83 | 1.85 |
| 94 | 409.89 | 78.58 | 1.96 | 19.76 | -86.68 | 2.89 | 1.89 |
| 95 | 421.96 | 80.99 | 2.00 | 19.76 | -88.46 | 2.95 | 1.93 |
| 96 | 430.79 | 82.68 | 2.04 | 19.76 | -90.31 | 3.01 | 1.97 |
| 97 | 439.81 | 84.40 | 2.09 | 19.76 | -92.19 | 3.07 | 2.01 |
| 98 | 449.00 | 86.16 | 2.13 | 19.76 | -94.11 | 3.14 | 2.06 |
| 99 | 458.39 | 87.95 | 2.17 | 19.76 | -96.06 | 3.20 | 2.10 |

## Wisconsin

**All other ZIP codes**

**Monthly base rates**

**Male**

**Effective February 1, 2024**

| Attained Age | Basic coverage | Part A Deductible rider | Additional Home Health Care rider | Part B Deductible rider | Part B Copayment or Coinsurance rider | Part B Excess Charges rider | Foreign Travel rider |
|---|---|---|---|---|---|---|---|
| 0–64 | 738.48 | 111.87 | 3.87 | 19.76 | -224.66 | 5.70 | 3.74 |
| 65–66 | 164.11 | 24.86 | 0.86 | 19.76 | -49.92 | 1.27 | 0.83 |
| 67 | 164.11 | 24.86 | 0.86 | 19.76 | -53.68 | 1.27 | 0.83 |
| 68 | 163.92 | 25.03 | 0.86 | 19.76 | -51.37 | 1.27 | 0.83 |
| 69 | 164.88 | 25.58 | 0.88 | 19.76 | -50.70 | 1.29 | 0.84 |
| 70 | 167.97 | 25.93 | 0.89 | 19.76 | -50.03 | 1.32 | 0.86 |
| 71 | 173.63 | 27.18 | 0.92 | 19.76 | -50.77 | 1.36 | 0.89 |
| 72 | 179.29 | 28.43 | 0.95 | 19.76 | -51.51 | 1.40 | 0.92 |
| 73 | 184.95 | 29.68 | 0.98 | 19.76 | -52.51 | 1.44 | 0.94 |
| 74 | 190.58 | 30.96 | 1.01 | 19.76 | -53.29 | 1.48 | 0.97 |
| 75 | 197.95 | 32.50 | 1.04 | 19.76 | -54.54 | 1.54 | 1.01 |
| 76 | 207.34 | 34.64 | 1.09 | 19.76 | -56.01 | 1.61 | 1.05 |
| 77 | 217.06 | 36.88 | 1.14 | 19.76 | -57.75 | 1.68 | 1.10 |
| 78 | 227.13 | 39.21 | 1.19 | 19.76 | -59.49 | 1.76 | 1.15 |
| 79 | 237.54 | 41.64 | 1.25 | 19.76 | -61.16 | 1.84 | 1.20 |
| 80 | 248.33 | 44.17 | 1.30 | 19.76 | -62.82 | 1.92 | 1.26 |
| 81 | 262.32 | 47.18 | 1.36 | 19.76 | -65.17 | 2.01 | 1.32 |
| 82 | 276.64 | 50.34 | 1.43 | 19.76 | -67.54 | 2.10 | 1.38 |
| 83 | 291.63 | 53.64 | 1.49 | 19.76 | -69.99 | 2.20 | 1.44 |
| 84 | 307.30 | 57.12 | 1.56 | 19.76 | -72.53 | 2.30 | 1.51 |
| 85 | 323.68 | 60.77 | 1.64 | 19.76 | -75.16 | 2.41 | 1.58 |
| 86 | 339.63 | 63.97 | 1.71 | 19.76 | -77.91 | 2.52 | 1.65 |
| 87 | 356.26 | 67.31 | 1.78 | 19.76 | -80.75 | 2.63 | 1.72 |
| 88 | 373.61 | 70.81 | 1.86 | 19.76 | -83.69 | 2.74 | 1.79 |
| 89 | 391.72 | 74.48 | 1.94 | 19.76 | -86.74 | 2.86 | 1.87 |
| 90 | 407.23 | 77.68 | 2.01 | 19.76 | -89.18 | 2.96 | 1.94 |
| 91 | 422.45 | 80.68 | 2.07 | 19.76 | -91.68 | 3.05 | 2.00 |
| 92 | 435.00 | 83.20 | 2.11 | 19.76 | -93.60 | 3.11 | 2.04 |
| 93 | 447.90 | 85.77 | 2.16 | 19.76 | -95.54 | 3.18 | 2.08 |
| 94 | 461.13 | 88.41 | 2.21 | 19.76 | -97.51 | 3.25 | 2.13 |
| 95 | 474.71 | 91.11 | 2.25 | 19.76 | -99.52 | 3.32 | 2.17 |
| 96 | 484.64 | 93.02 | 2.30 | 19.76 | -101.60 | 3.39 | 2.22 |
| 97 | 494.78 | 94.95 | 2.35 | 19.76 | -103.72 | 3.46 | 2.26 |
| 98 | 505.13 | 96.93 | 2.40 | 19.76 | -105.88 | 3.53 | 2.31 |
| 99 | 515.69 | 98.94 | 2.45 | 19.76 | -108.07 | 3.60 | 2.36 |

wellabe®

# Medical Notice of Privacy Practices

**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, American Republic Corp Insurance Company, Medico Insurance Company, Medico Life and Health 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 affiliated covered entity known as the "Wellabe ACE." This designation may be amended from time to time to add new covered entities that are under common control and ownership with the Wellabe ACE. This Notice of Privacy Practices applies to Wellabe ACE health insurance plans.

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 Wellabe ACE's designated health care entities;
- 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

We may use and/or share the information we collect about you as allowed by law, including sharing your information among our affiliated companies for everyday business purposes. Subject to state and federal laws, we are permitted to use and/or share your information without your authorization in certain circumstances, such as:

- For treatment purposes, for example, we may collect or disclose information to health care providers in their provision of care.
- For payment purposes, such as paying your claims, processing payments, conducting utilization and medical necessity reviews, determining eligibility, and other administrative 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 perform health care operations, including normal everyday business purposes. For example, we may use the information for activities relating to underwriting, processing your application, customer service, preventative health, disease management, and wellness programs, case management, and care coordination, legal services, auditing functions, including fraud and abuse detection and compliance programs, and other administrative purposes. We will not use or disclose genetic information, including family history, for underwriting purposes.
- To communicate with you, electronically or via the telephone using contact information you provide to us.
- Administering surveys and promotions, or business research and analysis.
- To perform analytics and to improve our products, website, mobile application(s), and advertising.
- To an affiliate or to a business associate if they need your health information to provide a service to us and have confirmed that they follow the HIPAA rules related to protection of health information. Examples of these business associates include insurance agents, auditors, actuaries and underwriting support services, legal service providers, enrollment, and billing service providers, claim payment administrators, IT service or system providers, and collection agencies.
- To other covered entities, or business associates of those entities, for treatment, payment, and certain health care operations purposes.
- Providing you with information about health-related benefits and services that you may be interested in, subject to limits imposed by law. We may provide informational or promotional offers, as permitted by law, that we believe may be useful to you, such as information about products or services provided by us or other companies. We will not share your information with or sell it to telemarketing agencies or other agencies that market products or services other than those products and services provided or administered by the Wellabe ACE or its business associates without your authorization.
- To administer programs or services that add value to you but are not part of your benefit plan.
- 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.
- As otherwise necessary or useful for us to conduct our business, so long as such use is permitted by law or for any other purpose with your consent.

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, or determine a cause of death.
- 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.

Certain state and federal laws may restrict the use and disclosure of certain health information, including highly confidential information. This may include, but is not limited to, substance abuse, communicable diseases, HIV/AIDS, mental health, reproductive health, sexually transmitted infections, and biometric information. 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**. 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 success team. Contact information for our customer success team 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, pursuant to applicable state and federal law.
- **You have the right to ask us to restrict:**
  (a) how we use or disclose your information for treatment, 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. We may require such requests to be made in writing.
- **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 success team 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 success team.
- **You have the right to receive an accounting of certain disclosures of your information.** Accounting request forms are available from our customer success team 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 a 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. If you believe your privacy rights have been violated, you may file a complaint with us by contacting our customer success team. 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

You can contact our Customer Success team at:

**Wellabe, Inc.**
**P.O. Box 1**
**Des Moines, IA 50306-0001**
**800-247-2190**

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

**Wellabe, Inc.**
**Attn: Privacy Officer**
**601 6th Ave**
**Des Moines, IA 50309**

You may also visit us on our website at: **www.wellabe.com**

**Effective Date:** January 2024

wellabe®

# Financial Notice of Privacy Practices

**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 Wellabe, 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. For purposes of this Notice, "Wellabe," us," "our," or "we" includes Wellabe, Inc., and its affiliates including American Republic Insurance Company, American Republic Corp Insurance Company, Medico Insurance Company, Medico Life and Health Insurance Company, Medico Corp Life Insurance Company, and Great Western Insurance Company.

For information on how we use data collected from visitors to Wellabe websites, mobile applications, and products and services that we own or operate, please refer to the "Wellabe Notice of Online Services Privacy and Security Practices."

## 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 may collect the following:

- Information received from your application, surveys, or other forms, during conversations with us or our representatives, or electronically, including when you visit our website or mobile application(s). For example, name, address, social security number, age, medical and financial information.
- Information about your relationship and transactions with us, our affiliates, our agents, and others, including your identification and policy number(s), the type of products you buy, the premiums you pay, and your payment history.
- Information received from a consumer reporting or credit agency or from public records.
- Information received from a third party, for example, to verify your identity and to better understand your product and service needs.
- Information received from service providers regarding treatment of health conditions and payment for that treatment.
- Information collected as part of any programs or services we administer.

Information by which you cannot be identified, for example, anonymous or aggregated information, is not considered nonpublic personal information and therefore is not subject to this Notice.

## What information do we share with others?

We may share the information we collect about you as allowed by law, including sharing your information among our affiliated companies for everyday business purposes.

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

- Processing transactions you have requested, are legally required, or that are necessary to administer our business, including processing your application and issuing your policy.
- Maintaining or supporting products or services you have requested, including normal everyday business purposes, such as paying your claims, making policy changes, or other administrative handling.
- Providing customer service, responding to your inquiries, corresponding with you, providing you with updates about your account and service, sending you electronic newsletters, administering surveys and promotions, or business research and analysis.
- Performing analytics and to improve our products, website, mobile application(s), and advertising.
- Providing you with information about products and services that you may be interested in, subject to limits imposed by law. We may provide informational or promotional offers, as permitted by law, that we believe may be useful to you, such as information about products or services provided by us or other companies.
- Administer programs or services that add value to you but are not part of your benefit plan.
- As otherwise necessary or useful for us to conduct our business, so long as such use is permitted by law or for any other purpose with your consent.

We may disclose relevant portions of the information we collect, as described above, to third parties that perform services on our behalf or with whom we have joint marketing agreements. Before we share your information with a nonaffiliated third party for marketing purposes, we will offer you the opportunity to opt out, as required by applicable law.

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 Wellabe or its contracted third parties. Our contracted third parties are bound by the same restrictions on the release and use of such information.

There are state and federal laws that may require or permit us to release your information to government agencies, other regulatory bodies and law enforcement officials, or other organizations as permitted or required by law. For example, for tax purposes, fraud prevention, or to respond to a valid court order or subpoena.

## 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 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 or our contracted third parties who need the information we collect from or about you to provide products or services to you may access that information. Employees and contracted third parties 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.

## Financial Notice of Privacy Practices (continued)

### 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 our customer success team at the number listed on your contract materials. We will respond promptly when we learn corrections are needed.

### Contact Information

You can contact our Customer Success team at:

**Wellabe, Inc.**
**P.O. Box 1**
**Des Moines, IA 50306-0001**
**800-247-2190**

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

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