

**Medico® Life and Health Insurance Company**  
**A Wellabe® Company**

# **Medicare Supplement Insurance**

NEBRASKA SALES KIT

## **PRODUCER INSTRUCTIONS**

Submit applications electronically using MyEnroller:

**MyEnroller**  
Electronic Application Submission Tool  
Website: [wellabe.com/signin](http://wellabe.com/signin)

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

**Medico® Life and Health 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

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 or are losing 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, diabetes with complications or in combination with a prior diagnosis of retinopathy, neuropathy, stroke/TIA, heart disease or disorder, kidney disease, any circulatory disease that affects the heart and/or blood vessels, or skin ulcer? ☐ 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, congestive heart failure or atrial fibrillation episode(s)? ☐ 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<br>each time | Frequency<br>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:** 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.

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:

☐ Automatic bank withdrawal  
☐ Credit/Debit card

### Frequency of payment:

☐ Monthly ☐ Quarterly ☐ Semi-annually ☐ Annually  
☐ 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 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.wellabe.com/products](http://www.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

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.wellabe.com/products](http://www.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 its 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):

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

1.

1.

2.

2.

Replacement Notice

## 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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Senior Counseling Notice

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Counseling services are available in the State of Nebraska that offer seniors advice concerning the purchase of Medicare Supplement and/or Long-Term Care insurance.

This free senior counseling program is administered by:

Nebraska Department of Insurance  
Nebraska Senior Health Insurance Assistance Program (SHIP)  
1033 "O" Street, Suite 307 (Golds Building)  
Lincoln, NE 68508

The Senior Health Insurance Assistance Program (SHIP) offers a toll-free hotline for residents of Nebraska. Any person eligible for Medicare, concerned relatives or friends can call the SHIP hotline for answers to insurance questions or to arrange a meeting with a SHIP staff member or volunteer:

**800-234-7119**

**TTY: 800-833-7352**

The Nebraska Senior Health Insurance Assistance Program (SHIP) provides information and counseling to older Nebraskans and persons with disabilities regarding Medicare, Medicaid and health insurance.

## Outline of Medicare Supplement Plan Benefits

### Available Plans: A, F, HdF<sup>1</sup>, G, HdG<sup>1</sup>, 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 <sup>1</sup> | K       | L       | M   | N                              | C                                        | F <sup>1</sup> |
| 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%     | ✓   | ✓<br>copays apply <sup>3</sup> | ✓                                        | ✓              |
| 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 2024 <sup>2</sup>                                                                             |                                   |   |   |                | \$7,060 | \$3,530 |     |                                |                                          |                |

<sup>1</sup>Plans F and G also have a high deductible option which require first paying a plan deductible of \$2,800 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.

<sup>2</sup>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.

<sup>3</sup>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                        |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|---------------------------------------|--------------------------------|
| <b>HOSPITALIZATION*</b><br>Semiprivate room and board, general nursing and miscellaneous services and supplies                                                                                                             |                                                                                            |                                       |                                |
| First 60 days                                                                                                                                                                                                              | All but \$1,632                                                                            | \$0                                   | \$1,632<br>(Part A deductible) |
| 61st thru 90th day                                                                                                                                                                                                         | All but \$408 a day                                                                        | \$408 a day                           | \$0                            |
| 91st day and after:<br>• While using 60 lifetime reserve days                                                                                                                                                              | All but \$816 a day                                                                        | \$816 a day                           | \$0                            |
| • Once lifetime reserve days are used:<br>• Additional 365 days                                                                                                                                                            | \$0                                                                                        | 100% of Medicare<br>Eligible expenses | \$0**                          |
| • Beyond the additional 365 days                                                                                                                                                                                           | \$0                                                                                        | \$0                                   | All costs                      |
| <b>SKILLED NURSING FACILITY CARE*</b><br>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 \$204 a day                                                                        | \$0                                   | Up to \$204 a day              |
| 101st day and after                                                                                                                                                                                                        | \$0                                                                                        | \$0                                   | All costs                      |
| <b>BLOOD</b>                                                                                                                                                                                                               |                                                                                            |                                       |                                |
| First 3 pints                                                                                                                                                                                                              | \$0                                                                                        | 3 pints                               | \$0                            |
| Additional amounts                                                                                                                                                                                                         | 100%                                                                                       | \$0                                   | \$0                            |
| <b>HOSPICE CARE</b>                                                                                                                                                                                                        |                                                                                            |                                       |                                |
| 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                   |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|---------------|---------------------------|
| <b>MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT,</b><br>such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment |               |               |                           |
| First \$240 of Medicare Approved Amounts* (Part B deductible)                                                                                                                                                                                                         | \$0           | \$0           | \$240 (Part B deductible) |
| Remainder of Medicare Approved Amounts                                                                                                                                                                                                                                | Generally 80% | Generally 20% | \$0                       |
| <b>PART B EXCESS CHARGES</b>                                                                                                                                                                                                                                          |               |               |                           |
| Above Medicare Approved Amounts                                                                                                                                                                                                                                       | \$0           | \$0           | All costs                 |
| <b>BLOOD</b>                                                                                                                                                                                                                                                          |               |               |                           |
| First 3 pints                                                                                                                                                                                                                                                         | \$0           | All costs     | \$0                       |
| Next \$240 of Medicare Approved Amounts* (Part B deductible)                                                                                                                                                                                                          | \$0           | \$0           | \$240 (Part B deductible) |
| Remainder of Medicare Approved Amounts                                                                                                                                                                                                                                | 80%           | 20%           | \$0                       |
| <b>CLINICAL LABORATORY SERVICES</b>                                                                                                                                                                                                                                   |               |               |                           |
| Tests for Diagnostic Services                                                                                                                                                                                                                                         | 100%          | \$0           | \$0                       |

**MEDICARE (PARTS A AND B) - HOME HEALTH CARE**

| SERVICES                                                       | MEDICARE PAYS | PLAN PAYS | YOU PAY                   |
|----------------------------------------------------------------|---------------|-----------|---------------------------|
| <b>HOME HEALTH CARE - MEDICARE APPROVED SERVICES</b>           |               |           |                           |
| Medically necessary skilled care services and medical supplies | 100%          | \$0       | \$0                       |
| Durable medical equipment                                      |               |           |                           |
| • First \$240 of Medicare Approved Amounts*                    | \$0           | \$0       | \$240 (Part B deductible) |
| • Remainder of Medicare Approved Amounts                       | 80%           | 20%       | \$0                       |

\* Once you have been billed for \$240 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   |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|---------------------------------------|-----------|
| <b>HOSPITALIZATION*</b><br>Semiprivate room and board, general nursing and miscellaneous services and supplies                                                                                                             |                                                                                            |                                       |           |
| First 60 days                                                                                                                                                                                                              | All but \$1,632                                                                            | \$1,632<br>(Part A deductible)        | \$0       |
| 61st thru 90th day                                                                                                                                                                                                         | All but \$408 a day                                                                        | \$408 a day                           | \$0       |
| 91st day and after:<br>• While using 60 lifetime reserve days                                                                                                                                                              | All but \$816 a day                                                                        | \$816 a day                           | \$0       |
| • Once lifetime reserve days are used:<br>• Additional 365 days                                                                                                                                                            | \$0                                                                                        | 100% of Medicare<br>Eligible expenses | \$0**     |
| • Beyond the additional 365 days                                                                                                                                                                                           | \$0                                                                                        | \$0                                   | All costs |
| <b>SKILLED NURSING FACILITY CARE*</b><br>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 \$204 a day                                                                        | Up to \$204 a day                     | \$0       |
| 101st day and after                                                                                                                                                                                                        | \$0                                                                                        | \$0                                   | All costs |
| <b>BLOOD</b>                                                                                                                                                                                                               |                                                                                            |                                       |           |
| First 3 pints                                                                                                                                                                                                              | \$0                                                                                        | 3 pints                               | \$0       |
| Additional amounts                                                                                                                                                                                                         | 100%                                                                                       | \$0                                   | \$0       |
| <b>HOSPICE CARE</b>                                                                                                                                                                                                        |                                                                                            |                                       |           |
| 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 |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|---------------------------|---------|
| <b>MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b><br>Such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment |               |                           |         |
| First \$240 of Medicare Approved Amounts* (Part B deductible)                                                                                                                                                                                                        | \$0           | \$240 (Part B deductible) | \$0     |
| Remainder of Medicare Approved Amounts                                                                                                                                                                                                                               | Generally 80% | Generally 20%             | \$0     |
| <b>PART B EXCESS CHARGES</b>                                                                                                                                                                                                                                         |               |                           |         |
| Above Medicare Approved Amounts                                                                                                                                                                                                                                      | \$0           | 100%                      | \$0     |
| <b>BLOOD</b>                                                                                                                                                                                                                                                         |               |                           |         |
| First 3 pints                                                                                                                                                                                                                                                        | \$0           | All costs                 | \$0     |
| Next \$240 of Medicare Approved Amounts* (Part B deductible)                                                                                                                                                                                                         | \$0           | \$240 (Part B deductible) | \$0     |
| Remainder of Medicare Approved Amounts                                                                                                                                                                                                                               | 80%           | 20%                       | \$0     |
| <b>CLINICAL LABORATORY SERVICES</b>                                                                                                                                                                                                                                  |               |                           |         |
| Tests for Diagnostic Services                                                                                                                                                                                                                                        | 100%          | \$0                       | \$0     |

**MEDICARE (PARTS A AND B) - HOME HEALTH CARE**

| SERVICES                                                       | MEDICARE PAYS | PLAN PAYS                 | YOU PAY |
|----------------------------------------------------------------|---------------|---------------------------|---------|
| <b>HOME HEALTH CARE - MEDICARE APPROVED SERVICES</b>           |               |                           |         |
| Medically necessary skilled care services and medical supplies | 100%          | \$0                       | \$0     |
| Durable medical equipment                                      |               |                           |         |
| • First \$240 of Medicare Approved Amounts*                    | \$0           | \$240 (Part B deductible) | \$0     |
| • Remainder of Medicare Approved Amounts                       | 80%           | 20%                       | \$0     |

\* Once you have been billed for \$240 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                                                  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|-----------------------------------------------------|----------------------------------------------------------|
| <b>FOREIGN TRAVEL - NOT COVERED BY MEDICARE</b><br>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<br>Maximum Benefit of<br>\$50,000 | 20% and amounts over<br>the \$50,000 lifetime<br>maximum |

## HIGH DEDUCTIBLE PLAN F

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

| SERVICES                                                                                                                                                                                                                   | MEDICARE PAYS                                                                              | AFTER YOU PAY<br>\$2,800 DEDUCTIBLE**<br>PLAN PAYS | IN ADDITION TO<br>\$2,800 DEDUCTIBLE**<br>YOU PAY |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|----------------------------------------------------|---------------------------------------------------|
| <b>HOSPITALIZATION*</b><br>Semiprivate room and board, general nursing and miscellaneous services and supplies                                                                                                             |                                                                                            |                                                    |                                                   |
| First 60 days                                                                                                                                                                                                              | All but \$1,632                                                                            | \$1,632<br>(Part A deductible)                     | \$0                                               |
| 61st thru 90th day                                                                                                                                                                                                         | All but \$408 a day                                                                        | \$408 a day                                        | \$0                                               |
| 91st day and after:<br>• While using 60 lifetime reserve days                                                                                                                                                              | All but \$816 a day                                                                        | \$816 a day                                        | \$0                                               |
| • Once lifetime reserve days are used:<br>• Additional 365 days                                                                                                                                                            | \$0                                                                                        | 100% of Medicare<br>Eligible expenses              | \$0***                                            |
| • Beyond the additional 365 days                                                                                                                                                                                           | \$0                                                                                        | \$0                                                | All costs                                         |
| <b>SKILLED NURSING FACILITY CARE*</b><br>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 \$204 a day                                                                        | Up to \$204 a day                                  | \$0                                               |
| 101st day and after                                                                                                                                                                                                        | \$0                                                                                        | \$0                                                | All costs                                         |
| <b>BLOOD</b>                                                                                                                                                                                                               |                                                                                            |                                                    |                                                   |
| First 3 pints                                                                                                                                                                                                              | \$0                                                                                        | 3 pints                                            | \$0                                               |
| Additional amounts                                                                                                                                                                                                         | 100%                                                                                       | \$0                                                | \$0                                               |
| <b>HOSPICE CARE</b>                                                                                                                                                                                                        |                                                                                            |                                                    |                                                   |
| 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 \$2,800 deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are \$2,800. 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<br>\$2,800 DEDUCTIBLE**<br>PLAN PAYS | IN ADDITION TO<br>\$2,800 DEDUCTIBLE**<br>YOU PAY |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|----------------------------------------------------|---------------------------------------------------|
| <b>MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b><br>Such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment |               |                                                    |                                                   |
| First \$240 of Medicare Approved Amounts*<br>(Part B deductible)                                                                                                                                                                                                     | \$0           | \$240<br>(Part B deductible)                       | \$0                                               |
| Remainder of Medicare Approved Amounts                                                                                                                                                                                                                               | Generally 80% | Generally 20%                                      | \$0                                               |
| <b>PART B EXCESS CHARGES</b>                                                                                                                                                                                                                                         |               |                                                    |                                                   |
| Above Medicare Approved Amounts                                                                                                                                                                                                                                      | \$0           | 100%                                               | \$0                                               |
| <b>BLOOD</b>                                                                                                                                                                                                                                                         |               |                                                    |                                                   |
| First 3 pints                                                                                                                                                                                                                                                        | \$0           | All costs                                          | \$0                                               |
| Next \$240 of Medicare Approved Amounts* (Part B deductible)                                                                                                                                                                                                         | \$0           | \$240<br>(Part B deductible)                       | \$0                                               |
| Remainder of Medicare Approved Amounts                                                                                                                                                                                                                               | 80%           | 20%                                                | \$0                                               |
| <b>CLINICAL LABORATORY SERVICES</b>                                                                                                                                                                                                                                  |               |                                                    |                                                   |
| Tests for Diagnostic Services                                                                                                                                                                                                                                        | 100%          | \$0                                                | \$0                                               |

### MEDICARE (PARTS A AND B) - HOME HEALTH CARE

| SERVICES                                                       | MEDICARE PAYS | AFTER YOU PAY<br>\$2,800 DEDUCTIBLE**<br>PLAN PAYS | IN ADDITION TO<br>\$2,800 DEDUCTIBLE**<br>YOU PAY |
|----------------------------------------------------------------|---------------|----------------------------------------------------|---------------------------------------------------|
| <b>HOME HEALTH CARE - MEDICARE APPROVED SERVICES</b>           |               |                                                    |                                                   |
| Medically necessary skilled care services and medical supplies | 100%          | \$0                                                | \$0                                               |
| Durable medical equipment                                      |               |                                                    |                                                   |
| • First \$240 of Medicare Approved Amounts*                    | \$0           | \$240<br>(Part B deductible)                       | \$0                                               |
| • Remainder of Medicare Approved Amounts                       | 80%           | 20%                                                | \$0                                               |

\* Once you have been billed for \$240 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 \$2,800 deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are \$2,800. 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<br>\$2,800 DEDUCTIBLE**<br>PLAN PAYS  | IN ADDITION TO<br>\$2,800 DEDUCTIBLE**<br>YOU PAY        |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|-----------------------------------------------------|----------------------------------------------------------|
| <b>FOREIGN TRAVEL - NOT COVERED BY MEDICARE</b><br>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<br>Maximum Benefit of<br>\$50,000 | 20% and amounts over<br>the \$50,000 lifetime<br>maximum |

\*\* This high deductible plan pays the same benefits as Plan F after you have paid a calendar year \$2,800 deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are \$2,800. 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   |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|---------------------------------------|-----------|
| <b>HOSPITALIZATION*</b><br>Semiprivate room and board, general nursing and miscellaneous services and supplies                                                                                                             |                                                                                            |                                       |           |
| First 60 days                                                                                                                                                                                                              | All but \$1,632                                                                            | \$1,632<br>(Part A deductible)        | \$0       |
| 61st thru 90th day                                                                                                                                                                                                         | All but \$408 a day                                                                        | \$408 a day                           | \$0       |
| 91st day and after:<br>• While using 60 lifetime reserve days                                                                                                                                                              | All but \$816 a day                                                                        | \$816 a day                           | \$0       |
| • Once lifetime reserve days are used:<br>• Additional 365 days                                                                                                                                                            | \$0                                                                                        | 100% of Medicare<br>Eligible expenses | \$0**     |
| • Beyond the additional 365 days                                                                                                                                                                                           | \$0                                                                                        | \$0                                   | All costs |
| <b>SKILLED NURSING FACILITY CARE*</b><br>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 \$204 a day                                                                        | Up to \$204 a day                     | \$0       |
| 101st day and after                                                                                                                                                                                                        | \$0                                                                                        | \$0                                   | All costs |
| <b>BLOOD</b>                                                                                                                                                                                                               |                                                                                            |                                       |           |
| First 3 pints                                                                                                                                                                                                              | \$0                                                                                        | 3 pints                               | \$0       |
| Additional amounts                                                                                                                                                                                                         | 100%                                                                                       | \$0                                   | \$0       |
| <b>HOSPICE CARE</b>                                                                                                                                                                                                        |                                                                                            |                                       |           |
| 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                                       |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|---------------|-----------------------------------------------|
| <b>MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b><br>Such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment |               |               |                                               |
| First \$240 of Medicare Approved Amounts* (Part B deductible)                                                                                                                                                                                                        | \$0           | \$0           | \$240 (Unless Part B deductible has been met) |
| Remainder of Medicare Approved Amounts                                                                                                                                                                                                                               | Generally 80% | Generally 20% | \$0                                           |
| <b>PART B EXCESS CHARGES</b>                                                                                                                                                                                                                                         |               |               |                                               |
| Above Medicare Approved Amounts                                                                                                                                                                                                                                      | \$0           | 100%          | \$0                                           |
| <b>BLOOD</b>                                                                                                                                                                                                                                                         |               |               |                                               |
| First 3 pints                                                                                                                                                                                                                                                        | \$0           | All costs     | \$0                                           |
| Next \$240 of Medicare Approved Amounts* (Part B deductible)                                                                                                                                                                                                         | \$0           | \$0           | \$240 (Unless Part B deductible has been met) |
| Remainder of Medicare Approved Amounts                                                                                                                                                                                                                               | 80%           | 20%           | \$0                                           |
| <b>CLINICAL LABORATORY SERVICES</b>                                                                                                                                                                                                                                  |               |               |                                               |
| Tests for Diagnostic Services                                                                                                                                                                                                                                        | 100%          | \$0           | \$0                                           |

**MEDICARE (PARTS A AND B) - HOME HEALTH CARE**

| SERVICES                                                       | MEDICARE PAYS | PLAN PAYS | YOU PAY                                       |
|----------------------------------------------------------------|---------------|-----------|-----------------------------------------------|
| <b>HOME HEALTH CARE - MEDICARE APPROVED SERVICES</b>           |               |           |                                               |
| Medically necessary skilled care services and medical supplies | 100%          | \$0       | \$0                                           |
| Durable medical equipment                                      |               |           |                                               |
| • First \$240 of Medicare Approved Amounts*                    | \$0           | \$0       | \$240 (Unless Part B deductible has been met) |
| • Remainder of Medicare Approved Amounts                       | 80%           | 20%       | \$0                                           |

\* Once you have been billed for \$240 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                                                  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|-----------------------------------------------------|----------------------------------------------------------|
| <b>FOREIGN TRAVEL - NOT COVERED BY MEDICARE</b><br>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<br>Maximum Benefit of<br>\$50,000 | 20% and amounts over<br>the \$50,000 lifetime<br>maximum |



## HIGH DEDUCTIBLE PLAN G

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

| SERVICES                                                                                                                                                                                                                   | MEDICARE PAYS                                                                              | AFTER YOU PAY<br>\$2,800 DEDUCTIBLE**<br>PLAN PAYS | IN ADDITION TO<br>\$2,800 DEDUCTIBLE**<br>YOU PAY |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|----------------------------------------------------|---------------------------------------------------|
| <b>HOSPITALIZATION*</b><br>Semiprivate room and board, general nursing and miscellaneous services and supplies                                                                                                             |                                                                                            |                                                    |                                                   |
| First 60 days                                                                                                                                                                                                              | All but \$1,632                                                                            | \$1,632<br>(Part A deductible)                     | \$0                                               |
| 61st thru 90th day                                                                                                                                                                                                         | All but \$408 a day                                                                        | \$408 a day                                        | \$0                                               |
| 91st day and after:<br>• While using 60 lifetime reserve days                                                                                                                                                              | All but \$816 a day                                                                        | \$816 a day                                        | \$0                                               |
| • Once lifetime reserve days are used:<br>• Additional 365 days                                                                                                                                                            | \$0                                                                                        | 100% of Medicare<br>Eligible expenses              | \$0***                                            |
| • Beyond the additional 365 days                                                                                                                                                                                           | \$0                                                                                        | \$0                                                | All costs                                         |
| <b>SKILLED NURSING FACILITY CARE*</b><br>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 \$204 a day                                                                        | Up to \$204 a day                                  | \$0                                               |
| 101st day and after                                                                                                                                                                                                        | \$0                                                                                        | \$0                                                | All costs                                         |
| <b>BLOOD</b>                                                                                                                                                                                                               |                                                                                            |                                                    |                                                   |
| First 3 pints                                                                                                                                                                                                              | \$0                                                                                        | 3 pints                                            | \$0                                               |
| Additional amounts                                                                                                                                                                                                         | 100%                                                                                       | \$0                                                | \$0                                               |
| <b>HOSPICE CARE</b>                                                                                                                                                                                                        |                                                                                            |                                                    |                                                   |
| 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 \$2,800 deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are \$2,800. 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<br>\$2,800 DEDUCTIBLE**<br>PLAN PAYS | IN ADDITION TO<br>\$2,800 DEDUCTIBLE**<br>YOU PAY |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|----------------------------------------------------|---------------------------------------------------|
| <b>MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b><br>Such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment |               |                                                    |                                                   |
| First \$240 of Medicare Approved Amounts*<br>(Part B deductible)                                                                                                                                                                                                     | \$0           | \$0                                                | \$ 240 (Unless Part B deductible has been met)    |
| Remainder of Medicare Approved Amounts                                                                                                                                                                                                                               | Generally 80% | Generally 20%                                      | \$0                                               |
| <b>PART B EXCESS CHARGES</b>                                                                                                                                                                                                                                         |               |                                                    |                                                   |
| Above Medicare Approved Amounts                                                                                                                                                                                                                                      | \$0           | 100%                                               | \$0                                               |
| <b>BLOOD</b>                                                                                                                                                                                                                                                         |               |                                                    |                                                   |
| First 3 pints                                                                                                                                                                                                                                                        | \$0           | All costs                                          | \$0                                               |
| Next \$240 of Medicare Approved Amounts* (Part B deductible)                                                                                                                                                                                                         | \$0           | \$0                                                | \$240 (Unless Part B deductible has been met)     |
| Remainder of Medicare Approved Amounts                                                                                                                                                                                                                               | 80%           | 20%                                                | \$0                                               |
| <b>CLINICAL LABORATORY SERVICES</b>                                                                                                                                                                                                                                  |               |                                                    |                                                   |
| Tests for Diagnostic Services                                                                                                                                                                                                                                        | 100%          | \$0                                                | \$0                                               |

\* Once you have been billed for \$240 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 \$2,800 deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are \$2,800. 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<br>\$2,800 DEDUCTIBLE**<br>PLAN PAYS | IN ADDITION TO<br>\$2,800 DEDUCTIBLE**<br>YOU PAY |
|----------------------------------------------------------------|---------------|----------------------------------------------------|---------------------------------------------------|
| <b>HOME HEALTH CARE - MEDICARE APPROVED SERVICES</b>           |               |                                                    |                                                   |
| Medically necessary skilled care services and medical supplies | 100%          | \$0                                                | \$0                                               |
| Durable medical equipment                                      |               |                                                    |                                                   |
| • First \$240 of Medicare Approved Amounts*                    | \$0           | \$0                                                | \$240 (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<br>\$2,800 DEDUCTIBLE**<br>PLAN PAYS | IN ADDITION TO<br>\$2,800 DEDUCTIBLE**<br>YOU PAY  |
|-------------------------------------------------------------------------------------------------------------|---------------|----------------------------------------------------|----------------------------------------------------|
| <b>FOREIGN TRAVEL - NOT COVERED BY MEDICARE</b>                                                             |               |                                                    |                                                    |
| Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA |               |                                                    |                                                    |
| First \$250 each calendar year                                                                              | \$0           | \$0                                                | \$250                                              |
| Remainder of charges                                                                                        | \$0           | 80% to a Lifetime Maximum Benefit of \$50,000      | 20% and amounts over the \$50,000 lifetime maximum |

\* Once you have been billed for \$240 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 \$2,800 deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are \$2,800. 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   |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|---------------------------------------|-----------|
| <b>HOSPITALIZATION*</b><br>Semiprivate room and board, general nursing and miscellaneous services and supplies                                                                                                             |                                                                                            |                                       |           |
| First 60 days                                                                                                                                                                                                              | All but \$1,632                                                                            | \$1,632<br>(Part A deductible)        | \$0       |
| 61st thru 90th day                                                                                                                                                                                                         | All but \$408 a day                                                                        | \$408 a day                           | \$0       |
| 91st day and after:<br>• While using 60 lifetime reserve days                                                                                                                                                              | All but \$816 a day                                                                        | \$816 a day                           | \$0       |
| • Once lifetime reserve days are used:<br>• Additional 365 days                                                                                                                                                            | \$0                                                                                        | 100% of Medicare<br>Eligible expenses | \$0**     |
| • Beyond the additional 365 days                                                                                                                                                                                           | \$0                                                                                        | \$0                                   | All costs |
| <b>SKILLED NURSING FACILITY CARE*</b><br>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 \$204 a day                                                                        | Up to \$204 a day                     | \$0       |
| 101st day and after                                                                                                                                                                                                        | \$0                                                                                        | \$0                                   | All costs |
| <b>BLOOD</b>                                                                                                                                                                                                               |                                                                                            |                                       |           |
| First 3 pints                                                                                                                                                                                                              | \$0                                                                                        | 3 pints                               | \$0       |
| Additional amounts                                                                                                                                                                                                         | 100%                                                                                       | \$0                                   | \$0       |
| <b>HOSPICE CARE</b>                                                                                                                                                                                                        |                                                                                            |                                       |           |
| 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                                                                                                                                                                                                        |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT,</b><br>such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment |               |                                                                                                                                                                                                                                     |                                                                                                                                                                                                                |
| First \$240 of Medicare Approved Amounts*<br>(Part B deductible)                                                                                                                                                                                                      | \$0           | \$0                                                                                                                                                                                                                                 | \$240<br>(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 |
| <b>PART B EXCESS CHARGES</b>                                                                                                                                                                                                                                          |               |                                                                                                                                                                                                                                     |                                                                                                                                                                                                                |
| Above Medicare Approved Amounts                                                                                                                                                                                                                                       | \$0           | \$0                                                                                                                                                                                                                                 | All costs                                                                                                                                                                                                      |
| <b>BLOOD</b>                                                                                                                                                                                                                                                          |               |                                                                                                                                                                                                                                     |                                                                                                                                                                                                                |
| First 3 pints                                                                                                                                                                                                                                                         | \$0           | All costs                                                                                                                                                                                                                           | \$0                                                                                                                                                                                                            |
| Next \$240 of Medicare Approved Amounts* (Part B deductible)                                                                                                                                                                                                          | \$0           | \$0                                                                                                                                                                                                                                 | \$240<br>(Part B deductible)                                                                                                                                                                                   |
| Remainder of Medicare Approved Amounts                                                                                                                                                                                                                                | 80%           | 20%                                                                                                                                                                                                                                 | \$0                                                                                                                                                                                                            |
| <b>CLINICAL LABORATORY SERVICES</b>                                                                                                                                                                                                                                   |               |                                                                                                                                                                                                                                     |                                                                                                                                                                                                                |
| Tests for Diagnostic Services                                                                                                                                                                                                                                         | 100%          | \$0                                                                                                                                                                                                                                 | \$0                                                                                                                                                                                                            |

\* Once you have been billed for \$240 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                      |
|----------------------------------------------------------------|---------------|-----------|------------------------------|
| <b>HOME HEALTH CARE - MEDICARE APPROVED SERVICES</b>           |               |           |                              |
| Medically necessary skilled care services and medical supplies | 100%          | \$0       | \$0                          |
| Durable medical equipment                                      |               |           |                              |
| • First \$240 of Medicare Approved Amounts*                    | \$0           | \$0       | \$240<br>(Part B deductible) |
| • Remainder of Medicare Approved Amounts                       | 80%           | 20%       | \$0                          |

**OTHER BENEFITS - NOT COVERED BY MEDICARE**

| SERVICES                                                                                                                                                       | MEDICARE PAYS | PLAN PAYS                                     | YOU PAY                                            |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|-----------------------------------------------|----------------------------------------------------|
| <b>FOREIGN TRAVEL - NOT COVERED BY MEDICARE</b><br>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 \$240 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.

# **Nebraska**

## **Medicare Supplement Rates**

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

#### **Effective 8-1-2023**



## 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 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 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:

$$\begin{array}{ccccccc} \$ & \underline{\hspace{2cm}} & \times & \underline{\hspace{2cm}} & \times & \underline{\hspace{2cm}} & \times & \underline{\hspace{2cm}} & = \$ & \underline{\hspace{2cm}} \\ \text{Line 1} & & & \text{Line 2} & & \text{Line 3} & & \text{Line 4} & & \text{Final premium} \\ \text{Monthly base premium rate} & & & \text{Rate class factor} & & \text{Household discount factor} & & \text{Mode factor} & & \end{array}$$

**Please note:** Open Enrollment and guaranteed issue applicants will be rated as preferred rate class. 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     |

| Nebraska           |        |          |        | ZIP codes: 680–681, 685 |        |              |        | Effective August 1, 2023 |          |        |          |        |
|--------------------|--------|----------|--------|-------------------------|--------|--------------|--------|--------------------------|----------|--------|----------|--------|
| Monthly base rates |        |          |        |                         |        |              |        |                          |          |        |          |        |
| 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 |
| 131.98             | 144.14 | 43.24    | 123.25 | 41.08                   | 93.94  | 65–68        | 148.48 | 162.16                   | 48.65    | 138.66 | 46.22    | 105.68 |
| 131.59             | 144.14 | 43.24    | 123.25 | 41.08                   | 93.94  | 69           | 148.04 | 162.16                   | 48.65    | 138.66 | 46.22    | 105.68 |
| 131.40             | 144.14 | 43.24    | 123.25 | 41.08                   | 93.94  | 70           | 147.83 | 162.16                   | 48.65    | 138.66 | 46.22    | 105.68 |
| 131.56             | 145.11 | 43.53    | 124.07 | 41.36                   | 94.57  | 71           | 148.01 | 163.24                   | 48.97    | 139.58 | 46.52    | 106.39 |
| 131.77             | 146.07 | 43.82    | 124.90 | 41.63                   | 95.19  | 72           | 148.24 | 164.32                   | 49.30    | 140.51 | 46.83    | 107.09 |
| 132.00             | 149.48 | 44.84    | 125.72 | 42.60                   | 97.52  | 73           | 148.50 | 168.17                   | 50.45    | 141.43 | 47.93    | 109.71 |
| 134.01             | 152.52 | 45.76    | 128.21 | 43.47                   | 99.40  | 74           | 150.76 | 171.59                   | 51.48    | 144.23 | 48.90    | 111.83 |
| 137.12             | 156.98 | 47.09    | 131.93 | 44.74                   | 102.13 | 75           | 154.25 | 176.60                   | 52.98    | 148.42 | 50.33    | 114.90 |
| 139.79             | 161.50 | 48.45    | 135.66 | 46.03                   | 104.89 | 76           | 157.26 | 181.68                   | 54.50    | 152.62 | 51.78    | 118.00 |
| 143.71             | 167.46 | 50.24    | 140.63 | 47.73                   | 108.67 | 77           | 161.67 | 188.39                   | 56.52    | 158.21 | 53.69    | 122.26 |
| 147.73             | 173.66 | 52.10    | 145.75 | 49.49                   | 112.58 | 78           | 166.20 | 195.37                   | 58.61    | 163.96 | 55.68    | 126.65 |
| 151.94             | 180.07 | 54.02    | 151.08 | 51.32                   | 116.60 | 79           | 170.93 | 202.57                   | 60.77    | 169.96 | 57.73    | 131.17 |
| 162.18             | 189.32 | 56.80    | 162.50 | 53.96                   | 131.47 | 80           | 182.46 | 212.99                   | 63.90    | 182.82 | 60.70    | 147.91 |
| 169.50             | 199.51 | 59.85    | 171.66 | 56.86                   | 143.26 | 81           | 190.69 | 224.45                   | 67.34    | 193.12 | 63.97    | 161.17 |
| 176.96             | 209.99 | 63.00    | 181.28 | 59.85                   | 151.18 | 82           | 199.08 | 236.23                   | 70.87    | 203.94 | 67.33    | 170.08 |
| 184.73             | 220.95 | 66.29    | 191.37 | 62.97                   | 159.47 | 83           | 207.83 | 248.57                   | 74.57    | 215.30 | 70.84    | 179.40 |
| 192.84             | 232.43 | 69.73    | 201.97 | 66.24                   | 168.13 | 84           | 216.94 | 261.48                   | 78.44    | 227.22 | 74.52    | 189.15 |
| 201.28             | 244.44 | 73.33    | 213.09 | 69.67                   | 177.19 | 85           | 226.44 | 274.99                   | 82.50    | 239.73 | 78.37    | 199.34 |
| 209.24             | 255.90 | 76.77    | 223.71 | 72.93                   | 185.60 | 86           | 235.40 | 287.89                   | 86.37    | 251.68 | 82.05    | 208.80 |
| 217.51             | 267.87 | 80.36    | 234.83 | 76.34                   | 194.37 | 87           | 244.70 | 301.35                   | 90.40    | 264.19 | 85.88    | 218.67 |
| 226.11             | 280.36 | 84.11    | 246.47 | 79.90                   | 203.52 | 88           | 254.37 | 315.40                   | 94.62    | 277.28 | 89.89    | 228.96 |
| 235.03             | 293.40 | 88.02    | 258.65 | 83.62                   | 213.05 | 89           | 264.41 | 330.07                   | 99.02    | 290.98 | 94.07    | 239.68 |
| 242.40             | 304.61 | 91.38    | 269.02 | 86.81                   | 221.68 | 90           | 272.71 | 342.69                   | 102.81   | 302.64 | 97.67    | 249.39 |
| 249.23             | 315.49 | 94.65    | 279.07 | 89.92                   | 229.94 | 91           | 280.38 | 354.93                   | 106.48   | 313.96 | 101.15   | 258.68 |
| 254.48             | 324.49 | 97.35    | 289.48 | 92.48                   | 238.24 | 92           | 286.29 | 365.05                   | 109.52   | 325.67 | 104.04   | 268.02 |
| 259.85             | 333.73 | 100.12   | 298.19 | 95.11                   | 246.34 | 93           | 292.33 | 375.44                   | 112.63   | 335.47 | 107.00   | 277.13 |
| 265.32             | 343.20 | 102.96   | 307.14 | 97.81                   | 254.68 | 94           | 298.49 | 386.10                   | 115.83   | 345.54 | 110.04   | 286.51 |
| 270.92             | 352.92 | 105.88   | 316.03 | 100.58                  | 263.27 | 95           | 304.78 | 397.04                   | 119.11   | 355.53 | 113.16   | 296.18 |
| 276.36             | 360.02 | 108.00   | 322.38 | 102.60                  | 269.36 | 96           | 310.91 | 405.02                   | 121.51   | 362.67 | 115.43   | 303.03 |
| 281.92             | 367.25 | 110.18   | 328.86 | 104.67                  | 275.59 | 97           | 317.16 | 413.16                   | 123.95   | 369.96 | 117.75   | 310.04 |
| 287.58             | 374.63 | 112.39   | 335.47 | 106.77                  | 281.96 | 98           | 323.53 | 421.46                   | 126.44   | 377.40 | 120.12   | 317.21 |
| 293.36             | 382.16 | 114.65   | 342.21 | 108.92                  | 288.48 | 99           | 330.03 | 429.93                   | 128.98   | 384.99 | 122.53   | 324.54 |

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

| Nebraska |        |          |        |          |        |              | All other ZIP codes |        |          |        |          | Effective August 1, 2023 |  |
|----------|--------|----------|--------|----------|--------|--------------|---------------------|--------|----------|--------|----------|--------------------------|--|
|          |        |          |        |          |        |              | Monthly base rates  |        |          |        |          |                          |  |
| 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                   |  |
| 175.98   | 192.19 | 57.66    | 164.34 | 54.77    | 125.25 | 65–68        | 197.98              | 216.22 | 64.87    | 184.88 | 61.62    | 140.91                   |  |
| 175.45   | 192.19 | 57.66    | 164.34 | 54.77    | 125.25 | 69           | 197.39              | 216.22 | 64.87    | 184.88 | 61.62    | 140.91                   |  |
| 175.20   | 192.19 | 57.66    | 164.34 | 54.77    | 125.25 | 70           | 197.10              | 216.22 | 64.87    | 184.88 | 61.62    | 140.91                   |  |
| 175.42   | 193.47 | 58.04    | 165.43 | 55.14    | 126.09 | 71           | 197.35              | 217.66 | 65.30    | 186.11 | 62.03    | 141.85                   |  |
| 175.69   | 194.76 | 58.43    | 166.53 | 55.51    | 126.92 | 72           | 197.65              | 219.10 | 65.73    | 187.34 | 62.44    | 142.79                   |  |
| 176.00   | 199.31 | 59.79    | 167.62 | 56.80    | 130.03 | 73           | 198.00              | 224.22 | 67.27    | 188.58 | 63.90    | 146.28                   |  |
| 178.68   | 203.36 | 61.01    | 170.94 | 57.96    | 132.54 | 74           | 201.02              | 228.79 | 68.64    | 192.31 | 65.20    | 149.11                   |  |
| 182.82   | 209.31 | 62.79    | 175.91 | 59.65    | 136.18 | 75           | 205.67              | 235.47 | 70.64    | 197.90 | 67.11    | 153.20                   |  |
| 186.38   | 215.33 | 64.60    | 180.88 | 61.37    | 139.85 | 76           | 209.68              | 242.24 | 72.67    | 203.49 | 69.04    | 157.33                   |  |
| 191.61   | 223.28 | 66.98    | 187.51 | 63.64    | 144.90 | 77           | 215.56              | 251.19 | 75.36    | 210.95 | 71.59    | 163.01                   |  |
| 196.98   | 231.54 | 69.46    | 194.33 | 65.99    | 150.11 | 78           | 221.60              | 260.49 | 78.15    | 218.62 | 74.24    | 168.87                   |  |
| 202.58   | 240.09 | 72.03    | 201.44 | 68.43    | 155.47 | 79           | 227.91              | 270.10 | 81.03    | 226.62 | 76.98    | 174.90                   |  |
| 216.24   | 252.43 | 75.73    | 216.67 | 71.94    | 175.30 | 80           | 243.27              | 283.99 | 85.20    | 243.76 | 80.94    | 197.21                   |  |
| 226.00   | 266.02 | 79.81    | 228.89 | 75.81    | 191.01 | 81           | 254.25              | 299.27 | 89.78    | 257.50 | 85.29    | 214.89                   |  |
| 235.94   | 279.98 | 83.99    | 241.71 | 79.79    | 201.58 | 82           | 265.44              | 314.98 | 94.49    | 271.92 | 89.77    | 226.77                   |  |
| 246.31   | 294.60 | 88.38    | 255.17 | 83.96    | 212.63 | 83           | 277.10              | 331.43 | 99.43    | 287.06 | 94.46    | 239.21                   |  |
| 257.12   | 309.90 | 92.97    | 269.29 | 88.32    | 224.18 | 84           | 289.26              | 348.64 | 104.59   | 302.95 | 99.36    | 252.20                   |  |
| 268.38   | 325.92 | 97.78    | 284.12 | 92.89    | 236.25 | 85           | 301.93              | 366.66 | 110.00   | 319.63 | 104.50   | 265.79                   |  |
| 278.99   | 341.20 | 102.36   | 298.29 | 97.24    | 247.47 | 86           | 313.86              | 383.85 | 115.15   | 335.57 | 109.40   | 278.41                   |  |
| 290.02   | 357.15 | 107.15   | 313.11 | 101.79   | 259.17 | 87           | 326.27              | 401.80 | 120.54   | 352.25 | 114.51   | 291.56                   |  |
| 301.47   | 373.81 | 112.14   | 328.63 | 106.54   | 271.36 | 88           | 339.16              | 420.53 | 126.16   | 369.71 | 119.85   | 305.28                   |  |
| 313.38   | 391.19 | 117.36   | 344.87 | 111.49   | 284.07 | 89           | 352.55              | 440.09 | 132.03   | 387.97 | 125.43   | 319.57                   |  |
| 323.21   | 406.15 | 121.84   | 358.69 | 115.75   | 295.57 | 90           | 363.61              | 456.91 | 137.07   | 403.52 | 130.22   | 332.51                   |  |
| 332.31   | 420.66 | 126.20   | 372.10 | 119.89   | 306.58 | 91           | 373.84              | 473.24 | 141.97   | 418.61 | 134.87   | 344.90                   |  |
| 339.31   | 432.66 | 129.80   | 385.98 | 123.31   | 317.66 | 92           | 381.72              | 486.74 | 146.02   | 434.22 | 138.72   | 357.36                   |  |
| 346.46   | 444.97 | 133.49   | 397.59 | 126.82   | 328.45 | 93           | 389.77              | 500.59 | 150.18   | 447.29 | 142.67   | 369.50                   |  |
| 353.76   | 457.60 | 137.28   | 409.52 | 130.42   | 339.57 | 94           | 397.99              | 514.80 | 154.44   | 460.71 | 146.72   | 382.01                   |  |
| 361.22   | 470.56 | 141.17   | 421.37 | 134.11   | 351.03 | 95           | 406.37              | 529.38 | 158.82   | 474.04 | 150.87   | 394.90                   |  |
| 368.48   | 480.02 | 144.01   | 429.84 | 136.81   | 359.14 | 96           | 414.54              | 540.02 | 162.01   | 483.57 | 153.91   | 404.04                   |  |
| 375.89   | 489.67 | 146.90   | 438.48 | 139.56   | 367.45 | 97           | 422.87              | 550.88 | 165.26   | 493.28 | 157.00   | 413.38                   |  |
| 383.44   | 499.51 | 149.85   | 447.29 | 142.36   | 375.95 | 98           | 431.37              | 561.95 | 168.59   | 503.20 | 160.16   | 422.95                   |  |
| 391.15   | 509.55 | 152.87   | 456.28 | 145.22   | 384.65 | 99           | 440.04              | 573.24 | 171.97   | 513.31 | 163.37   | 432.73                   |  |

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



## 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.

## Medical Notice of Privacy Practices (continued)

- 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](http://www.wellabe.com)

**Effective Date:** January 2024





## 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:

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

You may also visit us on our website at: [www.wellabe.com](http://www.wellabe.com)

**Effective Date:** January 2024