THE AMERICAN HOME LIFE INSURANCE COMPANY
MEDICARE SUPPLEMENT ADMINISTRATIVE OFFICE
1021 Reams Fleming Boulevard, Franklin, TN 37064
Telephone: 1-833-504-0334

OUTLINE OF MEDICARE SUPPLEMENT INSURANCE
OUTLINE OF COVERAGE FOR POLICY FORM AMHMSP21BC-WI

MEDICARE SUPPLEMENT INSURANCE

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

PREMIUM INFORMATION - We, The American Home Life Insurance Company, can only raise your premium if we raise the premium for all policies like yours in the same geographic area in this state. Your premium will change each year. The new premium will be based on your age.

DISCLOSURES - Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY - This is only an Outline of Coverage describing your policy's most important features. This is not 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 - If you find you are not satisfied with your policy, you may return it to The American Home Life Insurance Company, 1021 Reams Fleming Boulevard, Franklin, TN 37064. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments directly to you.

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 - The policy may not fully cover all of your medical costs.

NEITHER THE AMERICAN HOME LIFE INSURANCE COMPANY NOR ITS AGENTS ARE CONNECTED WITH MEDICARE.

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

ANNUAL PREMIUMS
Female – Preferred
ZIP Codes: 535-549

Effective Date: 08/01/2023

Age	Base	Part A Deductible	Part B Deductible	Part B Excess	Foreign Travel	Home Health Care	Part B Copayment
0-64	4,441.95	772.85	226.00	41.84	30.58	52.00	2,644.97
65	1,269.12	220.81	226.00	11.95	8.74	14.86	755.71
66	1,269.12	220.81	226.00	11.95	8.74	14.86	755.71
67	1,269.12	220.81	226.00	11.95	8.74	14.86	755.71
68	1,269.12	220.81	226.00	11.95	8.74	14.86	755.71
69	1,269.12	220.81	226.00	11.95	8.74	14.86	755.71
70	1,319.93	227.52	226.00	12.40	9.06	15.41	776.05
71	1,378.24	240.96	226.00	12.92	9.45	16.07	820.69
72	1,437.58	254.66	226.00	13.45	9.84	16.72	866.13
73	1,505.39	269.94	226.00	14.06	10.28	17.48	916.92
74	1,574.90	285.62	226.00	14.68	10.74	18.26	969.03
75	1,646.16	301.70	226.00	15.33	11.21	19.05	1,022.51
76	1,701.91	317.81	226.00	15.84	11.58	19.69	1,068.89
77	1,760.67	334.66	226.00	16.38	11.98	20.37	1,117.54
78	1,822.69	352.32	226.00	16.95	12.39	21.07	1,168.62
79	1,888.15	370.85	226.00	17.56	12.84	21.81	1,222.31
80	1,957.30	390.31	226.00	18.19	13.30	22.60	1,278.80
81	2,030.15	410.05	226.00	18.74	13.70	23.29	1,338.09
82	2,109.25	431.27	226.00	19.35	14.15	24.05	1,401.96
83	2,190.84	453.22	226.00	19.98	14.60	24.82	1,467.98
84	2,275.01	475.94	226.00	20.61	15.06	25.62	1,536.25
85	2,361.81	499.42	226.00	21.28	15.55	26.44	1,606.80
86	2,442.19	518.31	226.00	21.89	16.00	27.22	1,670.58
87	2,524.96	537.76	226.00	22.54	16.46	28.01	1,736.37
88	2,610.19	557.84	226.00	23.19	16.96	28.83	1,804.25
89	2,697.95	578.52	226.00	23.86	17.45	29.67	1,874.27
90	2,788.30	599.86	226.00	24.55	17.95	30.53	1,946.51
91	2,875.25	619.32	226.00	25.12	18.36	31.23	2,014.94
92	2,964.67	639.33	226.00	25.69	18.78	31.95	2,085.43
93	3,056.64	659.93	226.00	26.27	19.21	32.67	2,158.05
94	3,151.23	681.13	226.00	26.87	19.65	33.41	2,232.87
95	3,248.48	702.94	226.00	27.48	20.09	34.17	2,309.92
96	3,348.74	725.44	226.00	28.11	20.55	34.95	2,389.54
97	3,452.11	748.68	226.00	28.74	21.02	35.74	2,471.80
98	3,558.65	772.64	226.00	29.40	21.50	36.55	2,556.78
99	3,668.49	797.38	226.00	30.06	21.98	37.38	2,644.57

* Area factors will not apply to the Part B Deductible premium.

Modal Factors: Semi-Annual - 0.5200, Quarterly - 0.2650, Monthly - 0.08333
Add a One-Time Policy Fee $25
To calculate a Household discount:
Annual premium x modal factor = modal premium (round to nearest whole cent)
Modal premium x .93 = discounted premium

ANNUAL PREMIUMS
Male – Preferred
ZIP Codes: 535-549

Effective Date: 08/01/2023

Age	Base	Part A Deductible	Part B Deductible	Part B Excess	Foreign Travel	Home Health Care	Part B Copayment
0-64	5,108.25	888.76	226.00	48.10	35.18	59.83	3,041.74
65	1,459.50	253.93	226.00	13.74	10.05	17.09	869.07
66	1,459.50	253.93	226.00	13.74	10.05	17.09	869.07
67	1,459.50	253.93	226.00	13.74	10.05	17.09	869.07
68	1,459.50	253.93	226.00	13.74	10.05	17.09	869.07
69	1,459.50	253.93	226.00	13.74	10.05	17.09	869.07
70	1,517.92	261.65	226.00	14.25	10.42	17.72	892.46
71	1,584.98	277.12	226.00	14.86	10.86	18.47	943.78
72	1,653.22	292.87	226.00	15.47	11.31	19.24	996.05
73	1,731.19	310.44	226.00	16.18	11.83	20.11	1,054.44
74	1,811.14	328.47	226.00	16.88	12.35	21.00	1,114.39
75	1,893.09	346.96	226.00	17.63	12.89	21.92	1,175.89
76	1,957.19	365.48	226.00	18.22	13.31	22.65	1,229.23
77	2,024.78	384.86	226.00	18.84	13.77	23.42	1,285.17
78	2,096.09	405.17	226.00	19.50	14.25	24.23	1,343.91
79	2,171.37	426.48	226.00	20.19	14.75	25.09	1,405.66
80	2,250.90	448.85	226.00	20.92	15.29	26.00	1,470.63
81	2,334.67	471.56	226.00	21.55	15.76	26.79	1,538.80
82	2,425.63	495.96	226.00	22.25	16.26	27.66	1,612.24
83	2,519.46	521.20	226.00	22.97	16.78	28.55	1,688.18
84	2,616.26	547.33	226.00	23.70	17.32	29.47	1,766.69
85	2,716.09	574.34	226.00	24.46	17.88	30.41	1,847.83
86	2,808.52	596.04	226.00	25.18	18.40	31.30	1,921.16
87	2,903.70	618.43	226.00	25.92	18.94	32.21	1,996.82
88	3,001.72	641.51	226.00	26.67	19.50	33.15	2,074.89
89	3,102.63	665.31	226.00	27.44	20.07	34.12	2,155.41
90	3,206.55	689.84	226.00	28.24	20.65	35.11	2,238.48
91	3,306.53	712.22	226.00	28.88	21.11	35.92	2,317.17
92	3,409.38	735.24	226.00	29.54	21.60	36.73	2,398.25
93	3,515.14	758.92	226.00	30.21	22.09	37.56	2,481.77
94	3,623.90	783.29	226.00	30.90	22.60	38.42	2,567.80
95	3,735.76	808.37	226.00	31.60	23.11	39.30	2,656.42
96	3,851.06	834.25	226.00	32.31	23.63	40.19	2,747.97
97	3,969.92	860.97	226.00	33.05	24.17	41.10	2,842.57
98	4,092.45	888.54	226.00	33.81	24.72	42.03	2,940.29
99	4,218.77	916.98	226.00	34.58	25.28	42.99	3,041.26

* Area factors will not apply to the Part B Deductible premium.

Modal Factors: Semi-Annual - 0.5200, Quarterly - 0.2650, Monthly - 0.08333
Add a One-Time Policy Fee $25
To calculate a Household discount:
Annual premium x modal factor = modal premium (round to nearest whole cent)
Modal premium x .93 = discounted premium

ANNUAL PREMIUMS
Female – Standard
ZIP Codes: 535-549

Effective Date: 08/01/2023

Age	Base	Part A Deductible	Part B Deductible	Part B Excess	Foreign Travel	Home Health Care	Part B Copayment
0-64	5,108.25	888.76	226.00	48.10	35.18	59.83	3,041.74
65	1,459.50	253.93	226.00	13.74	10.05	17.09	869.07
66	1,459.50	253.93	226.00	13.74	10.05	17.09	869.07
67	1,459.50	253.93	226.00	13.74	10.05	17.09	869.07
68	1,459.50	253.93	226.00	13.74	10.05	17.09	869.07
69	1,459.50	253.93	226.00	13.74	10.05	17.09	869.07
70	1,517.92	261.65	226.00	14.25	10.42	17.72	892.46
71	1,584.98	277.12	226.00	14.86	10.86	18.47	943.78
72	1,653.22	292.87	226.00	15.47	11.31	19.24	996.05
73	1,731.19	310.44	226.00	16.18	11.83	20.11	1,054.44
74	1,811.14	328.47	226.00	16.88	12.35	21.00	1,114.39
75	1,893.09	346.96	226.00	17.63	12.89	21.92	1,175.89
76	1,957.19	365.48	226.00	18.22	13.31	22.65	1,229.23
77	2,024.78	384.86	226.00	18.84	13.77	23.42	1,285.17
78	2,096.09	405.17	226.00	19.50	14.25	24.23	1,343.91
79	2,171.37	426.48	226.00	20.19	14.75	25.09	1,405.66
80	2,250.90	448.85	226.00	20.92	15.29	26.00	1,470.63
81	2,334.67	471.56	226.00	21.55	15.76	26.79	1,538.80
82	2,425.63	495.96	226.00	22.25	16.26	27.66	1,612.24
83	2,519.46	521.20	226.00	22.97	16.78	28.55	1,688.18
84	2,616.26	547.33	226.00	23.70	17.32	29.47	1,766.69
85	2,716.09	574.34	226.00	24.46	17.88	30.41	1,847.83
86	2,808.52	596.04	226.00	25.18	18.40	31.30	1,921.16
87	2,903.70	618.43	226.00	25.92	18.94	32.21	1,996.82
88	3,001.72	641.51	226.00	26.67	19.50	33.15	2,074.89
89	3,102.63	665.31	226.00	27.44	20.07	34.12	2,155.41
90	3,206.55	689.84	226.00	28.24	20.65	35.11	2,238.48
91	3,306.53	712.22	226.00	28.88	21.11	35.92	2,317.17
92	3,409.38	735.24	226.00	29.54	21.60	36.73	2,398.25
93	3,515.14	758.92	226.00	30.21	22.09	37.56	2,481.77
94	3,623.90	783.29	226.00	30.90	22.60	38.42	2,567.80
95	3,735.76	808.37	226.00	31.60	23.11	39.30	2,656.42
96	3,851.06	834.25	226.00	32.31	23.63	40.19	2,747.97
97	3,969.92	860.97	226.00	33.05	24.17	41.10	2,842.57
98	4,092.45	888.54	226.00	33.81	24.72	42.03	2,940.29
99	4,218.77	916.98	226.00	34.58	25.28	42.99	3,041.26

* Area factors will not apply to the Part B Deductible premium.

Modal Factors: Semi-Annual - 0.5200, Quarterly - 0.2650, Monthly - 0.08333
Add a One-Time Policy Fee $25
To calculate a Household discount:
Annual premium x modal factor = modal premium (round to nearest whole cent)
Modal premium x .93 = discounted premium

ANNUAL PREMIUMS
Male – Standard
ZIP Codes: 535-549

Effective Date: 08/01/2023

Age	Base	Part A Deductible	Part B Deductible	Part B Excess	Foreign Travel	Home Health Care	Part B Copayment
0-64	5,874.51	1,022.09	226.00	55.33	40.45	68.80	3,498.02
65	1,678.43	292.03	226.00	15.81	11.56	19.66	999.43
66	1,678.43	292.03	226.00	15.81	11.56	19.66	999.43
67	1,678.43	292.03	226.00	15.81	11.56	19.66	999.43
68	1,678.43	292.03	226.00	15.81	11.56	19.66	999.43
69	1,678.43	292.03	226.00	15.81	11.56	19.66	999.43
70	1,745.61	300.90	226.00	16.40	11.99	20.39	1,026.33
71	1,822.72	318.69	226.00	17.09	12.49	21.24	1,085.36
72	1,901.20	336.80	226.00	17.79	13.00	22.12	1,145.45
73	1,990.87	356.99	226.00	18.60	13.60	23.13	1,212.62
74	2,082.81	377.73	226.00	19.42	14.20	24.15	1,281.55
75	2,177.05	399.00	226.00	20.27	14.83	25.21	1,352.27
76	2,250.77	420.30	226.00	20.95	15.32	26.05	1,413.62
77	2,328.49	442.60	226.00	21.66	15.83	26.93	1,477.94
78	2,410.51	465.95	226.00	22.41	16.39	27.86	1,545.50
79	2,497.08	490.44	226.00	23.21	16.97	28.85	1,616.50
80	2,588.53	516.18	226.00	24.05	17.58	29.90	1,691.21
81	2,684.87	542.29	226.00	24.79	18.12	30.80	1,769.61
82	2,789.47	570.35	226.00	25.59	18.71	31.80	1,854.08
83	2,897.39	599.38	226.00	26.42	19.30	32.83	1,941.41
84	3,008.70	629.42	226.00	27.27	19.93	33.89	2,031.69
85	3,123.50	660.49	226.00	28.14	20.56	34.97	2,125.00
86	3,229.80	685.45	226.00	28.96	21.16	35.99	2,209.33
87	3,339.26	711.19	226.00	29.80	21.78	37.04	2,296.35
88	3,451.98	737.74	226.00	30.68	22.42	38.13	2,386.12
89	3,568.03	765.11	226.00	31.57	23.07	39.24	2,478.72
90	3,687.53	793.32	226.00	32.48	23.74	40.38	2,574.26
91	3,802.52	819.05	226.00	33.22	24.28	41.29	2,664.76
92	3,920.78	845.52	226.00	33.97	24.84	42.24	2,757.99
93	4,042.41	872.76	226.00	34.74	25.40	43.20	2,854.03
94	4,167.49	900.79	226.00	35.53	25.98	44.18	2,952.97
95	4,296.11	929.63	226.00	36.35	26.57	45.18	3,054.88
96	4,428.72	959.39	226.00	37.17	27.17	46.22	3,160.16
97	4,565.41	990.11	226.00	38.02	27.80	47.27	3,268.95
98	4,706.32	1,021.81	226.00	38.88	28.43	48.34	3,381.34
99	4,851.58	1,054.54	226.00	39.77	29.07	49.44	3,497.45

* Area factors will not apply to the Part B Deductible premium.

Modal Factors: Semi-Annual - 0.5200, Quarterly - 0.2650, Monthly - 0.08333
Add a One-Time Policy Fee $25
To calculate a Household discount:
Annual premium x modal factor = modal premium (round to nearest whole cent)
Modal premium x .93 = discounted premium

ANNUAL PREMIUMS
Female – Preferred
ZIP Codes: 530-534

Effective Date: 08/01/2023

Age	Base	Part A Deductible	Part B Deductible	Part B Excess	Foreign Travel	Home Health Care	Part B Copayment
0-64	5,076.51	883.26	226.00	47.82	34.95	59.42	3,022.82
65	1,450.43	252.36	226.00	13.66	9.98	16.98	863.66
66	1,450.43	252.36	226.00	13.66	9.98	16.98	863.66
67	1,450.43	252.36	226.00	13.66	9.98	16.98	863.66
68	1,450.43	252.36	226.00	13.66	9.98	16.98	863.66
69	1,450.43	252.36	226.00	13.66	9.98	16.98	863.66
70	1,508.50	260.03	226.00	14.17	10.36	17.62	886.92
71	1,575.13	275.39	226.00	14.76	10.80	18.36	937.93
72	1,642.95	291.04	226.00	15.37	11.24	19.11	989.87
73	1,720.44	308.51	226.00	16.07	11.75	19.98	1,047.91
74	1,799.88	326.42	226.00	16.78	12.27	20.87	1,107.47
75	1,881.33	344.80	226.00	17.52	12.81	21.77	1,168.58
76	1,945.04	363.22	226.00	18.11	13.24	22.50	1,221.59
77	2,012.20	382.47	226.00	18.72	13.69	23.28	1,277.18
78	2,083.08	402.65	226.00	19.37	14.16	24.08	1,335.56
79	2,157.89	423.83	226.00	20.06	14.67	24.93	1,396.92
80	2,236.92	446.06	226.00	20.78	15.20	25.83	1,461.48
81	2,320.17	468.62	226.00	21.42	15.66	26.62	1,529.24
82	2,410.57	492.88	226.00	22.11	16.17	27.48	1,602.24
83	2,503.81	517.97	226.00	22.83	16.68	28.37	1,677.70
84	2,600.01	543.93	226.00	23.56	17.21	29.28	1,755.72
85	2,699.21	570.77	226.00	24.32	17.77	30.22	1,836.35
86	2,791.08	592.35	226.00	25.02	18.29	31.10	1,909.23
87	2,885.67	614.58	226.00	25.76	18.82	32.01	1,984.43
88	2,983.08	637.53	226.00	26.51	19.38	32.95	2,062.00
89	3,083.37	661.17	226.00	27.27	19.94	33.91	2,142.02
90	3,186.63	685.56	226.00	28.06	20.52	34.90	2,224.58
91	3,286.00	707.80	226.00	28.70	20.99	35.69	2,302.79
92	3,388.20	730.67	226.00	29.36	21.47	36.51	2,383.35
93	3,493.31	754.20	226.00	30.02	21.96	37.33	2,466.35
94	3,601.40	778.44	226.00	30.71	22.45	38.18	2,551.85
95	3,712.55	803.36	226.00	31.40	22.96	39.05	2,639.91
96	3,827.14	829.08	226.00	32.12	23.48	39.95	2,730.90
97	3,945.26	855.63	226.00	32.85	24.02	40.85	2,824.92
98	4,067.03	883.02	226.00	33.60	24.57	41.77	2,922.03
99	4,192.56	911.29	226.00	34.36	25.12	42.72	3,022.37

* Area factors will not apply to the Part B Deductible premium.

Modal Factors: Semi-Annual - 0.5200, Quarterly - 0.2650, Monthly - 0.08333
Add a One-Time Policy Fee $25
To calculate a Household discount:
Annual premium x modal factor = modal premium (round to nearest whole cent)
Modal premium x .93 = discounted premium

ANNUAL PREMIUMS
Male – Preferred
ZIP Codes: 530-534

Effective Date: 08/01/2023

Age	Base	Part A Deductible	Part B Deductible	Part B Excess	Foreign Travel	Home Health Care	Part B Copayment
0-64	5,838.00	1,015.73	226.00	54.97	40.20	68.38	3,476.28
65	1,668.00	290.21	226.00	15.71	11.48	19.54	993.23
66	1,668.00	290.21	226.00	15.71	11.48	19.54	993.23
67	1,668.00	290.21	226.00	15.71	11.48	19.54	993.23
68	1,668.00	290.21	226.00	15.71	11.48	19.54	993.23
69	1,668.00	290.21	226.00	15.71	11.48	19.54	993.23
70	1,734.77	299.03	226.00	16.29	11.91	20.26	1,019.95
71	1,811.40	316.70	226.00	16.98	12.41	21.11	1,078.61
72	1,889.40	334.70	226.00	17.68	12.92	21.98	1,138.34
73	1,978.50	354.79	226.00	18.49	13.52	22.98	1,205.08
74	2,069.88	375.39	226.00	19.30	14.11	24.00	1,273.59
75	2,163.53	396.53	226.00	20.15	14.73	25.05	1,343.88
76	2,236.79	417.70	226.00	20.82	15.22	25.88	1,404.84
77	2,314.03	439.84	226.00	21.53	15.73	26.76	1,468.77
78	2,395.54	463.06	226.00	22.28	16.28	27.70	1,535.89
79	2,481.57	487.40	226.00	23.07	16.86	28.68	1,606.46
80	2,572.45	512.98	226.00	23.90	17.47	29.71	1,680.72
81	2,668.20	538.92	226.00	24.63	18.01	30.61	1,758.62
82	2,772.14	566.81	226.00	25.43	18.59	31.61	1,842.56
83	2,879.39	595.66	226.00	26.26	19.18	32.63	1,929.35
84	2,990.01	625.52	226.00	27.09	19.80	33.68	2,019.07
85	3,104.10	656.39	226.00	27.96	20.44	34.75	2,111.81
86	3,209.74	681.19	226.00	28.78	21.03	35.77	2,195.62
87	3,318.52	706.78	226.00	29.63	21.65	36.82	2,282.08
88	3,430.54	733.15	226.00	30.48	22.28	37.89	2,371.31
89	3,545.87	760.36	226.00	31.36	22.93	39.00	2,463.32
90	3,664.63	788.39	226.00	32.28	23.60	40.13	2,558.27
91	3,778.90	813.96	226.00	33.00	24.12	41.05	2,648.20
92	3,896.43	840.27	226.00	33.76	24.68	41.98	2,740.86
93	4,017.30	867.34	226.00	34.53	25.25	42.93	2,836.31
94	4,141.60	895.19	226.00	35.31	25.82	43.91	2,934.62
95	4,269.44	923.86	226.00	36.12	26.41	44.91	3,035.91
96	4,401.21	953.43	226.00	36.93	27.00	45.94	3,140.53
97	4,537.06	983.97	226.00	37.78	27.62	46.97	3,248.65
98	4,677.08	1,015.47	226.00	38.64	28.25	48.04	3,360.34
99	4,821.45	1,047.97	226.00	39.52	28.90	49.13	3,475.73

* Area factors will not apply to the Part B Deductible premium.

Modal Factors: Semi-Annual - 0.5200, Quarterly - 0.2650, Monthly - 0.08333
Add a One-Time Policy Fee $25
To calculate a Household discount:
Annual premium x modal factor = modal premium (round to nearest whole cent)
Modal premium x .93 = discounted premium

ANNUAL PREMIUMS
Female – Standard
ZIP Codes: 530-534

Effective Date: 08/01/2023

Age	Base	Part A Deductible	Part B Deductible	Part B Excess	Foreign Travel	Home Health Care	Part B Copayment
0-64	5,838.00	1,015.73	226.00	54.97	40.20	68.38	3,476.28
65	1,668.00	290.21	226.00	15.71	11.48	19.54	993.23
66	1,668.00	290.21	226.00	15.71	11.48	19.54	993.23
67	1,668.00	290.21	226.00	15.71	11.48	19.54	993.23
68	1,668.00	290.21	226.00	15.71	11.48	19.54	993.23
69	1,668.00	290.21	226.00	15.71	11.48	19.54	993.23
70	1,734.77	299.03	226.00	16.29	11.91	20.26	1,019.95
71	1,811.40	316.70	226.00	16.98	12.41	21.11	1,078.61
72	1,889.40	334.70	226.00	17.68	12.92	21.98	1,138.34
73	1,978.50	354.79	226.00	18.49	13.52	22.98	1,205.08
74	2,069.88	375.39	226.00	19.30	14.11	24.00	1,273.59
75	2,163.53	396.53	226.00	20.15	14.73	25.05	1,343.88
76	2,236.79	417.70	226.00	20.82	15.22	25.88	1,404.84
77	2,314.03	439.84	226.00	21.53	15.73	26.76	1,468.77
78	2,395.54	463.06	226.00	22.28	16.28	27.70	1,535.89
79	2,481.57	487.40	226.00	23.07	16.86	28.68	1,606.46
80	2,572.45	512.98	226.00	23.90	17.47	29.71	1,680.72
81	2,668.20	538.92	226.00	24.63	18.01	30.61	1,758.62
82	2,772.14	566.81	226.00	25.43	18.59	31.61	1,842.56
83	2,879.39	595.66	226.00	26.26	19.18	32.63	1,929.35
84	2,990.01	625.52	226.00	27.09	19.80	33.68	2,019.07
85	3,104.10	656.39	226.00	27.96	20.44	34.75	2,111.81
86	3,209.74	681.19	226.00	28.78	21.03	35.77	2,195.62
87	3,318.52	706.78	226.00	29.63	21.65	36.82	2,282.08
88	3,430.54	733.15	226.00	30.48	22.28	37.89	2,371.31
89	3,545.87	760.36	226.00	31.36	22.93	39.00	2,463.32
90	3,664.63	788.39	226.00	32.28	23.60	40.13	2,558.27
91	3,778.90	813.96	226.00	33.00	24.12	41.05	2,648.20
92	3,896.43	840.27	226.00	33.76	24.68	41.98	2,740.86
93	4,017.30	867.34	226.00	34.53	25.25	42.93	2,836.31
94	4,141.60	895.19	226.00	35.31	25.82	43.91	2,934.62
95	4,269.44	923.86	226.00	36.12	26.41	44.91	3,035.91
96	4,401.21	953.43	226.00	36.93	27.00	45.94	3,140.53
97	4,537.06	983.97	226.00	37.78	27.62	46.97	3,248.65
98	4,677.08	1,015.47	226.00	38.64	28.25	48.04	3,360.34
99	4,821.45	1,047.97	226.00	39.52	28.90	49.13	3,475.73

* Area factors will not apply to the Part B Deductible premium.

Modal Factors: Semi-Annual - 0.5200, Quarterly - 0.2650, Monthly - 0.08333
Add a One-Time Policy Fee $25
To calculate a Household discount:
Annual premium x modal factor = modal premium (round to nearest whole cent)
Modal premium x .93 = discounted premium

ANNUAL PREMIUMS
Male – Standard
ZIP Codes: 530-534

Effective Date: 08/01/2023

Age	Base	Part A Deductible	Part B Deductible	Part B Excess	Foreign Travel	Home Health Care	Part B Copayment
0-64	6,713.72	1,168.10	226.00	63.24	46.23	78.62	3,997.74
65	1,918.20	333.74	226.00	18.07	13.21	22.46	1,142.21
66	1,918.20	333.74	226.00	18.07	13.21	22.46	1,142.21
67	1,918.20	333.74	226.00	18.07	13.21	22.46	1,142.21
68	1,918.20	333.74	226.00	18.07	13.21	22.46	1,142.21
69	1,918.20	333.74	226.00	18.07	13.21	22.46	1,142.21
70	1,994.99	343.88	226.00	18.74	13.70	23.30	1,172.95
71	2,083.11	364.21	226.00	19.53	14.28	24.28	1,240.41
72	2,172.80	384.91	226.00	20.33	14.86	25.28	1,309.08
73	2,275.28	407.99	226.00	21.25	15.54	26.43	1,385.85
74	2,380.35	431.69	226.00	22.20	16.23	27.60	1,464.62
75	2,488.06	456.00	226.00	23.16	16.94	28.81	1,545.46
76	2,572.31	480.35	226.00	23.94	17.51	29.77	1,615.56
77	2,661.13	505.82	226.00	24.76	18.10	30.78	1,689.07
78	2,754.86	532.51	226.00	25.61	18.73	31.84	1,766.28
79	2,853.81	560.51	226.00	26.52	19.39	32.97	1,847.42
80	2,958.32	589.92	226.00	27.48	20.09	34.17	1,932.82
81	3,068.42	619.76	226.00	28.33	20.71	35.20	2,022.41
82	3,187.97	651.83	226.00	29.24	21.38	36.35	2,118.95
83	3,311.30	685.01	226.00	30.19	22.06	37.52	2,218.75
84	3,438.51	719.34	226.00	31.16	22.78	38.73	2,321.93
85	3,569.71	754.85	226.00	32.16	23.50	39.96	2,428.57
86	3,691.20	783.37	226.00	33.10	24.18	41.14	2,524.95
87	3,816.30	812.79	226.00	34.06	24.89	42.34	2,624.40
88	3,945.12	843.13	226.00	35.06	25.62	43.57	2,727.00
89	4,077.75	874.41	226.00	36.08	26.37	44.85	2,832.83
90	4,214.32	906.65	226.00	37.12	27.13	46.15	2,942.01
91	4,345.74	936.06	226.00	37.97	27.75	47.19	3,045.44
92	4,480.90	966.31	226.00	38.82	28.39	48.28	3,151.99
93	4,619.89	997.44	226.00	39.71	29.03	49.37	3,261.74
94	4,762.85	1,029.48	226.00	40.61	29.69	50.50	3,374.82
95	4,909.84	1,062.43	226.00	41.54	30.36	51.64	3,491.29
96	5,061.39	1,096.44	226.00	42.48	31.06	52.82	3,611.62
97	5,217.61	1,131.55	226.00	43.45	31.77	54.02	3,735.95
98	5,378.65	1,167.78	226.00	44.44	32.49	55.25	3,864.38
99	5,544.66	1,205.18	226.00	45.45	33.23	56.51	3,997.08

* Area factors will not apply to the Part B Deductible premium.

Modal Factors: Semi-Annual - 0.5200, Quarterly - 0.2650, Monthly - 0.08333
Add a One-Time Policy Fee $25
To calculate a Household discount:
Annual premium x modal factor = modal premium (round to nearest whole cent)
Modal premium x .93 = discounted premium

THE AMERICAN HOME LIFE INSURANCE COMPANY
OUTLINE OF MEDICARE SUPPLEMENT INSURANCE

BASIC PLAN

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

A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.
*NOTICE: When your Medicare Part A hospital benefits are exhausted, the issuer stands in the place of Medicare and will pay whatever amount Medicare would have paid as provided in the policy's "Core Benefits."
**These are optional riders. You purchased this benefit if the box is checked and you paid the premium.

MEDICARE PART A BENEFITS	MEDICARE PAYS	THIS POLICY PAYS	YOU PAY
HOSPITALIZATION Semiprivate room and board, general nursing and miscellaneous hospital services and supplies (Does not include personal items)			
First 60 days	All but $1,632	$0 or ☐ Part A Deductible Rider **	$1,632 (Part A Deductible) or $0
61st through 90th day	All but $408 a day	$408 a day	$0
91st day and after			
• While using 60 lifetime reserve days	All but $816 a day	$816 a day	$0
• Once lifetime reserve days are used:			
• Additional 365 days	$0	100% of Medicare Eligible Expenses*	$0
• Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $204 a day	Up to $204 a day	$0
101st day and after	$0	$0	All Costs

MEDICARE PART A BENEFITS	MEDICARE PAYS	THIS POLICY PAYS	YOU PAY
INPATIENT PSYCHIATRIC CARE Inpatient psychiatric care in a participating psychiatric hospital	190 days per lifetime	175 days per lifetime	All charges not covered by policy nor by Medicare
BLOOD First 3 pints Additional Amounts	 $0 100%	 First 3 pints $0	 $0 $0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance or copayment for outpatient drugs and inpatient respite care	Medicare copayment / coinsurance	$0

BASIC PLAN

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

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

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

MEDICARE PART B BENEFITS	MEDICARE PAYS	THIS POLICY PAYS	YOU PAY
MEDICAL EXPENSES Eligible expense for physician's services, in-patient and out-patient medical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $240 of Medicare-approved amounts	$0	$0 or ☐ Optional Part B Deductible Rider**	$240 or $0 or
Remainder of Medicare-approved amounts	Generally 80%	☐ Optional Medicare Copayment or Coinsurance Rider** Generally 20% ☐ Optional Medicare Part B Excess Charges Rider**	Up to $20 per office visit and up to $50 per emergency room visit. Charges in excess of 20% up to the limiting charge Balance, if any, or expenses if not covered by Medicare or this policy
BLOOD			
First 3 pints	$0	All costs	$0
Next $240 of Medicare-approved amounts	$0	$0 or ☐ Optional Part B Deductible Rider**	$240 or $0
Remainder of Medicare-approved amounts	80%	20%	Charges not covered by the policy or Medicare

MEDICARE PART B BENEFITS	MEDICARE PAYS	THIS POLICY PAYS	YOU PAY
CLINICAL LABORATORY SERVICES Tests for diagnostic services	100%	$0	$0
HOME HEALTH CARE	100% of charges for visits considered medically necessary by Medicare	40 visits or ☐ Optional Additional Home Health Care Rider**	Charges not covered by policy or Medicare

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

BASIC PLAN
OTHER BENEFITS – NOT COVERED BY MEDICARE

	MEDICARE PAYS	THIS POLICY PAYS	YOU PAY
PREVENTIVE MEDICAL CARE BENEFIT-NOT COVERED BY MEDICARE Some annual physical and preventive tests and services administered or ordered by your doctor when not covered by Medicare			
First $120 each calendar year	$0	$120	Charges not covered by policy or Medicare
Additional charges	$0	$0	
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside of the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	$0 or ☐ Optional Foreign Travel Emergency Rider** (80% to a lifetime maximum benefit of $50,000)	All costs or 20% and amounts over the $50,000 lifetime maximum

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

THE FOLLOWING BENEFITS ARE MANDATED BY YOUR STATE:

SKILLED NURSING FACILITY BENEFITS FOR NON-MEDICARE ELIGIBLE CONFINEMENT - We will pay the expenses you incur during any Medicare benefit period for confinement in a Wisconsin state licensed Skilled Nursing Facility, up to a maximum of 30 days. The daily rate payable shall be no less than the maximum daily rate established for skilled nursing care in that facility by the Department of Health and Social Services. Your confinement must be certified initially as Medically Necessary by the attending Physician and recertified every 7 days.

Benefits are not payable for services provided by or paid for by the Veterans Administration or Custodial Care or Skilled Nursing Facility confinement certified by Medicare.

KIDNEY DISEASE BENEFITS - We will pay the expenses you incur for treatment of kidney Disease by dialysis, transplantation and/or donor related services as defined by the Wisconsin Department of Health and Social Services, up to a maximum of $30,000 each calendar year. We will not pay for charges covered by another policy covering kidney disease expenses or for charges covered by Medicare.

DIABETES BENEFITS - We will pay the usual and customary charges for expenses incurred, and not covered by Medicare, for the installation and use of an insulin infusion pump or other equipment or supplies, including insulin or any other prescription medication, used in the treatment of diabetes and coverage of diabetic self-management education programs. Coverage for an insulin infusion pump is limited to one pump per year and is subject to a 30 day trial period prior to purchase.

Benefits are not payable if the equipment and supplies are covered under the Medicare Part D Prescription Drug program, whether or not the insured person is enrolled in a Medicare Part D plan.

CHIROPRACTIC BENEFITS - When Medicare Part B does not pay for Medically Necessary Services received from a Chiropractor, we will 100% of the usual and customary charges for chiropractor services. Benefits are not payable for that portion of expense for which benefits were paid by Medicare or under any other part of this policy.

HOSPITAL AND AMBULATORY SURGICAL CENTER CHARGES - We will pay the usual and customary charges incurred, and anesthetics provided, in conjunction with dental care that is provided to a covered individual in a Hospital or Ambulatory Surgical Center, if any of the Following applies:

a. you have a chronic disability that is attributable to a mental or physical impairment which results in a substantial functional limitation in an area of your major life activity, and the disability is likely to continue indefinitely.
b. you have a medical condition that requires hospitalization or general anesthesia for dental care.

BREAST RECONSTRUCTION BENEFITS - We will pay the usual and customary charges Incurred, not payable under Medicare, in the manner recommended by the attending Physician or Oncologist for breast reconstruction of the affected tissue incident to a mastectomy.

COLORECTAL EXAMS – We will pay your expense incurred for colorectal screening exams and lab tests if you are over 50 years of age or if you are under 50 years of age and are symptomatic or in a high-risk category. This coverage is subject to any deductible, coinsurance, co-payment, or other limitation on coverage applicable to other coverages under this policy. Benefits are not payable for that portion of expense for which benefits were paid by Medicare or under any other part of this policy.

CANCER CLINICAL TRIAL - We will provide coverage for the cost of any routine patient care that is administered to an insured in a cancer clinical trial satisfying the following criteria and would be covered under the policy, plan, or contract if the insured were not enrolled in the cancer clinical trial:

a. The purpose of the trial is to test whether the intervention potentially improves the trial participants' health outcomes.
b. The treatment provided as part of the trial is given with the intention of improving the trial participants' health outcomes.
c. The trial has therapeutic intent and is not designed exclusively to test toxicity or disease pathophysiology.
d. The trial does one of the following:
    1. Tests how to administer a health care service, item, or drug for the treatment of cancer.
    2. Tests responses to a health care service, item, or drug for the treatment of cancer.
    3. Compares the effectiveness of health care services, items, or drugs for the treatment of cancer with that of other health care services, items, or drugs for the treatment of cancer.
    4. Studies new uses of health care services, items, or drugs for the treatment of cancer.
e. The trial is approved by one of the following:
    1. A National Institute of Health, or one of its cooperative groups or centers, under the federal department of health and human services.
    2. The Federal Food and Drug Administration.
    3. The Federal Department of Defense.
    4. The Federal Department of Veterans Affairs.

EXCEPTIONS, REDUCTIONS AND LIMITATIONS OF THE POLICY - We will not pay benefits for:

1. expenses deemed unnecessary or unreasonable by Medicare, except in the Benefit Provisions and in Optional Riders, if any;
2. expenses incurred prior to the coverage effective date;
3. drugs (other than prescription drugs furnished during a hospital or skilled nursing facility stay);
4. custodial care, dental care (except as provided in the mandated benefits) eye or ear examinations to prescribe or fit eyeglasses or hearing aids, routine immunizations, cosmetic surgery or routine foot care;
5. services for which a charge is normally not made when there is no insurance;
6. nursing home care costs (beyond what is covered by Medicare and the Wisconsin 30-day skilled nursing mandated by Wisconsin 632.895(3);
7. home health care above the number of visits covered by Medicare and the 40-visits mandated by Wisconsin 632.895(2), unless you select the Additional Home Health Care Rider; or
8. care received outside the U.S.A.

Benefits will be increased to match any increases in Medicare deductible amounts or co-payment charges. The premium may automatically increase to correspond with these increases.

RENEWABILITY OF THE POLICY - We will renew the policy each time you send us the premium. It must be paid on or before the date it is due or during the 31 days that follow.

Your premium will change on the first renewal date that coincides with or follows the anniversary date of the policy.

MATERIAL MISREPRESENTATION - in the event of a material misrepresentation, the coverage will be cancelled as of the coverage effective date. A "material misrepresentation" occurs when a condition or combination of conditions you were requested to name on the application was not named and which, if named, would have caused us to deny issuing the coverage. This limitation for material misrepresentation is subject to the Time Limit for Certain defenses provision.

GRIEVANCE - A grievance may be made by you or on your behalf in writing to us. A grievance is any dissatisfaction regarding our services, decision to rescind a policy, or claims practices.

IN ADDITION TO THIS OUTLINE OF COVERAGE, THE AMERICAN HOME LIFE INSURANCE COMPANY WILL SEND AN ANNUAL NOTICE TO YOU, 30 DAYS PRIOR TO THE EFFECTIVE DATE OF MEDICARE CHANGES, WHICH WILL DESCRIBE THESE CHANGES AND THE CHANGES IN YOUR MEDICARE SUPPLEMENT COVERAGE.

MEDICARE SUPPLEMENT PREMIUM INFORMATION

ANNUAL PREMIUM

$_____ BASIC MEDICARE SUPPLEMENT COVERAGE

OPTIONAL BENEFITS FOR MEDICARE SUPPLEMENT POLICY - Each of these riders may be purchased separately.

$_____ MEDICARE PART A DEDUCTIBLE RIDER - 100% of Part A Deductible

$_____ MEDICARE PART B DEDUCTIBLE RIDER - 100% of Part B Deductible **This rider is not available for those newly eligible for Medicare after January 1, 2020.**

$_____ MEDICARE PART B EXCESS CHARGES RIDER - Difference between what Medicare pays and the amount charged by the provider which shall be no greater than the actual charge or the limiting charge allowed by Medicare, whichever is less.

$_____ ADDITIONAL HOME HEALTH CARE RIDER - An aggregate of 365 visits per year including those covered by Medicare.

$_____ FOREIGN TRAVEL EMERGENCY RIDER - After a deductible of not greater than $250, covers at least 80% of expenses associated with emergency medical care received outside the United States during the first 60 days of a trip with a maximum of at least $50,000.

$_____ MEDICARE PART B COPAYMENT OR COINSURANCE RIDER - Pays the Part B coinsurance subject to a copayment or coinsurance of no more than $20 per office visit and no more than $50 per emergency room visit or the Medicare Part B coinsurance that is in addition to the Medicare Part B medical deductible and in addition to out-of-pocket maximums.

$_____ TOTAL FOR BASIC POLICY, POLICY FEE AND SELECTED OPTIONAL RIDERS

Total Premium, if other than Annual Mode (at time of application), including premium for any Optional Rider selected above:

$_____ EFT $_____ Quarterly $_____ Semi-annual