



Outline of Medicare Supplement Coverage - Benefit Plans A, F, G 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.

BASIC BENEFITS

Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.

Medical Expenses: Part B coinsurance (generally 20% of Medicare-approved

expenses), or copayments for hospital outpatient services. Plans K, L, and N require insureds to pay a portion of Part B coinsurance or copayments.

Blood: First 3 pints of blood each year.

Hospice: Part A coinsurance.

A	B	C	D	F	F*	G	K	L	M	N
Basic Benefits, including 100% Part B coinsurance	Basic Benefits, including 100% Part B coinsurance	Basic Benefits, including 100% Part B coinsurance	Basic Benefits, including 100% Part B coinsurance	Basic Benefits, including 100% Part B coinsurance	Basic Benefits, including 100% Part B coinsurance	Basic Benefits, including 100% Part B coinsurance	Hospitalization and Preventive Care paid at 100%; other basic benefits paid at 50%	Hospitalization and Preventive Care paid at 100%; other basic benefits paid at 75%	Basic Benefits, including 100% Part B coinsurance	Basic Benefits, including 100% Part B coinsurance, except up to \$20 copayment for office visit, and up to \$50 copayment for Emergency Room
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Part B Deductible		Part B Deductible						
				Part B Excess (100%)		Part B Excess (100%)				
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency		Foreign Travel Emergency			Foreign Travel Emergency	Foreign Travel Emergency
							Out-of-pocket limit \$5,120; paid at 100% after limit reached	Out-of-pocket limit \$2,560; paid at 100% after limit reached		

*Plan F also has an option called a high deductible Plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year \$2,200 deductible. Benefits from high deductible Plan F will not begin until out-of-pocket expenses exceed \$2,200. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan’s separate foreign travel emergency deductible.

Premium Information

We 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 over 18 years of age, 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 10482, 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 Corp Life 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*

* 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.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after: <ul style="list-style-type: none"> • While using 60 lifetime reserve days • Once lifetime reserve days are used: <ul style="list-style-type: none"> • Additional 365 days • Beyond the additional 365 days 	All but \$1,316 All but \$329 a day All but \$658 a day \$0 \$0	\$0 \$329 a day \$658 a day 100% of Medicare Eligible expenses \$0	\$1,316 (Part A deductible) \$0 \$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 21st thru 100th day 101st day and after	All approved amounts All but \$164.50 a day \$0	\$0 \$0 \$0	\$0 Up to \$164.50 a day All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE You must meet Medicare's requirements, including a physician's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

** **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

* Once you have been billed \$183 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.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT , such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First \$183 of Medicare Approved Amounts* (Part B deductible) Remainder of Medicare Approved Amounts	\$0 Generally 80%	\$0 Generally 20%	\$183 (Part B deductible) \$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All costs
BLOOD First 3 pints Next \$183 of Medicare Approved Amounts* (Part B deductible) Remainder of Medicare Approved Amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$183 (Part B deductible) \$0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

Medicare (Parts A and B) - Home Health Care

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE - MEDICARE APPROVED SERVICES <ul style="list-style-type: none"> • Medically necessary skilled care services and medical supplies • Durable medical equipment First \$183 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$183 (Part B deductible) \$0

PLAN F

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.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after: <ul style="list-style-type: none"> • While using 60 lifetime reserve days • Once lifetime reserve days are used: <ul style="list-style-type: none"> • Additional 365 days • Beyond the additional 365 days 	All but \$1,316 All but \$329 a day All but \$658 a day \$0 \$0	\$1,316 (Part A deductible) \$329 a day \$658 a day 100% of Medicare Eligible expenses \$0	\$0 \$0 \$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 21st thru 100th day 101st day and after	All approved amounts All but \$164.50 a day \$0	\$0 Up to \$164.50 a day \$0	\$0 \$0 All costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE You must meet Medicare's requirements, including a physician's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	\$0

** **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

* Once you have been billed \$183 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.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT , such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First \$183 of Medicare Approved Amounts*	\$0	\$183 (Part B deductible)	\$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	100%	\$0
BLOOD			
First 3 pints	\$0	All costs	\$0
Next \$183 of Medicare Approved Amounts*	\$0	\$183 (Part B deductible)	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

MEDICARE (PARTS A AND B) - HOME HEALTH CARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE - MEDICARE APPROVED SERVICES			
<ul style="list-style-type: none"> • Medically necessary skilled care services and medical supplies • Durable medical equipment 	100%	\$0	\$0
First \$183 of Medicare Approved Amounts*	\$0	\$183 (Part B deductible)	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0

PLAN F (continued)
OTHER BENEFITS NOT COVERED BY MEDICARE

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

PLAN G

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.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<p>HOSPITALIZATION*</p> <p>Semiprivate room and board, general nursing and miscellaneous services and supplies</p> <p>First 60 days</p> <p>61st thru 90th day</p> <p>91st day and after:</p> <ul style="list-style-type: none"> • While using 60 lifetime reserve days • Once lifetime reserve days are used: <ul style="list-style-type: none"> • Additional 365 days • Beyond the additional 365 days 	<p>All but \$1,316</p> <p>All but \$329 a day</p> <p>All but \$658 a day</p> <p>\$0</p> <p>\$0</p>	<p>\$1,316 (Part A deductible)</p> <p>\$329 a day</p> <p>\$658 a day</p> <p>100% of Medicare Eligible expenses</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>\$0</p> <p>\$0**</p> <p>All costs</p>
<p>SKILLED NURSING FACILITY CARE*</p> <p>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</p> <p>First 20 days</p> <p>21st thru 100th day</p> <p>101st day and after</p>	<p>All approved amounts</p> <p>All but \$164.50 a day</p> <p>\$0</p>	<p>\$0</p> <p>Up to \$164.50 a day</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>All costs</p>
<p>BLOOD</p> <p>First 3 pints</p> <p>Additional amounts</p>	<p>\$0</p> <p>100%</p>	<p>3 pints</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p>
<p>HOSPICE CARE</p> <p>You must meet Medicare's requirements, including a physician's certification of terminal illness.</p>	<p>All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care</p>	<p>Medicare copayment/coinsurance</p>	<p>\$0</p>

** **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

* Once you have been billed \$183 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.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT , such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First \$183 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 Generally 80%	\$0 Generally 20%	\$183 (Part B deductible) \$0
Part B Excess Charges (Above Medicare Approved Amounts)	\$0	100%	\$0
BLOOD First 3 pints Next \$183 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$183 (Part B deductible) \$0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PLAN G (continued)

MEDICARE (PARTS A AND B) - HOME HEALTH CARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE - MEDICARE APPROVED SERVICES			
<ul style="list-style-type: none"> • Medically necessary skilled care services and medical supplies • Durable medical equipment 	100%	\$0	\$0
First \$183 of Medicare Approved Amounts*	\$0	\$0	\$183 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

OTHER BENEFITS NOT COVERED BY MEDICARE

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

PLAN N

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.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<p>HOSPITALIZATION*</p> <p>Semiprivate room and board, general nursing and miscellaneous services and supplies</p> <p>First 60 days</p> <p>61st thru 90th day</p> <p>91st day and after:</p> <ul style="list-style-type: none"> • While using 60 lifetime reserve days • Once lifetime reserve days are used: <ul style="list-style-type: none"> • Additional 365 days • Beyond the additional 365 days 	<p>All but \$1,316</p> <p>All but \$329 a day</p> <p>All but \$658 a day</p> <p>\$0</p> <p>\$0</p>	<p>\$1,316 (Part A deductible)</p> <p>\$329 a day</p> <p>\$658 a day</p> <p>100% of Medicare Eligible expenses</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>\$0</p> <p>\$0**</p> <p>All costs</p>
<p>SKILLED NURSING FACILITY CARE*</p> <p>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</p> <p>First 20 days</p> <p>21st thru 100th day</p> <p>101st day and after</p>	<p>All approved amounts</p> <p>All but \$164.50 a day</p> <p>\$0</p>	<p>\$0</p> <p>Up to \$164.50 a day</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>All costs</p>
<p>BLOOD</p> <p>First 3 pints</p> <p>Additional amounts</p>	<p>\$0</p> <p>100%</p>	<p>3 pints</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p>
<p>HOSPICE CARE</p> <p>You must meet Medicare's requirements, including a physician's certification of terminal illness.</p>	<p>All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care</p>	<p>Medicare copayment/coinsurance</p>	<p>\$0</p>

** **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

* Once you have been billed \$183 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.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<p>MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment</p> <p>First \$183 of Medicare Approved Amounts*</p> <p>Remainder of Medicare Approved Amounts</p>	<p>\$0</p> <p>Generally 80%</p>	<p>\$0</p> <p>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.</p>	<p>\$183 (Part B deductible)</p> <p>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</p>
<p>Part B Excess Charges (Above Medicare Approved Amounts)</p>	\$0	\$0	All costs
<p>BLOOD</p> <p>First 3 pints</p> <p>Next \$183 of Medicare Approved Amounts*</p> <p>Remainder of Medicare Approved Amounts</p>	<p>\$0</p> <p>\$0</p> <p>80%</p>	<p>All costs</p> <p>\$0</p> <p>20%</p>	<p>\$0</p> <p>\$183 (Part B deductible)</p> <p>\$0</p>
<p>CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES</p>	100%	\$0	\$0

PLAN N (continued)

MEDICARE (PARTS A AND B) - HOME HEALTH CARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE - MEDICARE APPROVED SERVICES			
<ul style="list-style-type: none"> • Medically necessary skilled care services and medical supplies • Durable medical equipment 	100%	\$0	\$0
First \$183 of Medicare Approved Amounts*	\$0	\$0	\$183 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

OTHER BENEFITS NOT COVERED BY MEDICARE

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

Printed First Name of Producer _____ M.I. _____ Last Name _____

Street Address, Rural Route or Box Number _____

City _____ State _____ ZIP Code _____

Phone Number _____ Date (MM/DD/YYYY) _____

X _____
 Producer/Home Office Employee Signature