Filing at a Glance

Company:	Medico Insurance Company
Product Name:	AR A20 MIPPA Bracketing
State:	Arkansas
TOI:	MS08I Individual Medicare Supplement - Standard Plans 2010
Sub-TOI:	MS08I.012 Multi-Plan 2010
Filing Type:	Form
Date Submitted:	01/08/2013
SERFF Tr Num:	MDIC-128740502
SERFF Status:	Closed-Approved-Closed
State Tr Num:	
State Status:	Approved-Closed
Co Tr Num:	AR A20 MIPPA BRACKETING
Implementation Date Requested:	On Approval
Author(s):	Luanne Melies
Reviewer(s):	Stephanie Fowler (primary)
Disposition Date:	01/15/2013
Disposition Status:	Approved-Closed
Implementation Date:	

State Filing Description:

State: *Arkansas* **Filing Company:** *Medico Insurance Company*
TOI/Sub-TOI: *MS08I Individual Medicare Supplement - Standard Plans 2010/MS08I.012 Multi-Plan 2010*
Product Name: *AR A20 MIPPA Bracketing*
Project Name/Number: *AR A20 MIPPA Bracketing/AR A20 MIPPA Bracketing*

General Information

Project Name: AR A20 MIPPA Bracketing
Project Number: AR A20 MIPPA Bracketing
Requested Filing Mode: Informational

Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:

Deemer Date:
Submitted By: Luanne Melies

Status of Filing in Domicile: Not Filed
Date Approved in Domicile:
Domicile Status Comments: Not filed with Nebraska, our state of domicile, at this time.

Market Type: Individual
Individual Market Type:
Filing Status Changed: 01/15/2013
State Status Changed: 01/15/2013
Created By: Luanne Melies
Corresponding Filing Tracking Number:

Filing Description:

Changes from the previous version of these forms to the new forms are limited only to bracketing variable text as concerning our contact information that is subject to change (i.e., Home Office physical address, website address and telephone and fax numbers, time of operation, company inter department names, officers) as well as potential changes in payment methods, payment modes. No such items will be contradictory to any applicable state or federal law.

Company and Contact

Filing Contact Information

Luanne Melies, Compliance Analyst
11808 Grant Street
Omaha, NE 68164

lmelies@gomedico.com
402-496-8237 [Phone]

Filing Company Information

Medico Insurance Company
11808 Grant Street
Omaha, NE 68164
(402) 496-8209 ext. [Phone]

CoCode: 31119
Group Code: 3527
Group Name: Medico
FEIN Number: 47-0122200

State of Domicile: Nebraska
Company Type: Life and Health
State ID Number:

Filing Fees

Fee Required? Yes
Fee Amount: $50.00
Retaliatory? No
Fee Explanation: General Instructions #4. Policy and contract forms, all lines, filing corrections in previously filed policy and contract form...$50.00.
Per Company: No

Company	Amount	Date Processed	Transaction #
Medico Insurance Company	$50.00	01/08/2013	66360994

State: Arkansas **Filing Company:** Medico Insurance Company
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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Stephanie Fowler	01/15/2013	01/15/2013

State: Arkansas **Filing Company:** Medico Insurance Company
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Disposition

Disposition Date: 01/15/2013
Implementation Date:
Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	AR A20-C Cover Letter	Approved-Closed	Yes
Supporting Document	Form For Informational Purposes	Approved-Closed	Yes
Form	Medicare Supplement Policy Plan A	Approved-Closed	Yes
Form	Medicare Supplement Policy Plan D	Approved-Closed	Yes
Form	Medicare Supplement Policy PlanF	Approved-Closed	Yes
Form	Benefit Notice for Plan A	Approved-Closed	Yes
Form	Benefit Notice for Plan D	Approved-Closed	Yes
Form	Benefit Notice for Plan F	Approved-Closed	Yes
Form	Replacement Notice	Approved-Closed	Yes
Form	Policy Schedule Page Plan A	Approved-Closed	Yes
Form	Policy Schedule Page Plan D	Approved-Closed	Yes
Form	Policy Schedule Page Plan F	Approved-Closed	Yes
Form	TOLL-FREE CLIENT SERVICES	Approved-Closed	Yes

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Schedule	Schedule Item	Schedule Item Status	Public Access
Form	Medicare Supplement Policy Plan G	Approved-Closed	Yes
Form	Medicare Supplement Policy Plan N	Approved-Closed	Yes
Form	Policy Schedule Page for Plan G	Approved-Closed	Yes
Form	Policy Schedule Page for Plan N	Approved-Closed	Yes
Form	Benefit Notice for Plan G	Approved-Closed	Yes
Form	Benefit Notice for Plan N	Approved-Closed	Yes

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Project Name/Number: AR A20 MIPPA Bracketing/AR A20 MIPPA Bracketing

Form Schedule

Lead Form Number:

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data		Readability Score	Attachments
1	Approved-Closed 01/15/2013	Medicare Supplement Policy Plan A	MI-MSA20A(AR)	POL	Revised	Previous Filing Number:	MDIC-126453783		MI-MSA20A(AR)-07112012.pdf
						Replaced Form Number:	MI-MSA20A(AR) version 09082009		
2	Approved-Closed 01/15/2013	Medicare Supplement Policy Plan D	MI-MSA20D(AR)	POL	Revised	Previous Filing Number:	MDIC-126453841		MI-MSA20D(AR)-07112012.pdf
						Replaced Form Number:	MI-MSA20D(AR) version 09082009		
3	Approved-Closed 01/15/2013	Medicare Supplement Policy PlanF	MI-MSA20F(AR)	POL	Revised	Previous Filing Number:	MDIC-126453857		MI-MSA20F(AR)-07112012.pdf
						Replaced Form Number:	MI-MSA20F(AR) version 09082009		
4	Approved-Closed 01/15/2013	Benefit Notice for Plan A	MI9F-4367A-C	OTH	Revised	Previous Filing Number:	MDIC-126453783		MI9F-4367A-C 07112012.pdf
						Replaced Form Number:	MI9F-4367A		
5	Approved-Closed 01/15/2013	Benefit Notice for Plan D	MI9F-4367D-C	OTH	Revised	Previous Filing Number:	MDIC-126453841		MI9F-4367D-C-07112012.pdf
						Replaced Form Number:	MI9F-4367D		

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Project Name/Number: AR A20 MIPPA Bracketing/AR A20 MIPPA Bracketing

Lead Form Number:

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data		Readability Score	Attachments
6	Approved-Closed 01/15/2013	Benefit Notice for Plan F	MI9F-4367F-C	OTH	Revised	Previous Filing Number:	MDIC-126453857		MI9F-4367F-C-07112012.pdf
						Replaced Form Number:	MI9F-4367F		
7	Approved-Closed 01/15/2013	Replacement Notice	MI9F-4368-C	OTH	Revised	Previous Filing Number:	MDIC-126453783		MI9F-4368-C-08222012.pdf
						Replaced Form Number:	MI9F-4368		
8	Approved-Closed 01/15/2013	Policy Schedule Page Plan A	POLICY A20A-C	SCH	Revised	Previous Filing Number:	MDIC-126453783		A20A-C 07122012.pdf
						Replaced Form Number:	POLICY A20(A)		
9	Approved-Closed 01/15/2013	Policy Schedule Page Plan D	POLICY A20D-C	SCH	Revised	Previous Filing Number:	MDIC-126453841		A20D-C 07122012.pdf
						Replaced Form Number:	POLICY A20(D)		
10	Approved-Closed 01/15/2013	Policy Schedule Page Plan F	POLICY A20F-C	SCH	Revised	Previous Filing Number:	MDIC-126453857		A20F-C 07122012.pdf
						Replaced Form Number:	POLICY A20(F)		
11	Approved-Closed 01/15/2013	TOLL-FREE CLIENT SERVICES	MIR-AR-763	OTH	Revised	Previous Filing Number:	MDIC-128060718		MIR-AR-763-07112012.pdf
						Replaced Form Number:	MIR-AR-763 version 09162010		

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Lead Form Number:

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data		Readability Score	Attachments
12	Approved-Closed 01/15/2013	Medicare Supplement Policy Plan G	MI-MSA20G(AR)	POL	Revised	Previous Filing Number:	MDIC-127102602		MI-MSA20G(AR)-01082013.pdf
						Replaced Form Number:	MI-MSA20G(AR) version 03292011		
13	Approved-Closed 01/15/2013	Medicare Supplement Policy Plan N	MI-MSA20N(AR)	POL	Revised	Previous Filing Number:	MDIC-127102646		MI-MSA20N(AR)-01082013.pdf
						Replaced Form Number:	MI-MSA20N(AR) version 03292011		
14	Approved-Closed 01/15/2013	Policy Schedule Page for Plan G	POLICY A20G-C	SCH	Revised	Previous Filing Number:	MDIC-127102602		A20G-C 01102011.pdf
						Replaced Form Number:	POLICY A20G		
15	Approved-Closed 01/15/2013	Policy Schedule Page for Plan N	POLICY A20N-C	SCH	Revised	Previous Filing Number:	MDIC-127102646		A20N-C 07122012.pdf
						Replaced Form Number:	POLICY A20N		
16	Approved-Closed 01/15/2013	Benefit Notice for Plan G	MI9F-4367G-C	OTH	Revised	Previous Filing Number:	MDIC-127102602		MI9F-4367G-C-11012012.pdf
						Replaced Form Number:	MI9F-4367G		
17	Approved-Closed 01/15/2013	Benefit Notice for Plan N	MI9F-4367N-C	OTH	Revised	Previous Filing Number:	MDIC-127102646		MI9F-4367N-C-11012012.pdf
						Replaced Form Number:	MI9F-4367N		

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Product Name: *AR A20 MIPPA Bracketing*
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Form Type Legend:

ADV	Advertising	**AEF**	Application/Enrollment Form
CER	Certificate	**CERA**	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	**FND**	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	**NOC**	Notice of Coverage
OTH	Other	**OUT**	Outline of Coverage
PJK	Policy Jacket	**POL**	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	**SCH**	Schedule Pages

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INSURANCE COMPANY

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MEDICARE SUPPLEMENT INSURANCE POLICY
BENEFIT PLAN A

This policy is a legal contract between you and us. **READ YOUR POLICY CAREFULLY.** Also, read the copy of your application and the policy Schedule. If there is any error or omission, tell us. We will make any needed change.

The first premium you, the Insured, paid before the Policy Date (and the copy of your attached application), put this policy in force as of the Policy Date. That date is shown in the Schedule. The Schedule is attached and is a part of this policy.

PART A PLEASE READ — 30-DAY RIGHT TO RETURN

Please read your policy. If you are not satisfied, send it back to us, or to the Producer who sold it to you, within 30 days after you receive it. We will return your money. That will mean your policy was never in force. Any refund made pursuant to this section will be paid directly to you in a timely manner.

PART B GUARANTEED RENEWABLE SUBJECT TO OUR LIMITED RIGHT TO CHANGE PREMIUMS

We guarantee to renew your policy for life as long as the premium is paid within the allowable time. We cannot make a change in your policy without your consent. We do have the right to change your premium as stated below.

Premium Change: We may change the premium rates for this policy. The change may be due to a change in policy coverage or a new table of rates. We can change your premium only if we do the same to all policies of this form issued to persons of your class. “Class” means the factors of underwriting class and geographic area of your state of residence that determined your premium rate when coverage was issued. If we make a change, it will not be based on any physical impairment you might have or any claims you have incurred under this policy. If it is necessary to change the premium for your policy, we will notify you in advance of the change in premium.

PART C COVERAGE CHANGE

Automatic Change In Coverage: Policy benefits that are designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible, copayment, or coinsurance amounts. Premiums may change to correspond with these changes.

Insuring Clause: We agree to provide the benefits set out in this policy for any insured loss. This agreement is subject to all of the provisions of the policy. A "loss" is an expense you incur for care or services this policy covers and that you receive after the Policy Date and while the policy is in force.

Notice to buyer: This policy may not cover all of your medical expenses.

MEDICARE SUPPLEMENT POLICY

ALPHABETICAL GUIDE TO YOUR POLICY

	Part
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Definitions	E
Exceptions	D
Extension Of Benefits	G
How To File A Claim	J
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Payment Of Claims	K
Renewal Agreement And Premium Change	B
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Schedule	Last Page
Suspension Of Premiums And Coverage	H
Termination	I

PART D EXCEPTIONS

We will NOT pay benefits for:

1. any expense incurred for outpatient prescription drugs, other than drugs covered by Medicare Parts A and B;
2. non-Medicare Eligible Expenses, including, but not limited to: routine exams, take-home drugs and eye refractions;
3. services for which you are not liable or for which no charge normally is made in the absence of insurance; and
4. loss that occurs while this policy is not in force.

Nonduplication: This policy will not duplicate any benefit paid by Medicare.

PART E DEFINITIONS

Benefit Period: The period of time defined by Medicare as a Benefit Period.

Calendar Year: Begins on January 1 and ends on December 31.

Hospice Care: A program of palliative care approved for payment by Medicare that provides for the physical, emotional and spiritual care needs of a terminally ill patient and his or her family.

Injury: Accidental bodily Injury that results in loss, independent of Sickness or other causes.

Medicaid: The “Health Insurance for the Aged Act,” Title XIX of the Social Security Amendments of 1965, as then constituted or later amended.

Medicare: The "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

Medicare Eligible Expenses: Expenses eligible for coverage by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

Physician: A licensed practitioner of the healing arts acting within the scope of his/her license.

Policy Date: The date on which this policy first became effective. That date is shown on the Schedule.

Policy Renewal Date: The month and day your policy’s premium is due. The frequency of the Policy Renewal Date can vary depending on the premium payment option you selected. This is shown on the Schedule.

Producer: A person required to be licensed under the laws of the state to sell, solicit or negotiate insurance.

Respite Care: Hospice Care services provided by the Hospice Care program to give temporary relief to a hospice patient's family or other caregivers.

Schedule: Is attached to and is a part of this policy.

Sickness: An illness or disease that you have or acquire.

We, Us or Our: Medico Insurance Company.

You or Your: The Insured named in the Schedule.

PART F BASIC BENEFITS

We will pay benefits for the following expenses you incur.

1. Medicare Part A Eligible Expenses for hospitalization to the extent not covered by Medicare from the 61st through 90th day in any Medicare Benefit Period.
2. Medicare Part A Eligible Expenses for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used.
3. Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable Prospective Payment System (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider must accept our payment as payment in full and may not bill you for any balance.
4. Under Medicare Parts A and B, the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells as defined under federal regulations) unless replaced in accordance with federal regulations.
5. The coinsurance amount, or in the case of hospital outpatient department services paid under a Prospective Payment System, the copayment amount, of Medicare Eligible Expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible. In all cases involving hospital outpatient department services paid under a Prospective Payment System, the issuer is required to pay the copayment amount established by the Center for Medicaid and Medicare Services (CMS), which will be either the amount established for the Ambulatory Payment Classification (APC) Group, or a provider-elected reduced copayment amount.
6. Hospice Care: Coverage of cost sharing for all Medicare Part A Eligible Expenses for Hospice Care and Respite Care.

PART G EXTENSION OF BENEFITS

Termination of coverage shall be without prejudice to a continuous loss which commenced while your policy was in force. Extension of benefits beyond the period this policy was in force is:

1. subject to your continuous total disability;
2. limited to those conditions which caused the continuous loss beginning while this policy was in force; and
3. limited to the duration benefits would have been paid had your policy continued in force or payment of the maximum benefits.

Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

PART H SUSPENSION OF PREMIUMS AND COVERAGE

The benefits and premiums of this policy will be suspended at your request for the period, not to exceed 24 months, in which you have applied for and are determined to be entitled to medical assistance under the Medicaid program. We must receive your written notice within 90 days after the date you become entitled to this assistance. Upon our receipt of timely notice, we will return that portion of the premium paid for the period of time you are eligible for Medicaid. Your refunded premium will be reduced by the amount of any claims paid for the period.

If you lose entitlement to this medical assistance after suspension occurs, your policy will be reinstituted automatically, effective as of the date the entitlement to medical assistance terminated. We must receive your written notice of the loss of the entitlement within 90 days after the date you lose the entitlement. Your notice and payment of the required premium will put the policy back in force.

The benefits and premiums of this policy will also be suspended at your request (for any period that may be provided by federal regulation) if you are entitled to benefits under Section 226(b) of the Social Security Act and are covered under a group health plan. We must receive your written notice within 90 days after the date you become covered under the group health plan. Upon our receipt of timely notice, we will return that portion of the premium paid for the period of time you are covered under the group health plan. Your refunded premium will be reduced by the amount of any claims paid for the period.

If you lose coverage under the group health plan after suspension occurs, your policy will be reinstituted automatically, effective as of the date the coverage ended. We must receive your written notice of the loss of coverage within 90 days after the coverage ends.

Reinstitution of your policy after either suspension will:

1. not provide an additional waiting period with regard to pre-existing conditions;
2. be substantially equivalent to what it was before the date of suspension; and
3. provide for a premium class that is as favorable to you as it would have been if the coverage had not been suspended.

PART I TERMINATION

Your policy will terminate on the earliest of:

1. the Policy Renewal Date following the date we receive your written or verbal request to cancel the policy, unless you request a later termination date (the grace period will not apply);
2. the Policy Renewal Date if sufficient premium has not been paid before the end of the grace period; or
3. the date of your death.

In the event of your death, we will promptly return the unearned portion of any premium paid beyond the date of death.

Termination of coverage will not affect any claim originating while your policy was in force.

PART J HOW TO FILE A CLAIM

Notice of Claim: You must give us written notice of a claim within 20 days after loss starts or as soon as reasonably possible. You may give the notice or you may have someone do it for you. The notice should give your name and policy number. Notice should be mailed to [our Home Office in Omaha, Nebraska], or to one of our Producers.

Electronic Claim Filing Process: Your health care providers will usually submit electronically to Medicare the billed charges for any medical and hospital expenses you incur. Medicare then processes benefits for expenses eligible under Part A and/or Part B of Medicare, and passes your claim electronically to us for consideration of benefits under your Medicare supplement policy. We will accept Medicare's electronic submission of your claim to us as your notice of claim. For consideration of expenses that are not submitted electronically to us, a paper copy of your Medicare Summary Notice or Medicare Benefit Notice can serve as your notice of claim. This Medicare statement shows your Medicare Eligible Expenses and the amount approved and paid by Medicare. You may submit a paper copy of your Medicare statement to us or your health care provider may submit it to us on your behalf. If your claim is submitted electronically the requirements for claim forms and proof of loss will be met.

Claim Forms: When we receive your notice of claim, we will send you forms for filing proof of loss. If these forms are not sent to you within 15 days, you will have met the proof of loss rule below if you give us a written statement within 90 days after the loss began.

Proof of Loss: You must give us written proof of your loss within 90 days or as soon as reasonably possible. Proof must be furnished within 15 months after loss began, except in the absence of legal capacity.

PART K PAYMENT OF CLAIMS

Time of Payment of Claims: All benefits will be paid immediately upon receipt of due written proof of loss.

Payment of Claims: Subject to your written direction in the application or otherwise, all or a portion of any benefits provided by this policy due to hospital, nursing, medical or surgical services may, at our option and unless you request otherwise in writing not later than the time of filing proof of such loss, be paid directly to the hospital or person rendering such services. It is not required that the services be rendered by a particular hospital or person.

Benefits unpaid at your death will be paid to your beneficiary or your estate. If any benefit is payable to your estate, to a minor or to any person not able to give a valid release, we may pay up to $1,000 ($5,000 in Nebraska) to any relative of yours by blood or connection by marriage, or any beneficiary that we find entitled to the payment. Any payment we make in good faith will fully discharge us to the extent of the payment.

PART L OTHER IMPORTANT PROVISIONS

Entire Contract; Changes: This policy, with any attachments (and the copy of your application), is the entire contract of insurance. No Producer may make contracts, determine insurability or change the application or policy in any way. Only an executive officer of ours can approve a change. That change must be shown in the policy.

Time Limit on Certain Defenses: After three years from the Policy Date, no misstatements, except fraudulent misstatements in the application for the policy, can be used to void the policy or to deny a claim for loss incurred or disability commencing after the expiration of such three-year period.

Pre-Existing Conditions: We will not reduce or deny a claim under this policy because a Sickness or Injury existed before the Policy Date.

Grace Period: Your premium must be paid on or before the date it is due or during the 31-day grace period that follows. Your policy stays in force during your grace period.

Reinstatement: Your policy will lapse if you do not pay your premium before the end of the grace period. If we later accept a premium and do not require an application for reinstatement, that payment will put this policy back in force. If we require an application for reinstatement and, as may be needed, issue a conditional receipt, this policy will be put back in force when we approve it. If we fail to notify you of disapproval within 45 days of the date of application (or the date of the conditional receipt, where that is required), your policy will be put back in force on that 45th day.

Your reinstated policy will cover only loss due to Injuries received or Sickness that begins after the date your policy was put back in force.

In all other respects, you and we will have the same rights under this policy that we had before it lapsed. The premium we accept to reinstate this policy may be used for a period for which premiums had not been paid, but it will not be used for any period more than 60 days before the reinstatement date.

Physical Examination: We, at our expense, can have you examined as often as reasonably needed while a claim is pending.

Legal Action: You cannot bring a legal action to recover under your policy for at least 60 days after you have given us written proof of loss. You cannot start such an action more than three years after the date written proof of loss is required.

Change of Beneficiary; Assignment: Only you have the right to change the beneficiary. This right is yours unless you make a beneficiary designation that may not be changed. Consent of the beneficiary is not required to make a change in this policy. Also, such consent is not required to surrender this policy or to assign the benefits.

Refund of Unearned Premium: In the event of your death, we will promptly return the unearned portion of any premium paid beyond the end of the policy month in which your death occurred.

Other Insurance with Us: You may have only one policy like this one with us at any one time. If you have more than one such policy, the one you, your beneficiary or your estate selects will remain in force. We will return all premiums paid for all other such policies.

Term of Coverage: Your coverage starts on the Policy Date at 12:01 a.m. standard time where you live. It ends at 12:01 a.m. on the same standard time on the first Policy Renewal Date. Each time you renew your policy, the new term begins when the old term ends.

Conformity With State Statutes: The provisions of the policy must conform with the laws of the state in which you reside on the Policy Date. If any do not, this clause amends them so that they do conform.

Our [President and Secretary] sign this policy in our behalf.

[ ]
[President]

[ ]
[Secretary]

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MEDICARE SUPPLEMENT INSURANCE POLICY
BENEFIT PLAN D

This policy is a legal contract between you and us. **READ YOUR POLICY CAREFULLY.** Also, read the copy of your application and the policy Schedule. If there is any error or omission, tell us. We will make any needed change.

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Premium Change: We may change the premium rates for this policy. The change may be due to a change in policy coverage or a new table of rates. We can change your premium only if we do the same to all policies of this form issued to persons of your class. “Class” means the factors of underwriting class and geographic area of your state of residence that determined your premium rate when coverage was issued. If we make a change, it will not be based on any physical impairment you might have or any claims you have incurred under this policy. If it is necessary to change the premium for your policy, we will notify you in advance of the change in premium.

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Automatic Change In Coverage: Policy benefits that are designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible, copayment, or coinsurance amounts. Premiums may change to correspond with these changes.

Insuring Clause: We agree to provide the benefits set out in this policy for any insured loss. This agreement is subject to all of the provisions of the policy. A "loss" is an expense you incur for care or services this policy covers and that you receive after the Policy Date and while the policy is in force.

Notice to buyer: This policy may not cover all of your medical expenses.

MEDICARE SUPPLEMENT POLICY

ALPHABETICAL GUIDE TO YOUR POLICY

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PART D EXCEPTIONS

We will NOT pay benefits for:

1. any expense incurred for outpatient prescription drugs, other than drugs covered by Medicare Parts A and B;
2. non-Medicare Eligible Expenses, including, but not limited to: routine exams, take-home drugs and eye refractions;
3. services for which you are not liable or for which no charge normally is made in the absence of insurance; and
4. loss that occurs while this policy is not in force.

Nonduplication: This policy will not duplicate any benefit paid by Medicare.

PART E DEFINITIONS

Benefit Period: The period of time defined by Medicare as a Benefit Period.

Calendar Year: Begins on January 1 and ends on December 31.

Hospice Care: A program of palliative care approved for payment by Medicare that provides for the physical, emotional and spiritual care needs of a terminally ill patient and his or her family.

Injury: Accidental bodily Injury that results in loss, independent of Sickness or other causes.

Medicaid: The “Health Insurance for the Aged Act,” Title XIX of the Social Security Amendments of 1965, as then constituted or later amended.

Medicare: The "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

Medicare Eligible Expenses: Expenses eligible for coverage by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

Physician: A licensed practitioner of the healing arts acting within the scope of his/her license.

Policy Date: The date on which this policy first became effective. That date is shown on the Schedule.

Policy Renewal Date: The month and day your policy’s premium is due. The frequency of the Policy Renewal Date can vary depending on the premium payment option you selected. This is shown on the Schedule.

Producer: A person required to be licensed under the laws of the state to sell, solicit or negotiate insurance.

Respite Care: Hospice Care services provided by the Hospice Care program to give temporary relief to a hospice patient’s family or other caregivers.

Schedule: Is attached to and is a part of this policy.

Sickness: An illness or disease that you have or acquire.

We, Us or Our: Medico Insurance Company.

You or Your: The Insured named in the Schedule.

PART F BASIC BENEFITS

We will pay benefits for the following expenses you incur.

1. Medicare Part A Eligible Expenses for hospitalization to the extent not covered by Medicare from the 61st through 90th day in any Medicare Benefit Period.
2. Medicare Part A Eligible Expenses for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used.
3. Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable Prospective Payment System (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider must accept our payment as payment in full and may not bill you for any balance.
4. Under Medicare Parts A and B, the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells as defined under federal regulations) unless replaced in accordance with federal regulations.
5. The coinsurance amount, or in the case of hospital outpatient department services paid under a Prospective Payment System, the copayment amount, of Medicare Eligible Expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible. In all cases involving hospital outpatient department services paid under a Prospective Payment System, the issuer is required to pay the copayment amount established by the Center for Medicaid and Medicare Services (CMS), which will be either the amount established for the Ambulatory Payment Classification (APC) Group, or a provider-elected reduced copayment amount.
6. Hospice Care: Coverage of cost sharing for all Medicare Part A Eligible Expenses for Hospice Care and Respite Care.

PART G ADDITIONAL BENEFITS

We will pay benefits for the following expenses you incur. If you are not enrolled in Part B of Medicare, the benefits that supplement Part B of Medicare will be paid as if you were enrolled and Medicare paid benefits.

1. **Medicare Part A Deductible.** The Medicare Part A inpatient hospital deductible amount per Benefit Period.

2. **Skilled Nursing Facility Care.** The actual billed charge, up to the coinsurance amount, from the 21st day through the 100th day in a Medicare Benefit Period for posthospital skilled nursing facility care eligible under Medicare Part A.

3. **Medically Necessary Emergency Care in a Foreign Country.** To the extent not covered by Medicare, 80% of the billed charges for Medicare Eligible Expenses for medically necessary emergency hospital, Physician and medical care received in a foreign country, subject to the following limitations:

   a. such care would have been covered by Medicare if provided in the United States;
   b. such care began during the first 60 consecutive days of each trip outside the United States;
   c. benefits are subject to a $250 Calendar Year deductible; and

d. benefits are subject to a lifetime maximum benefit of $50,000.

For this benefit, **Emergency Care** means care needed immediately because of an Injury or Sickness of sudden and unexpected onset.

PART H EXTENSION OF BENEFITS

Termination of coverage shall be without prejudice to a continuous loss which commenced while your policy was in force. Extension of benefits beyond the period this policy was in force is:

1. subject to your continuous total disability;
2. limited to those conditions which caused the continuous loss beginning while this policy was in force; and
3. limited to the duration benefits would have been paid had your policy continued in force or payment of the maximum benefits.

Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

PART I SUSPENSION OF PREMIUMS AND COVERAGE

The benefits and premiums of this policy will be suspended at your request for the period, not to exceed 24 months, in which you have applied for and are determined to be entitled to medical assistance under the Medicaid program. We must receive your written notice within 90 days after the date you become entitled to this assistance. Upon our receipt of timely notice, we will return that portion of the premium paid for the period of time you are eligible for Medicaid. Your refunded premium will be reduced by the amount of any claims paid for the period.

If you lose entitlement to this medical assistance after suspension occurs, your policy will be reinstituted automatically, effective as of the date the entitlement to medical assistance terminated. We must receive your written notice of the loss of the entitlement within 90 days after the date you lose the entitlement. Your notice and payment of the required premium will put the policy back in force.

The benefits and premiums of this policy will also be suspended at your request (for any period that may be provided by federal regulation) if you are entitled to benefits under Section 226(b) of the Social Security Act and are covered under a group health plan. We must receive your written notice within 90 days after the date you become covered under the group health plan. Upon our receipt of timely notice, we will return that portion of the premium paid for the period of time you are covered under the group health plan. Your refunded premium will be reduced by the amount of any claims paid for the period.

If you lose coverage under the group health plan after suspension occurs, your policy will be reinstituted automatically, effective as of the date the coverage ended. We must receive your written notice of the loss of coverage within 90 days after the coverage ends.

Reinstitution of your policy after either suspension will:

1. not provide an additional waiting period with regard to pre-existing conditions;
2. be substantially equivalent to what it was before the date of suspension; and
3. provide for a premium class that is as favorable to you as it would have been if the coverage had not been suspended.

PART J TERMINATION

Your policy will terminate on the earliest of:

1. the Policy Renewal Date following the date we receive your written or verbal request to cancel the policy, unless you request a later termination date (the grace period will not apply);

2. the Policy Renewal Date if sufficient premium has not been paid before the end of the grace period; or
3. the date of your death.

In the event of your death, we will promptly return the unearned portion of any premium paid beyond the date of death.

Termination of coverage will not affect any claim originating while your policy was in force.

PART K HOW TO FILE A CLAIM

Notice of Claim: You must give us written notice of a claim within 20 days after loss starts or as soon as reasonably possible. You may give the notice or you may have someone do it for you. The notice should give your name and policy number. Notice should be mailed to [our Home Office in Omaha, Nebraska], or to one of our Producers.

Electronic Claim Filing Process: Your health care providers will usually submit electronically to Medicare the billed charges for any medical and hospital expenses you incur. Medicare then processes benefits for expenses eligible under Part A and/or Part B of Medicare, and passes your claim electronically to us for consideration of benefits under your Medicare supplement policy. We will accept Medicare's electronic submission of your claim to us as your notice of claim. For consideration of expenses that are not submitted electronically to us, a paper copy of your Medicare Summary Notice or Medicare Benefit Notice can serve as your notice of claim. This Medicare statement shows your Medicare Eligible Expenses and the amount approved and paid by Medicare. You may submit a paper copy of your Medicare statement to us or your health care provider may submit it to us on your behalf. If your claim is submitted electronically the requirements for claim forms and proof of loss will be met.

Claim Forms: When we receive your notice of claim, we will send you forms for filing proof of loss. If these forms are not sent to you within 15 days, you will have met the proof of loss rule below if you give us a written statement within 90 days after the loss began.

Proof of Loss: You must give us written proof of your loss within 90 days or as soon as reasonably possible. Proof must be furnished within 15 months after loss began, except in the absence of legal capacity.

PART L PAYMENT OF CLAIMS

Time of Payment of Claims: All benefits will be paid immediately upon receipt of due written proof of loss.

Payment of Claims: Subject to your written direction in the application or otherwise, all or a portion of any benefits provided by this policy due to hospital, nursing, medical or surgical services may, at our option and unless you request otherwise in writing not later than the time of filing proof of such loss, be paid directly to the hospital or person rendering such services. It is not required that the services be rendered by a particular hospital or person.

Benefits unpaid at your death will be paid to your beneficiary or your estate. If any benefit is payable to your estate, to a minor or to any person not able to give a valid release, we may pay up to $1,000 ($5,000 in Nebraska) to any relative of yours by blood or connection by marriage, or any beneficiary that we find entitled to the payment. Any payment we make in good faith will fully discharge us to the extent of the payment.

PART M OTHER IMPORTANT PROVISIONS

Entire Contract; Changes: This policy, with any attachments (and the copy of your application), is the entire contract of insurance. No Producer may make contracts, determine insurability or change the application or policy in any way. Only an executive officer of ours can approve a change. That change must be shown in the policy.

Time Limit on Certain Defenses: After three years from the Policy Date, no misstatements, except fraudulent misstatements in the application for the policy, can be used to void the policy or to deny a claim for loss incurred or disability commencing after the expiration of such three-year period.

Pre-Existing Conditions: We will not reduce or deny a claim under this policy because a Sickness or Injury existed before the Policy Date.

Grace Period: Your premium must be paid on or before the date it is due or during the 31-day grace period that follows. Your policy stays in force during your grace period.

Reinstatement: Your policy will lapse if you do not pay your premium before the end of the grace period. If we later accept a premium and do not require an application for reinstatement, that payment will put this policy back in force. If we require an application for reinstatement and, as may be needed, issue a conditional receipt, this policy will be put back in force when we approve it. If we fail to notify you of disapproval within 45 days of the date of application (or the date of the conditional receipt, where that is required), your policy will be put back in force on that 45th day.

Your reinstated policy will cover only loss due to Injuries received or Sickness that begins after the date your policy was put back in force.

In all other respects, you and we will have the same rights under this policy that we had before it lapsed. The premium we accept to reinstate this policy may be used for a period for which premiums had not been paid, but it will not be used for any period more than 60 days before the reinstatement date.

Physical Examination: We, at our expense, can have you examined as often as reasonably needed while a claim is pending.

Legal Action: You cannot bring a legal action to recover under your policy for at least 60 days after you have given us written proof of loss. You cannot start such an action more than three years after the date written proof of loss is required.

Change of Beneficiary; Assignment: Only you have the right to change the beneficiary. This right is yours unless you make a beneficiary designation that may not be changed. Consent of the beneficiary is not required to make a change in this policy. Also, such consent is not required to surrender this policy or to assign the benefits.

Refund of Unearned Premium: In the event of your death, we will promptly return the unearned portion of any premium paid beyond the end of the policy month in which your death occurred.

Other Insurance with Us: You may have only one policy like this one with us at any one time. If you have more than one such policy, the one you, your beneficiary or your estate selects will remain in force. We will return all premiums paid for all other such policies.

Term of Coverage: Your coverage starts on the Policy Date at 12:01 a.m. standard time where you live. It ends at 12:01 a.m. on the same standard time on the first Policy Renewal Date. Each time you renew your policy, the new term begins when the old term ends.

Conformity With State Statutes: The provisions of the policy must conform with the laws of the state in which you reside on the Policy Date. If any do not, this clause amends them so that they do conform.

Our [President and Secretary] sign this policy in our behalf.

[ ] [President]

[ ] [Secretary]

MEDICO®
INSURANCE COMPANY

A STOCK INSURANCE COMPANY
[1515 South 75th Street • Omaha, Nebraska 68124 • 1-800-228-6080]

MEDICARE SUPPLEMENT INSURANCE POLICY
BENEFIT PLAN F

This policy is a legal contract between you and us. **READ YOUR POLICY CAREFULLY.** Also, read the copy of your application and the policy Schedule. If there is any error or omission, tell us. We will make any needed change.

The first premium you, the Insured, paid before the Policy Date (and the copy of your attached application), put this policy in force as of the Policy Date. That date is shown in the Schedule. The Schedule is attached and is a part of this policy.

PART A PLEASE READ — 30-DAY RIGHT TO RETURN

Please read your policy. If you are not satisfied, send it back to us, or to the Producer who sold it to you, within 30 days after you receive it. We will return your money. That will mean your policy was never in force. Any refund made pursuant to this section will be paid directly to you in a timely manner.

PART B GUARANTEED RENEWABLE SUBJECT TO OUR LIMITED RIGHT TO CHANGE PREMIUMS

We guarantee to renew your policy for life as long as the premium is paid within the allowable time. We cannot make a change in your policy without your consent. We do have the right to change your premium as stated below.

Premium Change: We may change the premium rates for this policy. The change may be due to a change in policy coverage or a new table of rates. We can change your premium only if we do the same to all policies of this form issued to persons of your class. “Class” means the factors of underwriting class and geographic area of your state of residence that determined your premium rate when coverage was issued. If we make a change, it will not be based on any physical impairment you might have or any claims you have incurred under this policy. If it is necessary to change the premium for your policy, we will notify you in advance of the change in premium.

PART C COVERAGE CHANGE

Automatic Change In Coverage: Policy benefits that are designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible, copayment, or coinsurance amounts. Premiums may change to correspond with these changes.

Insuring Clause: We agree to provide the benefits set out in this policy for any insured loss. This agreement is subject to all of the provisions of the policy. A "loss" is an expense you incur for care or services this policy covers and that you receive after the Policy Date and while the policy is in force.

Notice to buyer: This policy may not cover all of your medical expenses.

MEDICARE SUPPLEMENT POLICY

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PART D EXCEPTIONS

We will NOT pay benefits for:

1. any expense incurred for outpatient prescription drugs, other than drugs covered by Medicare Parts A and B;
2. non-Medicare Eligible Expenses, including, but not limited to: routine exams, take-home drugs and eye refractions;
3. services for which you are not liable or for which no charge normally is made in the absence of insurance; and
4. loss that occurs while this policy is not in force.

Nonduplication: This policy will not duplicate any benefit paid by Medicare.

PART E DEFINITIONS

Benefit Period: The period of time defined by Medicare as a Benefit Period.

Calendar Year: Begins on January 1 and ends on December 31.

Hospice Care: A program of palliative care approved for payment by Medicare that provides for the physical, emotional and spiritual care needs of a terminally ill patient and his or her family.

Injury: Accidental bodily Injury that results in loss, independent of Sickness or other causes.

Medicaid: The “Health Insurance for the Aged Act,” Title XIX of the Social Security Amendments of 1965, as then constituted or later amended.

Medicare: The "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

Medicare Eligible Expenses: Expenses eligible for coverage by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

Physician: A licensed practitioner of the healing arts acting within the scope of his/her license.

Policy Date: The date on which this policy first became effective. That date is shown on the Schedule.

Policy Renewal Date: The month and day your policy’s premium is due. The frequency of the Policy Renewal Date can vary depending on the premium payment option you selected. This is shown on the Schedule.

Producer: A person required to be licensed under the laws of the state to sell, solicit or negotiate insurance.

Respite Care: Hospice Care services provided by the Hospice Care program to give temporary relief to a hospice patient's family or other caregivers.

Schedule: Is attached to and is a part of this policy.

Sickness: An illness or disease that you have or acquire.

We, Us or Our: Medico Insurance Company.

You or Your: The Insured named in the Schedule.

PART F BASIC BENEFITS

We will pay benefits for the following expenses you incur.

1. Medicare Part A Eligible Expenses for hospitalization to the extent not covered by Medicare from the 61st through 90th day in any Medicare Benefit Period.
2. Medicare Part A Eligible Expenses for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used.
3. Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable Prospective Payment System (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider must accept our payment as payment in full and may not bill you for any balance.
4. Under Medicare Parts A and B, the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells as defined under federal regulations) unless replaced in accordance with federal regulations.
5. The coinsurance amount, or in the case of hospital outpatient department services paid under a Prospective Payment System, the copayment amount, of Medicare Eligible Expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible. In all cases involving hospital outpatient department services paid under a Prospective Payment System, the issuer is required to pay the copayment amount established by the Center for Medicaid and Medicare Services (CMS), which will be either the amount established for the Ambulatory Payment Classification (APC) Group, or a provider-elected reduced copayment amount.
6. Hospice Care: Coverage of cost sharing for all Medicare Part A Eligible Expenses for Hospice Care and Respite Care.

PART G ADDITIONAL BENEFITS

We will pay benefits for the following expenses you incur. If you are not enrolled in Part B of Medicare, the benefits that supplement Part B of Medicare will be paid as if you were enrolled and Medicare paid benefits.

1. **Medicare Part A Deductible.** The Medicare Part A inpatient hospital deductible amount per Benefit Period.

2. **Skilled Nursing Facility Care.** The actual billed charge, up to the coinsurance amount, from the 21st day through the 100th day in a Medicare Benefit Period for posthospital skilled nursing facility care eligible under Medicare Part A.

3. **Medicare Part B Deductible.** The Medicare Part B deductible amount per Calendar Year, regardless of hospital confinement.

4. **Medicare Part B Excess Charges.** 100% of the Medicare Part B excess charges. This is the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

5. **Medically Necessary Emergency Care in a Foreign Country.** To the extent not covered by Medicare, 80% of the billed charges for Medicare Eligible Expenses for medically necessary emergency hospital, Physician and medical care received in a foreign country, subject to the following limitations:

   a. such care would have been covered by Medicare if provided in the United States;
   b. such care began during the first 60 consecutive days of each trip outside the United States;
   c. benefits are subject to a $250 Calendar Year deductible; and
   d. benefits are subject to a lifetime maximum benefit of $50,000.

   For this benefit, **Emergency Care** means care needed immediately because of an Injury or Sickness of sudden and unexpected onset.

PART H EXTENSION OF BENEFITS

Termination of coverage shall be without prejudice to a continuous loss which commenced while your policy was in force. Extension of benefits beyond the period this policy was in force is:

1. subject to your continuous total disability;
2. limited to those conditions which caused the continuous loss beginning while this policy was in force; and
3. limited to the duration benefits would have been paid had your policy continued in force or payment of the maximum benefits.

Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

PART I SUSPENSION OF PREMIUMS AND COVERAGE

The benefits and premiums of this policy will be suspended at your request for the period, not to exceed 24 months, in which you have applied for and are determined to be entitled to medical assistance under the Medicaid program. We must receive your written notice within 90 days after the date you become entitled to this assistance. Upon our receipt of timely notice, we will return that portion of the premium paid for the period of time you are eligible for Medicaid. Your refunded premium will be reduced by the amount of any claims paid for the period.

If you lose entitlement to this medical assistance after suspension occurs, your policy will be reinstituted automatically, effective as of the date the entitlement to medical assistance terminated. We must receive your written notice of the loss of the entitlement within 90 days after the date you lose the entitlement. Your notice and payment of the required premium will put the policy back in force.

The benefits and premiums of this policy will also be suspended at your request (for any period that may be provided by federal regulation) if you are entitled to benefits under Section 226(b) of the Social Security Act and are covered under a group health plan. We must receive your written notice within 90 days after the date you become covered under the group health plan. Upon our receipt of timely notice, we will return that portion of the premium paid for the period of time you are covered under the group health plan. Your refunded premium will be reduced by the amount of any claims paid for the period.

If you lose coverage under the group health plan after suspension occurs, your policy will be reinstituted automatically, effective as of the date the coverage ended. We must receive your written notice of the loss of coverage within 90 days after the coverage ends.

Reinstitution of your policy after either suspension will:

1. not provide an additional waiting period with regard to pre-existing conditions;
2. be substantially equivalent to what it was before the date of suspension; and
3. provide for a premium class that is as favorable to you as it would have been if the coverage had not been suspended.

PART J TERMINATION

Your policy will terminate on the earliest of:

1. the Policy Renewal Date following the date we receive your written or verbal request to cancel the policy, unless you request a later termination date (the grace period will not apply);
2. the Policy Renewal Date if sufficient premium has not been paid before the end of the grace period; or
3. the date of your death.

In the event of your death, we will promptly return the unearned portion of any premium paid beyond the date of death.

Termination of coverage will not affect any claim originating while your policy was in force.

PART K HOW TO FILE A CLAIM

Notice of Claim: You must give us written notice of a claim within 20 days after loss starts or as soon as reasonably possible. You may give the notice or you may have someone do it for you. The notice should give your name and policy number. Notice should be mailed to [our Home Office in Omaha, Nebraska], or to one of our Producers.

Electronic Claim Filing Process: Your health care providers will usually submit electronically to Medicare the billed charges for any medical and hospital expenses you incur. Medicare then processes benefits for expenses eligible under Part A and/or Part B of Medicare, and passes your claim electronically to us for consideration of benefits under your Medicare supplement policy. We will accept Medicare's electronic submission of your claim to us as your notice of claim. For consideration of expenses that are not submitted electronically to us, a paper copy of your Medicare Summary Notice or Medicare Benefit Notice can serve as your notice of claim. This Medicare statement shows your Medicare Eligible Expenses and the amount approved and paid by Medicare. You may submit a paper copy of your Medicare statement to us or your health care provider may submit it to us on your behalf. If your claim is submitted electronically the requirements for claim forms and proof of loss will be met.

Claim Forms: When we receive your notice of claim, we will send you forms for filing proof of loss. If these forms are not sent to you within 15 days, you will have met the proof of loss rule below if you give us a written statement within 90 days after the loss began.

Proof of Loss: You must give us written proof of your loss within 90 days or as soon as reasonably possible. Proof must be furnished within 15 months after loss began, except in the absence of legal capacity.

PART L PAYMENT OF CLAIMS

Time of Payment of Claims: All benefits will be paid immediately upon receipt of due written proof of loss.

Payment of Claims: Subject to your written direction in the application or otherwise, all or a portion of any benefits provided by this policy due to hospital, nursing, medical or surgical services may, at our option and unless you request otherwise in writing not later than the time of filing proof of such loss, be paid directly to the hospital or person rendering such services. It is not required that the services be rendered by a particular hospital or person.

Benefits unpaid at your death will be paid to your beneficiary or your estate. If any benefit is payable to your estate, to a minor or to any person not able to give a valid release, we may pay up to $1,000 ($5,000 in Nebraska) to any relative of yours by blood or connection by marriage, or any beneficiary that we find entitled to the payment. Any payment we make in good faith will fully discharge us to the extent of the payment.

PART M OTHER IMPORTANT PROVISIONS

Entire Contract; Changes: This policy, with any attachments (and the copy of your application), is the entire contract of insurance. No Producer may make contracts, determine insurability or change the application or policy in any way. Only an executive officer of ours can approve a change. That change must be shown in the policy.

Time Limit on Certain Defenses: After three years from the Policy Date, no misstatements, except fraudulent misstatements in the application for the policy, can be used to void the policy or to deny a claim for loss incurred or disability commencing after the expiration of such three-year period.

Pre-Existing Conditions: We will not reduce or deny a claim under this policy because a Sickness or Injury existed before the Policy Date.

Grace Period: Your premium must be paid on or before the date it is due or during the 31-day grace period that follows. Your policy stays in force during your grace period.

Reinstatement: Your policy will lapse if you do not pay your premium before the end of the grace period. If we later accept a premium and do not require an application for reinstatement, that payment will put this policy back in force. If we require an application for reinstatement and, as may be needed, issue a conditional receipt, this policy will be put back in force when we approve it. If we fail to notify you of disapproval within 45 days of the date of application (or the date of the conditional receipt, where that is required), your policy will be put back in force on that 45th day.

Your reinstated policy will cover only loss due to Injuries received or Sickness that begins after the date your policy was put back in force.

In all other respects, you and we will have the same rights under this policy that we had before it lapsed. The premium we accept to reinstate this policy may be used for a period for which premiums had not been paid, but it will not be used for any period more than 60 days before the reinstatement date.

Physical Examination: We, at our expense, can have you examined as often as reasonably needed while a claim is pending.

Legal Action: You cannot bring a legal action to recover under your policy for at least 60 days after you have given us written proof of loss. You cannot start such an action more than three years after the date written proof of loss is required.

Change of Beneficiary; Assignment: Only you have the right to change the beneficiary. This right is yours unless you make a beneficiary designation that may not be changed. Consent of the beneficiary is not required to make a change in this policy. Also, such consent is not required to surrender this policy or to assign the benefits.

Refund of Unearned Premium: In the event of your death, we will promptly return the unearned portion of any premium paid beyond the end of the policy month in which your death occurred.

Other Insurance with Us: You may have only one policy like this one with us at any one time. If you have more than one such policy, the one you, your beneficiary or your estate selects will remain in force. We will return all premiums paid for all other such policies.

Term of Coverage: Your coverage starts on the Policy Date at 12:01 a.m. standard time where you live. It ends at 12:01 a.m. on the same standard time on the first Policy Renewal Date. Each time you renew your policy, the new term begins when the old term ends.

Conformity With State Statutes: The provisions of the policy must conform with the laws of the state in which you reside on the Policy Date. If any do not, this clause amends them so that they do conform.

Our [President and Secretary] sign this policy in our behalf.

[ ]
[President]

[ ]
[Secretary]

[Corporate Office – Omaha, NE]
[Administrative Services – PO Box 10386]
[Des Moines, IA 50306]
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NOTICE ON CHANGES IN MEDICARE AND YOUR MEDICARE SUPPLEMENT INSURANCE

The following outline briefly describes the modifications in Medicare and in your Medicare supplement coverage. Please read carefully!

Services	**Medicare Benefits - Effective [2012] Medicare will pay**	**Your Medicare Supplement Coverage - Effective [2012] MSA20A will pay**
MEDICARE PART A SERVICES AND SUPPLIES		
Inpatient Hospital Benefits		
First 60 Days	All but $[1,156]	$[0]
61st to 90th Day	All but $[289] a day	$[289] a day
91st to 150th Day	All but $[578] a day	$[578] a day
151st Day for an Additional 365 Days	$[0]	100% of Medicare eligible expenses
Skilled Nursing Facility Care (if Medicare-Approved)		
First 20 Days	All approved amounts	$[0]
21st to 100th Day	All but $[144.50] a day	$[0]
After 100 Days	$[0]	$[0]
Hospice Care (must meet Medicare's certification requirements)	All but very limited copayment & coinsurance for outpatient drugs & inpatient respite care	Medicare copayment and coinsurance
MEDICARE PART B SERVICES AND SUPPLIES		
Medical Expenses		
*First $[140] of Medicare-Approved Amounts	$[0]	$[0]
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%
Blood		
First 3 Pints	$[0]	All costs
*Next $[140] of Medicare-Approved Amounts	$[0]	$[0]
Remainder of Medicare-Approved Amounts	80%	20%

(over)

MEDICARE PARTS A AND B SERVICES AND SUPPLIES		
Home Health Care (if Medicare-Approved –		
Medically necessary skilled care services and medical supplies	100%	$[0]
Durable Medical Equipment:		
*First $[140] of Medicare-Approved Amounts	$[0]	$[0]
Remainder of Medicare-Approved Amounts	80%	20%

* This is the Part B deductible, and only needs to be met once per calendar year.

If it is necessary to change the premium for your policy, we will notify you in advance of the change in premium.

THIS CHART SUMMARIZING THE CHANGES IN YOUR MEDICARE BENEFITS AND IN YOUR MEDICARE SUPPLEMENT PROVIDED BY MEDICO® INSURANCE COMPANY ONLY BRIEFLY DESCRIBES SUCH BENEFITS. FOR INFORMATION ON YOUR MEDICARE BENEFITS CONTACT YOUR SOCIAL SECURITY OFFICE OR THE CENTERS FOR MEDICARE & MEDICAID SERVICES. FOR INFORMATION ON YOUR MEDICARE SUPPLEMENT POLICY CONTACT MEDICO INSURANCE COMPANY AT [1515 SOUTH 75TH STREET, OMAHA, NE 68124], OR CONTACT THE PRODUCER WHO SOLD YOU THE POLICY.

[Corporate Office – Omaha, NE]
[Administrative Services – PO Box 10386]
[Des Moines, IA 50306]
[www.gomedico.com]
[Toll-Free 1-800-228-6080]

NOTICE ON CHANGES IN MEDICARE AND YOUR MEDICARE SUPPLEMENT INSURANCE

The following outline briefly describes the modifications in Medicare and in your Medicare supplement coverage. Please read carefully!

Services	**Medicare Benefits - Effective [2012] Medicare will pay**	**Your Medicare Supplement Coverage - Effective [2012] MSA20D will pay**
MEDICARE PART A SERVICES AND SUPPLIES		
Inpatient Hospital Benefits		
First 60 Days	All but $[1,156]	$[1,156]
61st to 90th Day	All but $[289] a day	$[289] a day
91st to 150th Day	All but $[578] a day	$[578] a day
151st Day for an Additional 365 Days	$[0]	100% of Medicare eligible expenses
Skilled Nursing Facility Care (if Medicare-Approved)		
First 20 Days	All approved amounts	$[0]
21st to 100th Day	All but $[144.50] a day	Up to $[144.50] a day
After 100 Days	$[0]	$[0]
Hospice Care (must meet Medicare's certification requirements)	All but very limited copayment & coinsurance for outpatient drugs & inpatient respite care	Medicare copayment and coinsurance
MEDICARE PART B SERVICES AND SUPPLIES		
Medical Expenses		
*First $[140] of Medicare-Approved Amounts	$[0]	$[0]
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%
Blood		
First 3 Pints	$[0]	All costs
*Next $[140] of Medicare-Approved Amounts	$[0]	$[0]
Remainder of Medicare-Approved Amounts	80%	20%

(over)

MEDICARE PARTS A AND B SERVICES AND SUPPLIES		
Home Health Care (if Medicare-Approved) –		
Medically necessary skilled care services and medical supplies	100%	$[0]
Durable Medical Equipment:		
*First $[140] of Medicare-Approved Amounts	$[0]	$[0]
Remainder of Medicare-Approved Amounts	80%	20%

* This is the Part B deductible, and only needs to be met once per calendar year.

If it is necessary to change the premium for your policy, we will notify you in advance of the change in premium.

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[Administrative Services – PO Box 10386]
[Des Moines, IA 50306]
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[Toll-Free 1-800-228-6080]

NOTICE ON CHANGES IN MEDICARE AND YOUR MEDICARE SUPPLEMENT INSURANCE

The following outline briefly describes the modifications in Medicare and in your Medicare supplement coverage. Please read carefully!

Services	**Medicare Benefits - Effective [2012] Medicare will pay**	**Your Medicare Supplement Coverage - Effective [2012] MSA20F will pay**
MEDICARE PART A SERVICES AND SUPPLIES		
Inpatient Hospital Benefits		
First 60 Days	All but $[1,156]	$[1,156]
61st to 90th Day	All but $[289] a day	$[289] a day
91st to 150th Day	All but $[578] a day	$[578] a day
151st Day for an Additional 365 Days	$[0]	100% of Medicare eligible expenses
Skilled Nursing Facility Care (if Medicare-Approved)		
First 20 Days	All approved amounts	$[0]
21st to 100th Day	All but $[144.50] a day	Up to $[144.50] a day
After 100 Days	$[0]	$[0]
Hospice Care (must meet Medicare's certification requirements)	All but very limited copayment & coinsurance for outpatient drugs & inpatient respite care	Medicare copayment and coinsurance
MEDICARE PART B SERVICES AND SUPPLIES		
Medical Expenses		
*First $[140] of Medicare-Approved Amounts	$[0]	$[140]
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%
Part B Excess Charges (Above Medicare-Approved Amounts)	$[0]	100%
Blood		
First 3 Pints	$[0]	All costs
*Next $[140] of Medicare-Approved Amounts	$[0]	$[140]
Remainder of Medicare-Approved Amounts	80%	20%

(over)

MEDICARE PARTS A AND B SERVICES AND SUPPLIES		
Home Health Care (if Medicare-Approved) –		
Medically necessary skilled care services and medical supplies	100%	$[0]
Durable Medical Equipment:		
*First $[140] of Medicare-Approved Amounts	$[0]	$[140]
Remainder of Medicare-Approved Amounts	80%	20%

* This is the Part B deductible, and only needs to be met once per calendar year.

If it is necessary to change the premium for your policy, we will notify you in advance of the change in premium.

THIS CHART SUMMARIZING THE CHANGES IN YOUR MEDICARE BENEFITS AND IN YOUR MEDICARE SUPPLEMENT PROVIDED BY MEDICO® INSURANCE COMPANY ONLY BRIEFLY DESCRIBES SUCH BENEFITS. FOR INFORMATION ON YOUR MEDICARE BENEFITS CONTACT YOUR SOCIAL SECURITY OFFICE OR THE CENTERS FOR MEDICARE & MEDICAID SERVICES. FOR INFORMATION ON YOUR MEDICARE SUPPLEMENT POLICY CONTACT MEDICO INSURANCE COMPANY AT [1515 SOUTH 75TH STREET, OMAHA, NE 68124], OR CONTACT THE PRODUCER WHO SOLD YOU THE POLICY.

MEDICO®
INSURANCE COMPANY

[1515 South 75th Street]
[Omaha, Nebraska 68124]

[www.gomedico.com]
[Toll-Free 1-800-228-6080]

NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE OR MEDICARE ADVANTAGE

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

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

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

STATEMENT TO APPLICANT BY ISSUER OR PRODUCER:

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

☐ Additional benefits.

☐ No change in benefits, but lower premiums.

☐ Fewer benefits and lower premiums.

☐ My plan has outpatient prescription drug coverage and I am enrolling in Part D.

☐ Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment below.

☐ 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

[Medico Insurance Company]
[Corporate office – Omaha, NE]
[Administrative Services – PO Box 10386]
[Des Moines, IA 50306]

S C H E D U L E

POLICY NO. - [0000000] POLICY TYPE – A20[A]

INSURED - [JOHN E. DOE]
[1234 ANY STREET]
[ANYTOWN, USA 00000]

------ POLICY PREMIUMS ------
[MODE ……..$ [XXX.XX]

POLICY DATE ..... [07/01/10]
FIRST RENEWAL DATE ..... [07/01/11]
TOTAL FIRST PREMIUM ..... $ [XXXX.XX]
AGE AT ISSUE ..... [65]

[Medico Insurance Company]
[Corporate Office – Omaha, NE]
[Administrative Services – PO Box 10386]
[Des Moines, IA 50306]

S C H E D U L E

POLICY NO. - [0000000] POLICY TYPE – A20[D]

INSURED - [JOHN E. DOE]
[1234 ANY STREET]
[ANYTOWN, USA 00000]

------ POLICY PREMIUMS ------
[MODE ……..$ [XXX.XX]

POLICY DATE ..... [07/01/10]
FIRST RENEWAL DATE ..... [07/01/11]
TOTAL FIRST PREMIUM ..... $ [XXXX.XX]
AGE AT ISSUE ..... [65]

[Medico Insurance Company]
[Corporate Office – Omaha, NE]
[Administrative Services – PO Box 10386]
[Des Moines, IA 50306]

S C H E D U L E

POLICY NO. - [0000000] POLICY TYPE – A20[F]

INSURED - [JOHN E. DOE]
[1234 ANY STREET]
[ANYTOWN, USA 00000]

------ POLICY PREMIUMS ------
[MODE ……..$ [XXX.XX]

POLICY DATE ..... [07/01/10]
FIRST RENEWAL DATE ..... [07/01/11]
TOTAL FIRST PREMIUM ..... $ [XXXX.XX]
AGE AT ISSUE ..... [65]

MEDICO® INSURANCE COMPANY

[Corporate Office – Omaha, NE]

[Administrative Services – PO Box 10386
[Des Moines, IA 50306]

POLICY NUMBER – XXXXXXX

[TOLL-FREE CLIENT SERVICES]

If you have any questions about your policy, you can call this Company's [Toll-Free Client Services] Line at [1-800-228-6080] between [7:30 A.M. and 4:45 P.M., Monday through Thursday; and 7:30 A.M. and 11:30 A.M. on Friday, Central Time].

If you prefer to write to us, please direct your letter to the [Client Services Department], using the Company's name and address shown above.

Questions can also be directed to your producer. (Producer: Attach your business card below.)

In addition, you may submit written inquiries to:

Arkansas Insurance Department
Consumer Services Division
1200 West Third Street
Little Rock, Arkansas 72201-1904

You may also call:

Arkansas Insurance Department
Consumer Services Division at
(800) 852-5494 or (501) 371-2640

MEDICO®
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A STOCK INSURANCE COMPANY
[Corporate Office – Omaha, Nebraska]
[Administrative Services – P.O. Box 10386, Des Moines, Iowa 50306-0386]
[1-800-228-6080]

MEDICARE SUPPLEMENT INSURANCE POLICY
BENEFIT PLAN G

This policy is a legal contract between you and us. **READ YOUR POLICY CAREFULLY.** Also, read the copy of your application and the policy Schedule. If there is any error or omission, tell us. We will make any needed change.

The first premium you, the Insured, paid before the Policy Date (and the copy of your attached application), put this policy in force as of the Policy Date. That date is shown in the Schedule. The Schedule is attached and is a part of this policy.

PART A PLEASE READ — 30-DAY RIGHT TO RETURN

Please read your policy. If you are not satisfied, send it back to us, or to the Producer who sold it to you, within 30 days after you receive it. We will return your money. That will mean your policy was never in force. Any refund made pursuant to this section will be paid directly to you in a timely manner.

PART B GUARANTEED RENEWABLE SUBJECT TO OUR LIMITED RIGHT TO CHANGE PREMIUMS

We guarantee to renew your policy for life as long as the premium is paid within the allowable time. We cannot make a change in your policy without your consent. We do have the right to change your premium as stated below.

Premium Change: We may change the premium rates for this policy. The change may be due to a change in policy coverage or a new table of rates. We can change your premium only if we do the same to all policies of this form issued to persons of your class. “Class” means the factors of underwriting class and geographic area of your state of residence that determined your premium rate when coverage was issued. If we make a change, it will not be based on any physical impairment you might have or any claims you have incurred under this policy. If it is necessary to change the premium for your policy, we will notify you in advance of the change in premium.

PART C COVERAGE CHANGE

Automatic Change In Coverage: Policy benefits that are designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible, copayment, or coinsurance amounts. Premiums may change to correspond with these changes.

Insuring Clause: We agree to provide the benefits set out in this policy for any insured loss. This agreement is subject to all of the provisions of the policy. A "loss" is an expense you incur for care or services this policy covers and that you receive after the Policy Date and while the policy is in force.

Notice to buyer: This policy may not cover all of your medical expenses.

MEDICARE SUPPLEMENT POLICY

ALPHABETICAL GUIDE TO YOUR POLICY

	Part
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Exceptions	D
Extension Of Benefits	H
How To File A Claim	K
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Payment Of Claims	L
Renewal Agreement And Premium Change	B
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Schedule	Last Page
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Termination	J

PART D EXCEPTIONS

We will NOT pay benefits for:

1. any expense incurred for outpatient prescription drugs, other than drugs covered by Medicare Parts A and B;
2. non-Medicare Eligible Expenses, including, but not limited to: routine exams, take-home drugs and eye refractions;
3. services for which you are not liable or for which no charge normally is made in the absence of insurance; and
4. loss that occurs while this policy is not in force.

Nonduplication: This policy will not duplicate any benefit paid by Medicare.

PART E DEFINITIONS

Benefit Period: The period of time defined by Medicare as a Benefit Period.

Calendar Year: Begins on January 1 and ends on December 31.

Hospice Care: A program of palliative care approved for payment by Medicare that provides for the physical, emotional and spiritual care needs of a terminally ill patient and his or her family.

Injury: Accidental bodily Injury that results in loss, independent of Sickness or other causes.

Medicaid: The “Health Insurance for the Aged Act,” Title XIX of the Social Security Amendments of 1965, as then constituted or later amended.

Medicare: The "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

Medicare Eligible Expenses: Expenses eligible for coverage by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

Physician: A licensed practitioner of the healing arts acting within the scope of his/her license.

Policy Date: The date on which this policy first became effective. That date is shown on the Schedule.

Policy Renewal Date: The month and day your policy’s premium is due. The frequency of the Policy Renewal Date can vary depending on the premium payment option you selected. This is shown on the Schedule.

Producer: A person required to be licensed under the laws of the state to sell, solicit or negotiate insurance.

Respite Care: Hospice Care services provided by the Hospice Care program to give temporary relief to a hospice patient’s family or other caregivers.

Schedule: Is attached to and is a part of this policy.

Sickness: An illness or disease that you have or acquire.

We, Us or Our: Medico Insurance Company.

You or Your: The Insured named in the Schedule.

PART F BASIC BENEFITS

We will pay benefits for the following expenses you incur.

1. Medicare Part A Eligible Expenses for hospitalization to the extent not covered by Medicare from the 61st through 90th day in any Medicare Benefit Period.
2. Medicare Part A Eligible Expenses for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used.
3. Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable Prospective Payment System (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider must accept our payment as payment in full and may not bill you for any balance.
4. Under Medicare Parts A and B, the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells as defined under federal regulations) unless replaced in accordance with federal regulations.
5. The coinsurance amount, or in the case of hospital outpatient department services paid under a Prospective Payment System, the copayment amount, of Medicare Eligible Expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible. In all cases involving hospital outpatient department services paid under a Prospective Payment System, the issuer is required to pay the copayment amount established by the Center for Medicaid and Medicare Services (CMS), which will be either the amount established for the Ambulatory Payment Classification (APC) Group, or a provider-elected reduced copayment amount.
6. Hospice Care: The coverage of cost sharing for all Medicare Part A Eligible Expenses for Hospice Care and Respite Care.

PART G ADDITIONAL BENEFITS

We will pay benefits for the following expenses you incur.

1. **Medicare Part A Deductible.** The Medicare Part A inpatient hospital deductible amount per Benefit Period.

2. **Skilled Nursing Facility Care.** The actual billed charge, up to the coinsurance amount, from the 21st day through the 100th day in a Medicare Benefit Period for posthospital skilled nursing facility care eligible under Medicare Part A.

3. **Medicare Part B Excess Charges.** 100% of the Medicare Part B excess charges. This is the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

4. **Medically Necessary Emergency Care in a Foreign Country.** To the extent not covered by Medicare, 80% of the billed charges for Medicare Eligible Expenses for medically necessary emergency hospital, Physician and medical care received in a foreign country, subject to the following limitations:

   a. such care would have been covered by Medicare if provided in the United States;
   b. such care began during the first 60 consecutive days of each trip outside the United States;
   c. benefits are subject to a $250 Calendar Year deductible; and
   d. benefits are subject to a lifetime maximum benefit of $50,000.

   For this benefit, **Emergency Care** means care needed immediately because of an Injury or Sickness of sudden and unexpected onset.

PART H EXTENSION OF BENEFITS

Termination of coverage shall be without prejudice to a continuous loss which commenced while your policy was in force. Extension of benefits beyond the period this policy was in force is:

1. subject to your continuous total disability;
2. limited to those conditions which caused the continuous loss beginning while this policy was in force; and
3. limited to the duration benefits would have been paid had your policy continued in force or payment of the maximum benefits.

Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

PART I SUSPENSION OF PREMIUMS AND COVERAGE

The benefits and premiums of this policy will be suspended at your request for the period, not to exceed 24 months, in which you have applied for and are determined to be entitled to medical assistance under the Medicaid program. We must receive your written notice within 90 days after the date you become entitled to this assistance. Upon our receipt of timely notice, we will return that portion of the premium paid for the period of time you are eligible for Medicaid. Your refunded premium will be reduced by the amount of any claims paid for the period.

If you lose entitlement to this medical assistance after suspension occurs, your policy will be reinstituted automatically, effective as of the date the entitlement to medical assistance terminated. We must receive your written notice of the loss of the entitlement within 90 days after the date you lose the entitlement. Your notice and payment of the required premium will put the policy back in force.

The benefits and premiums of this policy will also be suspended at your request (for any period that may be provided by federal regulation) if you are entitled to benefits under Section 226(b) of the Social Security Act and are covered under a group health plan. We must receive your written notice within 90 days after the date you become covered under the group plan. Upon our receipt of timely notice, we will return that portion of the premium paid for the period of time you are covered under the group health plan. Your refunded premium will be reduced by the amount of any claims paid for the period.

If you lose coverage under the group health plan after suspension occurs, your policy will be reinstituted automatically, effective as of the date the coverage ended. We must receive your written notice of the loss of coverage within 90 days after the coverage ends.

Reinstitution of your policy after either suspension will:

1. not provide an additional waiting period with regard to pre-existing conditions;
2. be substantially equivalent to what it was before the date of suspension; and
3. provide for a premium class that is as favorable to you as it would have been if the coverage had not been suspended.

PART J TERMINATION

Your policy will terminate on the earliest of:

1. the Policy Renewal Date following the date we receive your written or verbal request to cancel the policy, unless you request a later termination date (the grace period will not apply);
2. the Policy Renewal Date if sufficient premium has not been paid before the end of the grace period; or
3. the date of your death.

In the event of your death, we will promptly return the unearned portion of any premium paid beyond the date of death.

Termination of coverage will not affect any claim originating while your policy was in force.

PART K HOW TO FILE A CLAIM

Notice of Claim: You must give us written notice of a claim within 20 days after loss starts or as soon as reasonably possible. You may give the notice or you may have someone do it for you. The notice should give your name and policy number. Notice should be mailed to [PO Box 10386, Des Moines, IA 50306], or to one of our Producers.

Electronic Claim Filing Process: Your health care providers will usually submit electronically to Medicare the billed charges for any medical and hospital expenses you incur. Medicare then processes benefits for expenses eligible under Part A and/or Part B of Medicare, and passes your claim electronically to us for consideration of benefits under your Medicare supplement policy. We will accept Medicare's electronic submission of your claim to us as your notice of claim. For consideration of expenses that are not submitted electronically to us, a paper copy of your Medicare Summary Notice or Medicare Benefit Notice can serve as your notice of claim. This Medicare statement shows your Medicare Eligible Expenses and the amount approved and paid by Medicare. You may submit a paper copy of your Medicare statement to us or your health care provider may submit it to us on your behalf. If your claim is submitted electronically the requirements for claim forms and proof of loss will be met.

Claim Forms: When we receive your notice of claim, we will send you forms for filing proof of loss. If these forms are not sent to you within 15 days, you will have met the proof of loss rule below if you give us a written statement within 90 days after the loss began.

Proof of Loss: You must give us written proof of your loss within 90 days or as soon as reasonably possible. Proof must be furnished within 15 months after loss began, except in the absence of legal capacity.

PART L PAYMENT OF CLAIMS

Time of Payment of Claims: All benefits will be paid immediately upon receipt of due written proof of loss.

Payment of Claims: Subject to your written direction in the application or otherwise, all or a portion of any benefits provided by this policy due to hospital, nursing, medical or surgical services may, at our option and unless you request otherwise in writing not later than the time of filing proof of such loss, be paid directly to the hospital or person rendering such services. It is not required that the services be rendered by a particular hospital or person.

Benefits unpaid at your death will be paid to your beneficiary or your estate. If any benefit is payable to your estate, to a minor or to any person not able to give a valid release, we may pay up to $1,000 ($5,000 in Nebraska) to any relative of yours by blood or connection by marriage, or any beneficiary that we find entitled to the payment. Any payment we make in good faith will fully discharge us to the extent of the payment.

PART M OTHER IMPORTANT PROVISIONS

Entire Contract; Changes: This policy, with any attachments (and the copy of your application), is the entire contract of insurance. No Producer may make contracts, determine insurability or change the application or policy in any way. Only an executive officer of ours can approve a change. That change must be shown in the policy.

Time Limit on Certain Defenses: After three years from the Policy Date, no misstatements, except fraudulent misstatements in the application for the policy, can be used to void the policy or to deny a claim for loss incurred or disability commencing after the expiration of such three-year period.

Pre-Existing Conditions: We will not reduce or deny a claim under this policy because a Sickness or Injury existed before the Policy Date.

Grace Period: Your premium must be paid on or before the date it is due or during the 31-day grace period that follows. Your policy stays in force during your grace period.

Reinstatement: Your policy will lapse if you do not pay your premium before the end of the grace period. If we later accept a premium and do not require an application for reinstatement, that payment will put this policy back in force. If we require an application for reinstatement and, as may be needed, issue a conditional receipt, this policy will be put back in force when we approve it. If we fail to notify you of disapproval within 45 days of the date of application (or the date of the conditional receipt, where that is required), your policy will be put back in force on that 45th day.

Your reinstated policy will cover only loss due to Injuries received or Sickness that begins after the date your policy was put back in force.

In all other respects, you and we will have the same rights under this policy that we had before it lapsed. The premium we accept to reinstate this policy may be used for a period for which premiums had not been paid, but it will not be used for any period more than 60 days before the reinstatement date.

Physical Examination: We, at our expense, can have you examined as often as reasonably needed while a claim is pending.

Legal Action: You cannot bring a legal action to recover under your policy for at least 60 days after you have given us written proof of loss. You cannot start such an action more than three years after the date written proof of loss is required.

Change of Beneficiary; Assignment: Only you have the right to change the beneficiary. This right is yours unless you make a beneficiary designation that may not be changed. Consent of the beneficiary is not required to make a change in this policy. Also, such consent is not required to surrender this policy or to assign the benefits.

Refund of Unearned Premium: In the event of your death, we will promptly return the unearned portion of any premium paid beyond the end of the policy month in which your death occurred.

Other Insurance with Us: You may have only one policy like this one with us at any one time. If you have more than one such policy, the one you, your beneficiary or your estate selects will remain in force. We will return all premiums paid for all other such policies.

Term of Coverage: Your coverage starts on the Policy Date at 12:01 a.m. standard time where you live. It ends at 12:01 a.m. on the same standard time on the first Policy Renewal Date. Each time you renew your policy, the new term begins when the old term ends.

Conformity With State Statutes: The provisions of the policy must conform with the laws of the state in which you reside on the Policy Date. If any do not, this clause amends them so that they do conform.

Our [President and Assistant Corporate Secretary] sign this policy in our behalf.

[ ]
[President]

[ ]
[Assistant Corporate Secretary]

MEDICO®
INSURANCE COMPANY

A STOCK INSURANCE COMPANY
[Corporate Office – Omaha, Nebraska]
[Administrative Services – P.O. Box 10386, Des Moines, Iowa 50306-0386]
[1-800-228-6080]

MEDICARE SUPPLEMENT INSURANCE POLICY
BENEFIT PLAN N

This policy is a legal contract between you and us. **READ YOUR POLICY CAREFULLY.** Also, read the copy of your application and the policy Schedule. If there is any error or omission, tell us. We will make any needed change.

The first premium you, the Insured, paid before the Policy Date (and the copy of your attached application), put this policy in force as of the Policy Date. That date is shown in the Schedule. The Schedule is attached and is a part of this policy.

PART A PLEASE READ — 30-DAY RIGHT TO RETURN

Please read your policy. If you are not satisfied, send it back to us, or to the Producer who sold it to you, within 30 days after you receive it. We will return your money. That will mean your policy was never in force. Any refund made pursuant to this section will be paid directly to you in a timely manner.

PART B GUARANTEED RENEWABLE SUBJECT TO OUR LIMITED RIGHT TO CHANGE PREMIUMS

We guarantee to renew your policy for life as long as the premium is paid within the allowable time. We cannot make a change in your policy without your consent. We do have the right to change your premium as stated below.

Premium Change: We may change the premium rates for this policy. The change may be due to a change in policy coverage or a new table of rates. We can change your premium only if we do the same to all policies of this form issued to persons of your class. “Class” means the factors of underwriting class and geographic area of your state of residence that determined your premium rate when coverage was issued. If we make a change, it will not be based on any physical impairment you might have or any claims you have incurred under this policy. If it is necessary to change the premium for your policy, we will notify you in advance of the change in premium.

PART C COVERAGE CHANGE

Automatic Change In Coverage: Policy benefits that are designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible, copayment, or coinsurance amounts. Premiums may change to correspond with these changes.

Insuring Clause: We agree to provide the benefits set out in this policy for any insured loss. This agreement is subject to all of the provisions of the policy. A "loss" is an expense you incur for care or services this policy covers and that you receive after the Policy Date and while the policy is in force.

Notice to buyer: This policy may not cover all of your medical expenses.

MEDICARE SUPPLEMENT POLICY

ALPHABETICAL GUIDE TO YOUR POLICY

	Part
Benefits	F & G
Coverage Change	C
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Extension Of Benefits	H
How To File A Claim	K
Other Important Provisions	M
Payment Of Claims	L
Renewal Agreement And Premium Change	B
Right To Return	A
Schedule	Last Page
Suspension Of Premiums And Coverage	I
Termination	J

PART D EXCEPTIONS

We will NOT pay benefits for:

1. any expense incurred for outpatient prescription drugs, other than drugs covered by Medicare Parts A and B;
2. non-Medicare Eligible Expenses, including, but not limited to: routine exams, take-home drugs and eye refractions;
3. services for which you are not liable or for which no charge normally is made in the absence of insurance; and
4. loss that occurs while this policy is not in force.

Nonduplication: This policy will not duplicate any benefit paid by Medicare.

PART E DEFINITIONS

Benefit Period: The period of time defined by Medicare as a Benefit Period.

Calendar Year: Begins on January 1 and ends on December 31.

Hospice Care: A program of palliative care approved for payment by Medicare that provides for the physical, emotional and spiritual care needs of a terminally ill patient and his or her family.

Injury: Accidental bodily Injury that results in loss, independent of Sickness or other causes.

Medicaid: The “Health Insurance for the Aged Act,” Title XIX of the Social Security Amendments of 1965, as then constituted or later amended.

Medicare: The "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

Medicare Eligible Expenses: Expenses eligible for coverage by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

Physician: A licensed practitioner of the healing arts acting within the scope of his/her license.

Policy Date: The date on which this policy first became effective. That date is shown on the Schedule.

Policy Renewal Date: The month and day your policy’s premium is due. The frequency of the Policy Renewal Date can vary depending on the premium payment option you selected. This is shown on the Schedule.

Producer: A person required to be licensed under the laws of the state to sell, solicit or negotiate insurance.

Respite Care: Hospice Care services provided by the Hospice Care program to give temporary relief to a hospice patient’s family or other caregivers.

Schedule: Is attached to and is a part of this policy.

Sickness: An illness or disease that you have or acquire.

We, Us or Our: Medico Insurance Company.

You or Your: The Insured named in the Schedule.

PART F BASIC BENEFITS

We will pay benefits for the following expenses you incur.

1. Medicare Part A Eligible Expenses for hospitalization to the extent not covered by Medicare from the 61st through 90th day in any Medicare Benefit Period.
2. Medicare Part A Eligible Expenses for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used.
3. Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, 100% of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable Prospective Payment System (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider must accept our payment as payment in full and may not bill you for any balance.
4. Under Medicare Parts A and B, the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells as defined under federal regulations) unless replaced in accordance with federal regulations.
5. The coinsurance amount, or in the case of hospital outpatient department services paid under a Prospective Payment System, the copayment amount, of Medicare Eligible Expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible, except you are required to pay the following amounts:
   (a) Up to $[20] per covered health care provider office visit, including visits to medical specialists; and
   (b) Up to $[50] per emergency room visit. This amount will be waived if you are admitted to the hospital and your emergency room visit is covered as a Medicare Eligible Expense under Part A.

   In all cases involving hospital outpatient department services paid under a Prospective Payment System, the issuer is required to pay the copayment amount established by the Center for Medicaid and Medicare Services (CMS), which will be either the amount established for the Ambulatory Payment Classification (APC) Group, or a provider-elected reduced copayment amount.
6. Hospice Care: The coverage of cost sharing for all Medicare Part A Eligible Expenses for Hospice Care and Respite Care.

PART G ADDITIONAL BENEFITS

We will pay benefits for the following expenses you incur. If you are not enrolled in Part B of Medicare, the benefits that supplement Part B of Medicare will be paid as if you were enrolled and Medicare paid benefits.

1. **Medicare Part A Deductible.** The Medicare Part A inpatient hospital deductible amount per Benefit Period.

2. **Skilled Nursing Facility Care.** The actual billed charge, up to the coinsurance amount, from the 21st day through the 100th day in a Medicare Benefit Period for posthospital skilled nursing facility care eligible under Medicare Part A.

3. **Medically Necessary Emergency Care in a Foreign Country.** To the extent not covered by Medicare, 80% of the billed charges for Medicare Eligible Expenses for medically necessary emergency hospital, Physician and medical care received in a foreign country, subject to the following limitations:

   a. such care would have been covered by Medicare if provided in the United States;
   b. such care began during the first 60 consecutive days of each trip outside the United States;

c. benefits are subject to a $250 Calendar Year deductible; and
d. benefits are subject to a lifetime maximum benefit of $50,000.

For this benefit, **Emergency Care** means care needed immediately because of an Injury or Sickness of sudden and unexpected onset.

PART H EXTENSION OF BENEFITS

Termination of coverage shall be without prejudice to a continuous loss which commenced while your policy was in force. Extension of benefits beyond the period this policy was in force is:

1. subject to your continuous total disability;
2. limited to those conditions which caused the continuous loss beginning while this policy was in force; and
3. limited to the duration benefits would have been paid had your policy continued in force or payment of the maximum benefits.

Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

PART I SUSPENSION OF PREMIUMS AND COVERAGE

The benefits and premiums of this policy will be suspended at your request for the period, not to exceed 24 months, in which you have applied for and are determined to be entitled to medical assistance under the Medicaid program. We must receive your written notice within 90 days after the date you become entitled to this assistance. Upon our receipt of timely notice, we will return that portion of the premium paid for the period of time you are eligible for Medicaid. Your refunded premium will be reduced by the amount of any claims paid for the period.

If you lose entitlement to this medical assistance after suspension occurs, your policy will be reinstituted automatically, effective as of the date the entitlement to medical assistance terminated. We must receive your written notice of the loss of the entitlement within 90 days after the date you lose the entitlement. Your notice and payment of the required premium will put the policy back in force.

The benefits and premiums of this policy will also be suspended at your request (for any period that may be provided by federal regulation) if you are entitled to benefits under Section 226(b) of the Social Security Act and are covered under a group health plan. We must receive your written notice within 90 days after the date you become covered under the group health plan. Upon our receipt of timely notice, we will return that portion of the premium paid for the period of time you are covered under the group health plan. Your refunded premium will be reduced by the amount of any claims paid for the period.

If you lose coverage under the group health plan after suspension occurs, your policy will be reinstituted automatically, effective as of the date the coverage ended. We must receive your written notice of the loss of coverage within 90 days after the coverage ends.

Reinstitution of your policy after either suspension will:

1. not provide an additional waiting period with regard to pre-existing conditions;
2. be substantially equivalent to what it was before the date of suspension; and
3. provide for a premium class that is as favorable to you as it would have been if the coverage had not been suspended.

PART J TERMINATION

Your policy will terminate on the earliest of:

1. the Policy Renewal Date following the date we receive your written or verbal request to cancel the policy, unless you request a later termination date (the grace period will not apply);

2. the Policy Renewal Date if sufficient premium has not been paid before the end of the grace period; or
3. the date of your death.

In the event of your death, we will promptly return the unearned portion of any premium paid beyond the date of death.

Termination of coverage will not affect any claim originating while your policy was in force.

PART K HOW TO FILE A CLAIM

Notice of Claim: You must give us written notice of a claim within 20 days after loss starts or as soon as reasonably possible. You may give the notice or you may have someone do it for you. The notice should give your name and policy number. Notice should be mailed to [PO Box 10386, Des Moines, IA 50306], or to one of our Producers.

Electronic Claim Filing Process: Your health care providers will usually submit electronically to Medicare the billed charges for any medical and hospital expenses you incur. Medicare then processes benefits for expenses eligible under Part A and/or Part B of Medicare, and passes your claim electronically to us for consideration of benefits under your Medicare supplement policy. We will accept Medicare's electronic submission of your claim to us as your notice of claim. For consideration of expenses that are not submitted electronically to us, a paper copy of your Medicare Summary Notice or Medicare Benefit Notice can serve as your notice of claim. This Medicare statement shows your Medicare Eligible Expenses and the amount approved and paid by Medicare. You may submit a paper copy of your Medicare statement to us or your health care provider may submit it to us on your behalf. If your claim is submitted electronically the requirements for claim forms and proof of loss will be met.

Claim Forms: When we receive your notice of claim, we will send you forms for filing proof of loss. If these forms are not sent to you within 15 days, you will have met the proof of loss rule below if you give us a written statement within 90 days after the loss began.

Proof of Loss: You must give us written proof of your loss within 90 days or as soon as reasonably possible. Proof must be furnished within 15 months after loss began, except in the absence of legal capacity.

PART L PAYMENT OF CLAIMS

Time of Payment of Claims: All benefits will be paid immediately upon receipt of due written proof of loss.

Payment of Claims: Subject to your written direction in the application or otherwise, all or a portion of any benefits provided by this policy due to hospital, nursing, medical or surgical services may, at our option and unless you request otherwise in writing not later than the time of filing proof of such loss, be paid directly to the hospital or person rendering such services. It is not required that the services be rendered by a particular hospital or person.

Benefits unpaid at your death will be paid to your beneficiary or your estate. If any benefit is payable to your estate, to a minor or to any person not able to give a valid release, we may pay up to $1,000 ($5,000 in Nebraska) to any relative of yours by blood or connection by marriage, or any beneficiary that we find entitled to the payment. Any payment we make in good faith will fully discharge us to the extent of the payment.

PART M OTHER IMPORTANT PROVISIONS

Entire Contract; Changes: This policy, with any attachments (and the copy of your application), is the entire contract of insurance. No Producer may make contracts, determine insurability or change the application or policy in any way. Only an executive officer of ours can approve a change. That change must be shown in the policy.

Time Limit on Certain Defenses: After three years from the Policy Date, no misstatements, except fraudulent misstatements in the application for the policy, can be used to void the policy or to deny a claim for loss incurred or disability commencing after the expiration of such three-year period.

Pre-Existing Conditions: We will not reduce or deny a claim under this policy because a Sickness or Injury existed before the Policy Date.

Grace Period: Your premium must be paid on or before the date it is due or during the 31-day grace period that follows. Your policy stays in force during your grace period.

Reinstatement: Your policy will lapse if you do not pay your premium before the end of the grace period. If we later accept a premium and do not require an application for reinstatement, that payment will put this policy back in force. If we require an application for reinstatement and, as may be needed, issue a conditional receipt, this policy will be put back in force when we approve it. If we fail to notify you of disapproval within 45 days of the date of application (or the date of the conditional receipt, where that is required), your policy will be put back in force on that 45th day.

Your reinstated policy will cover only loss due to Injuries received or Sickness that begins after the date your policy was put back in force.

In all other respects, you and we will have the same rights under this policy that we had before it lapsed. The premium we accept to reinstate this policy may be used for a period for which premiums had not been paid, but it will not be used for any period more than 60 days before the reinstatement date.

Physical Examination: We, at our expense, can have you examined as often as reasonably needed while a claim is pending.

Legal Action: You cannot bring a legal action to recover under your policy for at least 60 days after you have given us written proof of loss. You cannot start such an action more than three years after the date written proof of loss is required.

Change of Beneficiary; Assignment: Only you have the right to change the beneficiary. This right is yours unless you make a beneficiary designation that may not be changed. Consent of the beneficiary is not required to make a change in this policy. Also, such consent is not required to surrender this policy or to assign the benefits.

Refund of Unearned Premium: In the event of your death, we will promptly return the unearned portion of any premium paid beyond the end of the policy month in which your death occurred.

Other Insurance with Us: You may have only one policy like this one with us at any one time. If you have more than one such policy, the one you, your beneficiary or your estate selects will remain in force. We will return all premiums paid for all other such policies.

Term of Coverage: Your coverage starts on the Policy Date at 12:01 a.m. standard time where you live. It ends at 12:01 a.m. on the same standard time on the first Policy Renewal Date. Each time you renew your policy, the new term begins when the old term ends.

Conformity With State Statutes: The provisions of the policy must conform with the laws of the state in which you reside on the Policy Date. If any do not, this clause amends them so that they do conform.

Our [President and Assistant Corporate Secretary] sign this policy in our behalf.

[ ]
[President]

[ ]
[Assistant Corporate Secretary]

[Medico Insurance Company]
[Corporate Office – Omaha, NE]
[Administrative Services – PO Box 10386]
[Des Moines, IA 50306]

S C H E D U L E

POLICY NO. - [0000000]

POLICY TYPE – A20[G]

INSURED - [JOHN E. DOE]
[1234 ANY STREET]
[ANYTOWN, USA 00000]

------ POLICY PREMIUMS ------
[MODE ……..$ [XXX.XX]

POLICY DATE ..... [07/01/10]
FIRST RENEWAL DATE ..... [07/01/11]
TOTAL FIRST PREMIUM ..... $ [XXXX.XX]
AGE AT ISSUE ..... [65]

[MEDICO INSURANCE COMPANY]
[Corporate office – Omaha, NE]
[Administrative Services – PO Box 10386]
[Des Moines, IA 50306]

S C H E D U L E

POLICY NO. - [0000000] POLICY TYPE – A20[N]

INSURED - [JOHN E. DOE]
[1234 ANY STREET]
[ANYTOWN, USA 00000]

------ POLICY PREMIUMS ------
[MODE ……..$ [XXX.XX]

POLICY DATE ..... [07/01/10]
FIRST RENEWAL DATE ..... [07/01/11]
TOTAL FIRST PREMIUM ..... $ [XXXX.XX]
AGE AT ISSUE ..... [65]

[Corporate Office – Omaha, NE]
[Administrative Services – PO Box 10386]
[Des Moines, IA 50306]
[www.gomedico.com]
[Toll-Free 1-800-228-6080]

NOTICE ON CHANGES IN MEDICARE AND YOUR MEDICARE SUPPLEMENT INSURANCE

The following outline briefly describes the modifications in Medicare and in your Medicare supplement coverage. Please read carefully!

Services	**Medicare Benefits - Effective [2013] Medicare will pay**	**Your Medicare Supplement Coverage - Effective [2013] MSA20G will pay**
MEDICARE PART A SERVICES AND SUPPLIES		
Inpatient Hospital Benefits		
First 60 Days	All but $[1,184]	$[1,184]
61st to 90th Day	All but $[296] a day	$[296] a day
91st to 150th Day	All but $[592] a day	$[592] a day
151st Day for an Additional 365 Days	$[0]	100% of Medicare eligible expenses
Skilled Nursing Facility Care (if Medicare-Approved)		
First 20 Days	All approved amounts	$[0]
21st to 100th Day	All but $[148] a day	Up to $[148] a day
After 100 Days	$[0]	$[0]
Hospice Care (must meet Medicare's certification requirements)	All but very limited copayment & coinsurance for outpatient drugs & inpatient respite care	Medicare copayment and coinsurance
MEDICARE PART B SERVICES AND SUPPLIES		
Medical Expenses		
*First $[147] of Medicare-Approved Amounts	$[0]	$[0]
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%
Part B Excess Charges (Above Medicare-Approved Amounts)	$[0]	100%
Blood		
First 3 Pints	$[0]	All costs
*Next $[147] of Medicare-Approved Amounts	$[0]	$[0]
Remainder of Medicare-Approved Amounts	80%	20%

(over)

MEDICARE PARTS A AND B SERVICES AND SUPPLIES		
Home Health Care (if Medicare-Approved) –		
Medically necessary skilled care services and medical supplies	100%	$[0]
Durable Medical Equipment:		
*First $[147] of Medicare-Approved Amounts	$[0]	$[0]
Remainder of Medicare-Approved Amounts	80%	20%

* This is the Part B deductible, and only needs to be met once per calendar year.

If it is necessary to change the premium for your policy, we will notify you in advance of the change in premium.

THIS CHART SUMMARIZING THE CHANGES IN YOUR MEDICARE BENEFITS AND IN YOUR MEDICARE SUPPLEMENT PROVIDED BY MEDICO® INSURANCE COMPANY ONLY BRIEFLY DESCRIBES SUCH BENEFITS. FOR INFORMATION ON YOUR MEDICARE BENEFITS CONTACT YOUR SOCIAL SECURITY OFFICE OR THE CENTERS FOR MEDICARE & MEDICAID SERVICES. FOR INFORMATION ON YOUR MEDICARE SUPPLEMENT POLICY CONTACT MEDICO INSURANCE COMPANY AT [PO BOX 10386, DES MOINES, IA 50306], OR CONTACT THE PRODUCER WHO SOLD YOU THE POLICY.

[Corporate Office – Omaha, NE]
[Administrative Services – PO Box 10386]
[Des Moines, IA 50306]
[www.gomedico.com]
[Toll-Free 1-800-228-6080]

NOTICE ON CHANGES IN MEDICARE AND YOUR MEDICARE SUPPLEMENT INSURANCE

The following outline briefly describes the modifications in Medicare and in your Medicare supplement coverage. Please read carefully!

Services	**Medicare Benefits - Effective [2013] Medicare will pay**	**Your Medicare Supplement Coverage - Effective [2013] MSA20N will pay**
MEDICARE PART A SERVICES AND SUPPLIES		
Inpatient Hospital Benefits		
First 60 Days	All but $[1,184]	$[1,184]
61st to 90th Day	All but $[296] a day	$[296] a day
91st to 150th Day	All but $[592] a day	$[592] a day
151st Day for an Additional 365 Days	$[0]	100% of Medicare eligible expenses
Skilled Nursing Facility Care (if Medicare-Approved)		
First 20 Days	All approved amounts	$[0]
21st to 100th Day	All but $[148] a day	Up to $[148] a day
After 100 Days	$[0]	$[0]
Hospice Care (must meet Medicare's certification requirements)	All but very limited copayment & coinsurance for outpatient drugs & inpatient respite care	Medicare copayment and coinsurance
MEDICARE PART B SERVICES AND SUPPLIES		
Medical Expenses		
*First $[147] of Medicare-Approved Amounts	$[0]	$[0]
Remainder of Medicare-Approved Amounts	Generally 80%	Balance, other than up to $[20] per covered health care provider office visit and up to $[50] per emergency room visit. The copayment of up to $[50] is waived if you are admitted to the hospital and the emergency visit is covered as a Medicare Part A expense.
Blood		
First 3 Pints	$[0]	All costs
*Next $[147] of Medicare-Approved Amounts	$[0]	$[0]
Remainder of Medicare-Approved Amounts	80%	20%

(over)

MEDICARE PARTS A AND B SERVICES AND SUPPLIES		
Home Health Care (if Medicare-Approved) –		
Medically necessary skilled care services and medical supplies	100%	$[0]
Durable Medical Equipment:		
*First $[147] of Medicare-Approved Amounts	$[0]	$[0]
Remainder of Medicare-Approved Amounts	80%	20%

* This is the Part B deductible, and only needs to be met once per calendar year.

If it is necessary to change the premium for your policy, we will notify you in advance of the change in premium.

THIS CHART SUMMARIZING THE CHANGES IN YOUR MEDICARE BENEFITS AND IN YOUR MEDICARE SUPPLEMENT PROVIDED BY MEDICO® INSURANCE COMPANY ONLY BRIEFLY DESCRIBES SUCH BENEFITS. FOR INFORMATION ON YOUR MEDICARE BENEFITS CONTACT YOUR SOCIAL SECURITY OFFICE OR THE CENTERS FOR MEDICARE & MEDICAID SERVICES. FOR INFORMATION ON YOUR MEDICARE SUPPLEMENT POLICY CONTACT MEDICO INSURANCE COMPANY AT [PO BOX 10386, DES MOINES, IA 50306], OR CONTACT THE PRODUCER WHO SOLD YOU THE POLICY.

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	01/15/2013
Comments:			
Attachment(s):			
AR A20-C Flesch Certificate MIPPA -Hall.doc.pdf			

		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	01/15/2013
Bypass Reason:	Application form MIHAA20(AR)-MH version 03292011 was approved on 04-20-2011 under Serff Filing MDIC-127102602		

		Item Status:	Status Date:
Bypassed - Item:	Health - Actuarial Justification	Approved-Closed	01/15/2013
Bypass Reason:	Actuarial Memorandum and Rates, filed and approved under Serff Filing: MDIC-128694021 will remian the same. There are no changes in the Actuarial Memorandum or Rates.		

		Item Status:	Status Date:
Bypassed - Item:	Outline of Coverage	Approved-Closed	01/15/2013
Bypass Reason:	Outline of Coverage form MI9F-4363(AR)-M versin 03292011 was approved on 04-20-2011 under Serff Filing MDIC-127102602		

		Item Status:	Status Date:
Satisfied - Item:	AR A20-C Cover Letter	Approved-Closed	01/15/2013
Comments:			
Attachment(s):			
AR-A20 -C Cover Letter.pdf			

		Item Status:	Status Date:
Satisfied - Item:	Form For Informational Purposes	Approved-Closed	01/15/2013

State: *Arkansas* **Filing Company:** *Medico Insurance Company*
TOI/Sub-TOI: *MS08I Individual Medicare Supplement - Standard Plans 2010/MS08I.012 Multi-Plan 2010*
Product Name: *AR A20 MIPPA Bracketing*
Project Name/Number: *AR A20 MIPPA Bracketing/AR A20 MIPPA Bracketing*

Comments:	The medical authorization MI9F-4218 will be sent with the application to obtain medical authorization from the applicant. This HIPAA Compliant Medical Authorization form is enclosed for informational purposes only.

Attachment(s):

MI9F-4218-10012012.pdf

FLESCH READABILITY CERTIFICATION

Form Number _MI-MSA20A(AR) has been Flesch tested. The Flesch Readability Score was computed to be_49.6.

Form Number _MI-MSA20D(AR) has been Flesch tested. The Flesch Readability Score was computed to be_48.1.

Form Number _MI-MSA20F(AR) has been Flesch tested. The Flesch Readability Score was computed to be_48.9.

Form Number _MI-MSA20G(AR) has been Flesch tested. The Flesch Readability Score was computed to be_47.8.

Form Number _MI-MSA20N(AR) has been Flesch tested. The Flesch Readability Score was computed to be_48.4.

Form Number _MI9F-4368-C has been Flesch tested. The Flesch Readability Score was computed to be_41.2.

Form Number _MI9F-4367[A-C, D-C, F-C, G-C & N-C] has been Flesch tested. The Flesch Readability Score was computed to be_42.2.

Form Number _____has been Flesch tested. The Flesch Readability Score was computed to be_____.

Form Number _____has been Flesch tested. The Flesch Readability Score was computed to be_____.

MEDICO INSURANCE COMPANY

Timothy Hall
President

MEDICO®
INSURANCE COMPANY
Corporate Office – Omaha, Nebraska
Administrative Services – P.O. Box 10386, Des Moines, Iowa 50306-0386

January 8, 2013

MEDICO INSURANCE COMPANY
NAIC # 31119
Serff Filing: MDIC-128740502

Commissioner Jay Bradford
Department of Insurance
1200 West Third Street
Little Rock, AR 72201-1904

RE: Medicare Supplement Insurance

Enclosed Material:
MI-MSA20A(AR) – Plan A Policy
POLICY A20A-C – Schedule Page Plan A
MI-MSA20D(AR) – Plan D Policy
POLICY A20D-C –Schedule Page Plan D
MI-MSA20F(AR) – Plan F Policy
POLICY A20F-C – Schedule Page Plan F
MI-MSA20G(AR) – Plan G Policy
POLICY A20G-C –Schedule Page Plan G
MI-MSA20N(AR) – Plan N Policy
POLICY A20N-C – Schedule Page Plan N
MI9F-4368-C – Replacement Notice
MI9F-4367A-C – Plan A Benefit Change Notice
MI9F-4367D-C – Plan D Benefit Change Notice
MI9F-4367F-C – Plan F Benefit Change Notice
MI9F-4367G-C – Plan G Benefit Change Notice
MI9F-4367N-C – Plan N Benefit Change Notice
MIR-AR-763 –Toll-Free Customer Service Notice

Previously Approved/Filed Form:
MI9F-4218 – Medical Authorization

SERFF Filing Numbers:
MDIC-126453783 Plan A, MDIC-126453841 Plan D
MDIC-126453857 Plan F, MDIC-127102602 Plan G
MDIC-127102646 Plan N

Enclosed for your review are copies of the Medicare Supplement Policies and accompanying forms for informational purposes. The revised forms will replace some of the forms in Serff Filings: MDIC-126453783 Plan A, MDIC-126453841 Plan D, MDIC-126453857 Plan F, MDIC-127102602 Plan G and MDIC-127102646 Plan N previously approved by your division. All other forms approved in the previous filings will remain active.

Changes from the previous version of these forms to the new forms are limited only to bracketing variable text as concerning our contact information that is subject to change (i.e., Home Office physical address, website address and telephone and fax numbers, time of operation, company inter department names, officers) as well as potential changes in payment methods, payment modes. No such items will be contradictory to any applicable state or federal law.

The appropriate benefit change notice will be sent annually to each policyholder residing in the state, no later than 30 days prior to deductible/co-payment changes. I request that any variable information within the deductible and co-payment amounts found in the outline and benefit change notices be approved as variable to allow updates each year without refiling. I also request that the premium amounts in the outline (although not in brackets due to the vast number of premiums) be approved as variable with the understanding that we will only change these premiums after approval of the rates by your Department.

Again, besides bracketing variable text, no other changes to the forms have been made.

I thank you in advance for your prompt review and approval of this submission. If you have any questions, please feel free to contact me.

Sincerely,

Luanne Melies
Compliance Analyst
1-800-695-5976 Ext. 8237
lmelies@gomedico.com

HIPAA AUTHORIZATION

I authorize any person described below who has health or non-health information about me or my minor dependents to disclose such information to Medico Insurance Company and the entities with which it contracts to administer insurance applications (collectively the "Company"), and their agents and representatives. The purpose of the disclosure is so that the information may be used to underwrite and determine eligibility for the insurance plan(s) for which I have applied.

Health information includes information on past and present physical or mental conditions (including, but not limited to, drug and/or alcohol conditions). It includes complete medical files. These files may include, but are not limited to: doctors' notes, lab reports, testing results, consulting doctor reports and test results. The information authorized for disclosure does not include psychotherapy notes.

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 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, P.O. Box 10386, Des Moines, Iowa 50306-0386.]
- 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 (180 days for confidential HIV-related information).
- 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.

Date

MM / DD / YYYY

Your Name (Please print)

Your Signature

X

Your Spouse's Name (if applying) (Please print)

Your Spouse's Signature (if applying)

X

Your Child's Name (if 18 or older)

Your Child's Signature (if 18 or older)

X

Your Child's Name (if 18 or older)

Your Child's Signature (if 18 or older)

X

Your Child(ren)'s Name(s) if younger than 18 (Please Print)

1.

2.

3.

4.

A personal representative must sign for each minor child. 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)

Person(s) to be Insured (Please print)	My relationship to applicant(s) (Please print)
1.	1.
2.	2.
3.	3.
4.	4.