AMERICO

Medicare Supplement

Application Packet

Included in this packet:

- Application for Medicare Supplement Insurance
- Supplemental Information Application for Medicare Supplement Insurance
- Health Information Authorization
- Bank Draft Authorization
- Important Consumer Notices
- Producer Statement
- Premium Worksheet
- Outline of Coverage
- Rate Guide
- Fax Transmittal

Additional forms that may be required:

- Choosing a MediGap Policy: A Guide to Health Insurance for People with Medicare – *Must be left with applicant at the point of sale for all states.*
- Medicare Supplement Replacement Notice – *Required in applicable states when replacing an existing Medicare Supplement or Medicare Advantage policy.*

AMERICO®

Medicare Supplement
Application Transmittal Form

15-138-11 (08/15)

AMERICO

Fax applications and New Business documents ONLY to: 855.864.8526

Important:

- Only applications paying the initial premium by bank draft are eligible to be faxed.
- **DO NOT** collect premium with an application that is being faxed.
- All applications submitted with this form must be written by the same agent.
- Please use one transmittal per application unless submitting companions. Companions should be faxed in together.
- Do not mail in applications/forms once you have faxed them, original copies should be maintained in case of fax transmission problems.
- It is important to include phone/fax number below.
- **DO NOT** submit Pre-Underwriting Issues through the fax number above (2nd applications, replacement forms, or other additional documents).

Forms Sequence:

1. Application *(include Application Addendum, if applicable)*
2. Producer Statement
3. Health Information Authorization
4. Replacement Notice *(if applicable)*
5. Other state-specific required forms *(if applicable)*
6. Guaranteed Issue documentation *(if applicable)*
7. Signed Bank Draft Authorization

PLEASE PRINT LEGIBLY

Agent Name		Agent Code
Agent Phone Number	Agent Fax Number	Total No. of Pages Faxed (including this cover sheet):

Applicant Name	Plan Applied For	Initial Premium Amount to be drafted or charged *(include policy fee)*

All application questions should be directed to the Underwriting Department at 877.212.2346.

Application for

Medicare Supplement Insurance AID5500

Americo Financial Life and Annuity Insurance Company
Medicare Supplement Administrative Office: PO Box 10812, Clearwater, FL 33757-8812

☐ New Business ☐ Coverage Change ☐ Reinstatement

Part I – Personal Information

Title: ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Other_____

Last Name	First Name	MI	Gender ☐ Male ☐ Female

Street Address

City	State	ZIP

Birthdate (mm/dd/yyyy)	Age	Social Security Number

Medicare ID Number	Requested Effective Date (if other than the Application Date) _____ (mm/dd/yyyy)

Daytime Phone	Evening Phone	Cell Phone

Email Address

Part II – Plan Selection

☐ A ☐ F ☐ G ☐ N

Part III – Eligibility

State law allows a 6-month open enrollment period beginning with the first day of the first month in which you are both: (1) age 65 or older; and (2) enrolled in Medicare Part B. *If you are a qualified open enrollee, you may apply for and receive any Medicare Supplement Plan available from us.*

1. Are you covered under Medicare Part A? ☐ Yes ☐ No
   a. If **Yes**, what is your Part A effective date? _____/_____/_____
   b. If **No**, what is your eligibility date? _____/_____/_____

2. Are you covered under Medicare Part B? ☐ Yes ☐ No
   a. If **Yes**, what is your Part B effective date? _____/_____/_____
   b. If **Yes**, is this your first time enrolling in Medicare Part B? ☐ Yes ☐ No
   c. If **No**, what is your eligibility date? _____/_____/_____

3. Did you turn 65 in the last 6 months? ☐ Yes ☐ No

Part IV – Medicare & Insurance Information

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you are eligible for guaranteed issue of a Medicare Supplement insurance policy or certificate, or that you had certain rights to buy such a policy or certificate, you may be guaranteed acceptance in one or more of our Medicare Supplement plans. Please include a copy of the notice from your prior insurer with this Application. *Please mark **Yes** or **No** below with an "X", to the best of your knowledge.*

PLEASE ANSWER ALL QUESTIONS

1. Are you currently in a guaranteed issue period? *(If **Yes**, please attach proof of eligibility)* ☐ Yes ☐ No

2. Are you covered for Medical Assistance through the state Medicaid program? ☐ Yes ☐ No
   *NOTE TO APPLICANT: If you are participating in a "Spend Down Program" and have not met your "Share of the Cost", please answer **No** to this question.*
   a. Will Medicaid pay your premiums for this Medicare Supplement policy? ☐ Yes ☐ No
   b. Do you receive any benefits from Medicaid, OTHER THAN payments toward your Part B premium? ☐ Yes ☐ No

3. a. If you had coverage from any Medicare Plan other than Original Medicare within the past 63 days, for example, a Medicare Advantage plan, or a Medicare HMO or PPO, fill in your *"Effective"* and *"Paid-to"* dates below. If you are still covered under this plan, leave *"Paid to"* blank.
   Effective _____/_____/_____ Paid to _____/_____/_____ (mm/dd/yyyy)
   b. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy? *(If **Yes**, complete Replacement Notice.)* ☐ Yes ☐ No
   If so, with what company? _____
   Company Address: _____
   Telephone Number: _____ What plan do you have? _____
   c. Was this your first time in this type of Medicare Plan? ☐ Yes ☐ No
   d. Did you drop a Medicare Supplement policy or certificate to enroll in the Medicare Plan? ☐ Yes ☐ No

4. a. Do you have another Medicare Supplement policy or certificate in force? ☐ Yes ☐ No
   b. If so, with what company? _____
   Company Address: _____
   Telephone Number: _____ What plan do you have? _____
   c. If so, do you intend to replace your current Medicare Supplement policy or certificate with this policy? *(If **Yes**, complete Replacement Notice.)* ☐ Yes ☐ No

5. Have you had coverage under any other health insurance within the past 63 days? *(For example, an employer, union, or individual plan.)* ☐ Yes ☐ No
   a. If so, with what company? _____
   b. What kind of policy and plan number? _____
   c. What are your dates of coverage under the policy?
   Effective _____/_____/_____ Paid to _____/_____/_____ (mm/dd/yyyy)
   d. Reason for termination or disenrollment: _____
   Effective _____/_____/_____ Paid to _____/_____/_____ (mm/dd/yyyy)

Part V – General Information

1. You do not need more than one Medicare Supplement policy or certificate.
2. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
3. You may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy or certificate.
4. If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. Upon receipt of your request, we will return to you that portion of the premium attributable to the period of your Medicaid eligibility, subject to an adjustment for paid claims. If you are no longer entitled to Medicaid, your suspended Medicare Supplement policy or, if that is no longer available, a substantially equivalent policy will be reinstituted, effective as of the date of termination of Medicaid, if requested within 90 days of losing your Medicaid eligibility. If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.
5. If you are eligible for, and have enrolled in a Medicare Supplement policy or certificate by reason of disability and you later become covered by an employer or union based group health plan, the benefits and premiums under your Medicare Supplement policy or certificate can be suspended, if requested, while you are covered under the employer or union based group health plan. If you suspend your Medicare Supplement policy or certificate under these circumstances, and later lose your employer or union based group health plan, your suspended Medicare Supplement policy or certificate or, if that is no longer available, a substantially equivalent policy or certificate, will be reinstituted if requested within 90 days of losing your employer or union based group health plan. If the Medicare Supplement policy or certificate provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy or certificate was suspended, the reinstituted policy or certificate will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.
6. Counseling services may be available in your state to provide advice concerning your purchase of Medicare Supplement insurance and concerning medical assistance through the state Medicaid Program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low Income Medicare Beneficiary (SLMB).

Part VI – Guarantee Issue Eligibility

Guaranteed Issue For Eligible Persons Under the Balanced Budget Act of 1997: The following are definitions of the categories of individuals who are eligible for Guaranteed Issue under the Balanced Budget Act of 1997:

- Enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare; and the plan terminates, or the plan ceases to provide all such supplemental health benefits to the individual, or the individual is enrolled under an employee welfare benefit plan that is primary to Medicare and the plan terminates, or the plan ceases to provide health benefits to the individual because the individual leaves the plan *(eligible for Plans A or F)*; or
- Enrolled in a Medicare Advantage plan or Program of All-Inclusive Care for the Elderly (PACE) and the organization's certification or plan is terminated or specific circumstances permit discontinuance including, but not limited to, a change in residence of the individual, the plan is terminated within a residence area, the organization substantially violated a material policy provision, including the failure to provide an enrollee on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide the covered care in accordance with applicable quality standards; or a material misrepresentation was made to the individual, or the person meets any other exceptional conditions as the secretary may provide *(eligible for Plans A or F)*; or
- Enrolled in a Medicare risk contract, health care prepayment plan, cost contract or Medicare Select plan, or similar organization, and the organization's certification or plan is terminated or specific circumstances permit discontinuance including, but not limited to, a change in residence of the individual, the plan is terminated within a residence area, the organization substantially violated a material policy provision, or a material misrepresentation was made to the individual *(eligible for Plans A or F)*; or
- Enrolled in a Medicare Supplement policy and coverage discontinues due to insolvency, substantial violation of a material policy provision, or material misrepresentation *(eligible for Plans A or F)*; or
- Enrolled under a Medicare Supplement policy, terminates and enrolls for the first time in a Medicare Advantage, a risk or cost contract, or a Medicare Select plan, a PACE provider, and then terminates coverage within 12 months of enrollment *(eligible for the same Plan you terminated with us, or, if that Plan is no longer available, Plans A or F)*; or Upon *first* becoming eligible for benefits under Part A at age 65, enrolls in a Medicare Advantage or PACE provider and then disenrolls within 12 months *(eligible for all plans available from us)*; or
- Enrolled in a Medicare Part D Plan during the initial Part D enrollment period while enrolled under a Medicare Supplement policy that covers outpatient prescription drugs and terminate the Medicare Supplement policy *(eligible for Plans A or F)*.

Documentation of these events must be submitted with this Application. You must apply within 63 days of the date of termination of previous coverage in order to qualify as an eligible person.

Part VII – Household Premium Discount Information

If another member of your household currently holds, or will hold an Americo policy, You may be eligible for a policy with a lower premium rate based on your answers to the questions in this section.

1. Do you have a household resident (at least one but no more than three) (a) with whom you have continuously resided for the last 12 months; or (b) with whom you reside and to whom you are either married or with whom you are in a civil union partnership? ☐ Yes ☐ No

2. If you answered **Yes** to question 1 above, please fill out the following information about the household resident:

   Name (First/Middle/Last): _____

   Relationship to Applicant: _____

   Street Address: _____

   City/State/ZIP: _____

   Existing Americo Medicare Supplement Plan policy number (if applicable):_____

Part VIII – Premium Payment & Administration

Initial Premium: _____	Premium Mode/Method: ☐ Monthly Bank Draft ☐ Annual Direct Bill

Part IX – Medical Questions

Do not answer health questions 2-10 if you are in an open enrollment or guaranteed issue period. Please see Part III and Part IV for an explanation of open enrollment/guaranteed issue period information.

NOTICE TO APPLICANT: Please answer all of the following questions. Please verify the accuracy and completeness of the medical information on this application. Incomplete or false information on this application could jeopardize future claims. If you answer YES to any of the following questions 2-9, you are not eligible for coverage.

1. Have you used any tobacco products, including cigarettes, cigars, chewing tobacco or a pipe, in the past 12 months? ☐ Yes ☐ No

2 a. Height: ____ft ____in b. Weight: _____ lbs

3. Are you currently hospitalized, in a nursing home or assisted living facility, confined to a wheelchair or require use of a motorized mobility aid, or are you bedridden, or have you been confined to a hospital three or more time, in the last 2 years? ☐ Yes ☐ No

4. Do you have an implanted cardiac defibrillator? ☐ Yes ☐ No

5. Within the past 10 years, have you been diagnosed with, advised, or treated by a member of the medical profession for:
   a. Emphysema, chronic obstructive pulmonary disease (COPD), or other chronic respiratory Disorders or do you require the use of supplemental oxygen? ☐ Yes ☐ No
   b. Parkinson's disease, systemic lupus, myasthenia gravis, multiple or lateral sclerosis, osteoporosis with fractures, cirrhosis, or chronic hepatitis? ☐ Yes ☐ No
   c. Alzheimer's disease, senile dementia, or any other cognitive disorder? ☐ Yes ☐ No
   d. Acquired immune deficiency syndrome (AIDS) or AIDS related complex (ARC)? ☐ Yes ☐ No
   e. Chronic kidney disease, kidney failure, renal insufficiency or kidney disease requiring dialysis? ☐ Yes ☐ No

6. Within the past 5 years, have you been diagnosed with, advised or treated by a member of the medical profession for:
   a. Cancer, tumor, lymphoma or melanoma (except basal cell cancer of the skin), alcoholism, drug abuse, mental or nervous disorder requiring psychiatric care or have you had any amputation caused by disease? ☐ Yes ☐ No
   b. Chest pain; heart attack; heart, coronary or carotid artery disease (not including high blood pressure); coronary artery bypass surgery, angioplasty, peripheral vascular disease, congestive heart failure or enlarged heart, stroke, transient ischemic attacks (TIA); valvular heart disease; or heart rhythm disorders? ☐ Yes ☐ No
   c. Degenerative bone disease, crippling/disabling or rheumatoid arthritis or have you been advised to have joint replacement? ☐ Yes ☐ No

Part IX – Medical Questions (continued)

7. Within the past 2 years have you been advised by a member of the medical profession:
   a. That surgery may be required within 12 months? ☐ Yes ☐ No
   b. To have surgery, medical test, treatment or therapy that has not been performed? ☐ Yes ☐ No
   c. To have an organ transplant or have you ever had an organ transplant? ☐ Yes ☐ No

8. Do you have diabetes that has ever required more than 50 units of insulin daily or do you have diabetes or been advised by a medical professional to take medications to reduce or control your blood sugar in addition to any of the following: neuropathy, retinopathy, amputation, peripheral artery disease, any heart disorder, stroke, transient ischemic attack (TIA), or kidney disease? *If you do **not** have diabetes this question should be answered **No.*** ☐ Yes ☐ No

9. If you have diabetes with high blood pressure, have you taken more than 2 medications for either condition or have there been any changes in your medications within the past 2 years? *If you do **not** have diabetes this question should be answered **No**.* ☐ Yes ☐ No

10. Are you taking or have you taken any prescription or over-the-counter medications within the past 24 months? *If **Yes**, please list the drug(s) below along with the date prescribed, dosage/frequency and diagnosis/medical condition for each medication. Attach a separate sheet if needed.* ☐ Yes ☐ No

Medication name (copy off pharmacy label)	
Date **Originally** prescribed	
Dosage and frequency	
Diagnosis/medical condition	
Medication name (copy off pharmacy label)	
Date **Originally** prescribed	
Dosage and frequency	
Diagnosis/medical condition	
Medication name (copy off pharmacy label)	
Date **Originally** prescribed	
Dosage and frequency	
Diagnosis/medical condition	
Medication name (copy off pharmacy label)	
Date **Originally** prescribed	
Dosage and frequency	
Diagnosis/medical condition	
Medication name (copy off pharmacy label)	
Date **Originally** prescribed	
Dosage and frequency	
Diagnosis/medical condition	
Medication name (copy off pharmacy label)	
Date **Originally** prescribed	
Dosage and frequency	
Diagnosis/medical condition	

Primary Care Physician Information

Physician's Name:________________________________

Telephone Number:________________________________

Part X – Agreement & Acknowledgment

I wish to apply for Medicare supplement insurance coverage. I acknowledge that I have received or been given access to review: (a) an Outline of Coverage for the coverage applied for, and (b) a "Guide to Health Insurance for People with Medicare."

I AUTHORIZE Americo to act on electronic and/or telephonic information from all parties specified in this application. This authorization may be revoked by sending written notice to Americo at its Medicare Supplement Administrative Office address. The absence of this authorization constitutes a rejection of this authorization.

I HAVE READ AND FULLY UNDERSTAND the questions and my answers on this Application. To the best of my knowledge and belief they are true and complete. I understand the Company may conduct a telephone interview with me regarding the answers. I understand and agree the coverage applied for will not take effect until issued by the Company, and that the agent is not authorized to extend, waive or change any terms, conditions or provisions of the coverage.

Caution: If your answers on this Application are incorrect or untrue, the Company has the right to deny benefits or rescind your coverage.

_____ _____

Signed at (City and State) Date

_____ Send policy to: ☐ Applicant ☐ Producer

Applicant's Signature

_____ _____

Producer's Signature Producer Number

_____

Producer's Phone

Supplemental Information for Individual

Medicare Supplement Insurance Application

AAA5500-ADDENDUM

Americo Financial Life and Annuity Insurance Company

Proposed Insured's Name *(Last, First, MI)*	Social Security Number

ADDITIONAL INFORMATION

Section/Question Number	Details to general and medical questions (diagnosis, dates, durations, and medications, dosages, frequency) medical facilities, and physicians' names, addresses, and phone numbers.

I represent to Americo Financial Life and Annuity Insurance Company that the above answers are true, complete, and correctly recorded to the best of my knowledge and belief. I also understand that this signed form will be used during the underwriting process and any misstatements may affect my ability to obtain coverage. I agree that the above answers shall form a part of my application and that the Company can rely on these answers to determine my eligibility for insurance.

Caution: If your answers on this Application are incorrect or untrue, the Company has the right to deny benefits or rescind your coverage.

Signed at (City and State)_____ on (Month/Day/Year) _____

_____ Applicant's Signature

_____ Producer's Signature

_____ Producer's Number

Health Information
Authorization

AAA8555

Americo Financial Life and Annuity Insurance Company

This Authorization complies with the HIPAA Privacy Rule

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, medical facility, or other health care provider that has provided services, treatment or payment to me, or on my behalf, within the past 10 years ("My Providers"), or consumer reporting agency, or the Health information Bureau, to disclose my entire medical record and any other protected health information, concerning me to Americo Financial Life and Annuity Insurance Company ("Americo") or its agents, employees and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes and excludes information related to generic tests or genetic services (except to pay a claim related to such tests or services).

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this Authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medial record without restriction.

My protected health information is to be disclosed under this Authorization so that Americo may: (1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; (2) obtain reinsurance; (3) administer claims and determine or fulfill their responsibility for coverage and provision for benefits; (4) administer coverage; and (5) conduct other legally permissible activities that relate to any coverage I have applied for with Americo.

This Authorization shall remain in force for 30 months following the date of my signature below, and a copy of this Authorization is as valid as the original. I understand that I have the right to revoke this Authorization in writing, at any time, by sending a written request for revocation to Americo at PO Box 410288, Kansas City, Missouri 64141-0288, Attention: Privacy Officer. I understand that a revocation is not effective to the extent that any of My Providers has relied on this Authorization or to the extent that Americo has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this Authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentially of health information.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this Authorization. I further understand that if I refuse to sign this Authorization to release my complete medical record, Americo may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments.

_____ _____

Name of Applicant *(please print)* | Applicant's Date of Birth

_____ _____

Signature of Applicant or Personal Representative | Date

_____

Description of Personal Representative's Authority or Relationship to Applicant *(if applicable)*

Bank Draft Authorization for

Medicare Supplement

15-138-10

Americo Financial Life and Annuity Insurance Company
Medicare Supplement Administrative Office: PO Box 10812, Clearwater, FL 33757-8812

Policy Number *(if known)*:	**Insured:**

Please indicate below when you would like your account drafted. Many of our customers have requested the option to pay their premiums on the same day they receive Social Security or SSI payments. The options below allow you to select the date that best fits your needs. You may select any option regardless of whether or not you receive Social Security or SSI payments.

Part I – Select one of the following date options

Bank Draft Day *(choose one)*: ***Note:*** *If one of the dates below falls on a weekend or holiday, deduction will be on* ***prior*** *business day.*

- ☐ 1st day of the Month
- ☐ 3rd day of the Month
- ☐ 2nd Wednesday of the Month
- ☐ 3rd Wednesday of the Month
- ☐ 4th Wednesday of the Month

☐ Other, please specify a day of the month from 1 to 28 _____ *(**Note:** if this date falls on a weekend or holiday, deduction will be on **next** business day that falls between the 1st and 28th)*

IMPORTANT: If this form is being submitted with an application and the bank draft day selected above differs from the bank draft day indicated on the application, the selection made on this form will govern.

Part II – Select one of the following payment options

☐ Checking ☐ Savings Branch/Bank Name:_____

Routing Number												
Account Number												

☐ Check here if this is a business account

To ensure accuracy, please include a voided check or deposit slip.

Part III – Complete name and address as shown on account

Accountholder Name: _____

Address (include City, State, and ZIP): _____

Part IV – Sign and Date

As a convenience to me, I hereby request and authorize the banking institution below (the "Bank") to pay and charge to my account drafts on my account by and payable to the order of the company who issued or assumed the policy listed below (the "Company") administering my insurance policy provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that the Bank's rights in respect to such draft shall be the same as if it were a check drawn on the bank and signed personally by me. **This authorization will remain in effect until revoked by me or the Company. Notifications should be sent to PO BOX 10812, Clearwater, FL 33757-8812. Our toll-free number is 877.212.2346 and our customer service fax number is 816.701.2534.** I agree that the Bank shall be fully protected in honoring any such draft. I further agree that if any such draft be dishonored, whether with or without cause and whether intentionally or inadvertently, the Bank shall be under no liability whatsoever. Should any draft not be honored by the Bank upon presentation, I understand that this method of payment may be terminated.

I understand that Americo requires a 5 business day advance notice to set up, change, or discontinue my bank draft information. I also understand that my insurance policy may lapse if said draft is returned unpaid by my Bank, or if I discontinue payments, prior to receiving confirmation of draft processing from the Company. ***Please keep a copy of this authorization with your banking records.***

_____ _____

Signature Date

Americo Financial Life and Annuity Insurance Company
Medicare Supplement Administrative Office: PO Box 10812, Clearwater, FL 33757-8812

INFORMATION PRACTICES NOTICE

THIS NOTIFICATION MUST BE DELIVERED TO THE PROPOSED INSURED WHEN THE APPLICATION IS COMPLETED.

Thank you for your application. This notice is given to you at the time you apply for life insurance to tell you about the kinds of information we may obtain in connection with your application. We rely primarily on information provided by you. We may also collect information from others, such as medical professionals who have treated you, hospitals, other insurance companies, and consumer reporting agencies. In certain limited situations, we are allowed by law to disclose necessary items of personal information to third parties without your specific authorization. You have a right of access and correction with respect to this information. You have the right to receive, in writing, the specific reason for an adverse underwriting decision. If you wish a more detailed explanation of our information practices, please write us at: Americo Financial Life and Annuity Insurance Company, PO BOX 410288, Kansas City, MO 64141-0288, Attention: Underwriting/New Business Department. Any requests to correct, amend or alter will be responded to within 30 days. Information that is corrected will be provided to any person who is designated by the requesting party and who may have received the information in the prior two years (within a seven year timeframe). Any statement of disagreement made by a requesting party will be filed and made available to those reviewing it in the future.

MIB, INC. PRE-NOTICE

Information regarding your insurability will be treated as confidential. However, Americo Financial Life and Annuity Insurance Company or its reinsurers may make a brief report to the MIB, Inc. formerly known as Medical Information Bureau, a nonprofit membership organization of life insurance companies operating as an information exchange for its members. If you apply to another MIB member company for life or health insurance or a claim is submitted to such a company, upon request the MIB will supply the company with the information it has in its file.

Upon receipt of a request from you, the MIB, Inc., will arrange disclosure of any information it has in your file. Please contact MIB at 866.692.6901 (TTY 866.346.3642). If you question the accuracy of information in the file, you may contact the MIB and seek a correction in accordance with the procedures in the Fair Credit Reporting Act. The MIB's information office address is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734. The Company or its reinsurers may release information in its file to its reinsurers and to other life and health insurance companies to whom you apply for insurance or to whom a claim is submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

INVESTIGATIVE CONSUMER REPORTS

We may make or obtain an investigative consumer report, which may contain information secured through personal interviews with your friends, neighbors and others with whom you are acquainted. This report may contain information as to your character, general reputation, personal characteristics and mode of living. The consumer reporting agency may keep a copy of the report and may disclose its contents to others for whom it performs such services. On receipt of a request from you, we will tell you if a report has been requested and we will provide you with the name, address, and telephone number of the consumer reporting agency. You may request to be personally interviewed and, when the report is completed, you have a right to inspect and receive a copy of it from the consumer reporting agency. Please send your request to: Americo Financial Life and Annuity Insurance Company, PO BOX 410288, Kansas City, MO 64141-0288, Attention: Underwriting Department.

Producer
Statement
AAA5500-AS

Americo Financial Life and Annuity Insurance Company
Medicare Supplement Administrative Office: PO Box 10812, Clearwater, FL 33757-8812

All questions must be completed

1. Did you meet with the Applicant in person? ☐ Yes ☐ No
2. Did you complete this Application over the phone? ☐ Yes ☐ No
3. State the name and relationship of any other person present with this Application was taken:
   Name:_____ Relationship to Applicant:_____
4. Did you review the Application for correctness and any omissions? ☐ Yes ☐ No
5. Did the Applicant review the Application for correctness and any omissions? ☐ Yes ☐ No
6. Are you related to the Proposed Insured? ☐ Yes ☐ No

   If **Yes**, provide relationship:_____

Listed below are all other health insurance policies or certificates I have sold (a) sold to the Applicant which are still in force; (b) sold to the Applicant in the last 5 years which are no longer in force.

Company	Type of Policy	Effective Date	In Force
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

_____ _____ _____
Producer #1 Name *(please print)* Producer # Split %

_____ _____ _____
Producer #2 Name *(please print)* Producer # Split %

Medicare Supplement
Premium Worksheet

15-138-9-BB

Americo Financial Life and Annuity Insurance Company

Before you begin, please go to the height and weight chart on the reverse side of this page to determine eligibility for coverage, unless the applicant is in an open enrollment or guaranteed issue period.

	Applicant 1	Applicant 2	**Premium Calculation Example** *Information shown below is for calculation purposes only.*
1. Medicare Supplement Insurance Plan			Plan F
2. Applicant's Age at Effective Date of Coverage			67
3. Applicant's ZIP Code			07104
4. Premium *Write in the Medicare Supplement plan's premium from the Outline of Coverage provided, based on age and ZIP Code.*			$196.78
5. Household Premium Discount *The applicant is eligible for a Household Premium Discount if, in the past year:* *a) The applicant resided with at least one, but no more than three, other adults* who are age 60 and older; or* *b) The applicant lived with another adult* who is their legal spouse.* *If **yes**, multiply the amount from Step 4 by .9.* *If **no**, enter the amount from Step 4.* **In Idaho, New Jersey, and North Dakota, the Household Premium Discount is only available if the other adult(s) also has or will have an Americo policy.*			$196.78 X .9 = $177.10 *In this example, the applicant qualifies for the household premium discount.*
6. Rate Adjustment *If the applicant is in open enrollment or guaranteed issue period, skip to Step 7.* *Locate height and weight on the next page.* *If weight is in the Standard column, enter the amount from Step 5.* *If weight is in the Class I column, multiply the amount from Step 5 by: 1.15.*			$177.10 X 1.15 = $203.67 *In this example, the applicant's weight is in the Class I column.*
7. Payment Options *The monthly payment is the last premium entered (Step 5 or 6).* *To determine annual premium, multiply by 12.*			$203.67 monthly payment $2,444.04 annual payment

Medicare Supplement
Premium Worksheet 15-138-9-BB

Americo Financial Life and Annuity Insurance Company

Eligibility: Find the applicant's height in the left-hand column and look across the row to find the applicant's weight. If the weight is in the Decline column, the applicant is not eligible for coverage at this time.

Rate Adjustment: The column heading above the applicant's weight will indicate your appropriate rate adjustment, if any (risk class).

	Decline	Class I	Standard	Class I	Decline
Height	Weight	Weight	Weight	Weight	Weight
4' 6"	< 63	63 – 70	71 – 128	129 – 170	171 +
4' 7"	< 65	65 – 73	74 – 133	134 – 176	177 +
4' 8"	< 67	67 – 75	76 – 138	139 – 182	183 +
4' 9"	< 70	70 – 78	79 – 143	144 – 189	190 +
4' 10"	< 72	72 – 81	82 – 148	149 – 196	197 +
4' 11"	< 75	75 – 84	85 – 153	154 – 202	203 +
5' 0"	< 77	77 – 87	88 – 158	159 – 209	210 +
5' 1"	< 80	80 – 89	90 – 164	165 – 216	217 +
5' 2"	< 83	83 – 92	93 – 169	170 – 224	225 +
5' 3"	< 85	85 – 95	96 – 175	176 – 231	232 +
5' 4"	< 88	88 – 99	100 – 180	181 – 238	239 +
5' 5"	< 91	91 – 102	103 – 186	187 – 246	247 +
5' 6"	< 93	93 – 105	106 – 192	193 – 254	255 +
5' 7"	< 96	96 – 108	109 – 197	198 – 261	262 +
5' 8"	< 99	99 – 111	112 – 203	204 – 269	270 +
5' 9"	< 102	102 – 115	116 – 209	210 – 277	278 +
5' 10"	< 105	105 – 118	119 – 216	217 – 285	286 +
5' 11"	< 108	108 – 121	122 – 222	223 – 293	294 +
6' 0"	< 111	111 – 125	126 – 228	229 – 302	303 +
6' 1"	< 114	114 – 128	129 – 234	235 – 310	311 +
6' 2"	< 117	117 – 132	133 – 241	242 – 319	320 +
6' 3"	< 121	121 – 136	137 – 248	249 – 328	329 +
6' 4"	< 124	124 – 139	140 – 254	255 – 336	337 +
6' 5"	< 127	127 – 143	144 – 261	262 – 345	346 +
6' 6"	< 130	130 – 147	148 – 268	269 – 354	355 +
6' 7"	< 134	134 – 150	151 – 275	276 – 363	364 +
6' 8"	< 137	137 – 154	155 – 282	283 – 373	374 +
6' 9"	< 140	140 – 158	159 – 289	290 – 382	383 +
6' 10"	< 144	144 – 162	163 – 296	297 – 392	393 +
6' 11"	< 147	147 – 166	167 – 303	304 – 401	402 +
7' 0"	< 151	151 – 170	171 – 311	312 – 411	412 +
7' 1"	< 155	155 – 174	175 – 318	319 – 421	422 +
7' 2"	< 158	158 – 178	179 – 326	327 – 431	432 +
7' 3"	< 162	162 – 183	184 – 333	334 – 441	442 +
7' 4"	< 166	166 – 187	188 – 341	342 – 451	452 +

AMERICO FINANCIAL LIFE AND ANNUITY INSURANCE COMPANY

Outline of Coverage

Medicare Supplement Benefit Plans A, F, G and N.

This chart show the benefits included in each of the standard Medicare Supplement plans. Every insurer must make available Plan "A." Some plans may not be available in your state. See Outline of Coverage sections for details about ALL plans. **"Basic Benefits"** are:

- **Hospitalization** – Part A coinsurance plus coverage for 365 additional days after Medicare Benefits end.
- **Medical Expenses** – Part B coinsurance (generally 20% of Medicare approved amounts) or copayments for hospital outpatient services. Plans K, L, and N require insured's to pay a portion of Part B coinsurance or copayments.
- **Blood** – First three pints of blood each year.
- **Hospice** – Part A coinsurance
- **Only Medicare Supplement Benefit Plans A, F, G, and N are offered by Americo Financial Life and Annuity Insurance Company.**

A	B	C	D	F / F*	G	K	L	M	N
Basic including 100% Part B Coinsurance	Basic including 100% Part B Coinsurance	Basic including 100% Part B Coinsurance	Basic including 100% Part B Coinsurance	Basic including 100% Part B Coinsurance	Basic including 100% Part B Coinsurance	Hospitalization and preventative care paid at 100%; other Basic Benefits paid at 50%	Hospitalization and preventative care paid at 100%; other Basic Benefits paid at 75%	Basic including 100% Part B Coinsurance	Basic including 100% Part B Coinsurance, except up to $20 copayment for office visit, and up to $50 copayment for Emergency Room that don't result in inpatient admission.
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Part B Deductible		Part B Deductible					
				Part B Excess 100%	Part B Excess 100%				
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency			Foreign Travel Emergency	Foreign Travel Emergency
						Out of Pocket limit $4,940; paid at 100% after limit reached.	Out of Pocket limit $2,470; paid at 100% after limit reached.		

*Plan F also has an option called a high Deductible Plan F. This high Deductible plan pays the same benefits as Plan F after one has paid a calendar years $2,180 Deductible. Benefits from high Deductible Plan F will not begin until out-of-pocket expenses exceed $2,180. Out-of-pocket expenses for this Deductible are expenses that would have ordinarily been paid by the Policy. These expenses include the Medicare Deductibles for Part A and Part B, but do not include the plans separate foreign travel emergency Deductible.

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Monthly Rates by Plan - Idaho
Zip Codes: All Zip Codes

Non-Tobacco Rates				Issue Age	Tobacco Rates			
Plan A	Plan F	Plan G	Plan N		Plan A	Plan F	Plan G	Plan N
121.87	150.46	127.89	105.32	**65**	140.15	173.03	147.07	121.12
121.87	150.46	127.89	105.32	**66**	140.15	173.03	147.07	121.12
121.87	150.46	127.89	105.32	**67**	140.15	173.03	147.07	121.12
125.00	154.32	131.17	108.02	**68**	143.75	177.46	150.84	124.22
128.20	158.27	134.53	110.79	**69**	147.43	182.02	154.71	127.41
131.49	162.33	137.98	113.63	**70**	151.21	186.68	158.68	130.68
134.86	166.50	141.52	116.55	**71**	155.09	191.47	162.75	134.03
138.32	170.77	145.15	119.54	**72**	159.07	196.38	166.93	137.47
141.83	175.10	148.84	122.57	**73**	163.11	201.37	171.16	140.96
145.43	179.54	152.61	125.68	**74**	167.24	206.47	175.50	144.53
149.12	184.10	156.48	128.87	**75**	171.49	211.71	179.96	148.20
152.90	188.77	160.45	132.14	**76**	175.84	217.08	184.52	151.96
156.78	193.56	164.52	135.49	**77**	180.30	222.59	189.20	155.81
159.80	197.28	167.69	138.10	**78**	183.77	226.87	192.84	158.81
162.87	201.08	170.92	140.75	**79**	187.30	231.24	196.55	161.87
166.01	204.95	174.21	143.46	**80**	190.91	235.69	200.34	164.98
169.20	208.89	177.56	146.22	**81**	194.58	240.23	204.19	168.16
172.46	212.91	180.98	149.04	**82**	198.33	244.85	208.12	171.39
175.13	216.22	183.78	151.35	**83**	201.40	248.65	211.35	174.05
177.85	219.57	186.63	153.70	**84**	204.53	252.50	214.63	176.75
180.61	222.97	189.53	156.08	**85**	207.70	256.42	217.96	179.49
183.41	226.43	192.47	158.50	**86**	210.92	260.40	221.34	182.28
186.26	229.95	195.45	160.96	**87**	214.19	264.44	224.77	185.11
188.12	232.24	197.41	162.57	**88**	216.34	267.08	227.02	186.96
190.00	234.57	199.38	164.20	**89**	218.50	269.75	229.29	188.83
191.90	236.91	201.38	165.84	**90**	220.68	272.45	231.58	190.72
193.82	239.28	203.39	167.50	**91**	222.89	275.17	233.90	192.62
195.76	241.68	205.42	169.17	**92**	225.12	277.93	236.24	194.55
197.71	244.09	207.48	170.86	**93**	227.37	280.71	238.60	196.49
199.69	246.53	209.55	172.57	**94**	229.65	283.51	240.99	198.46
201.69	249.00	211.65	174.30	**95**	231.94	286.35	243.40	200.44
201.69	249.00	211.65	174.30	**96**	231.94	286.35	243.40	200.44
201.69	249.00	211.65	174.30	**97**	231.94	286.35	243.40	200.44
201.69	249.00	211.65	174.30	**98**	231.94	286.35	243.40	200.44
201.69	249.00	211.65	174.30	**99**	231.94	286.35	243.40	200.44

For Annual Premium mode, multiply monthly rates by 12.
For Class 1 rates multiply by 1.15.

AMERICO FINANCIAL LIFE AND ANNUITY INSURANCE COMPANY

Outline of Coverage

Medicare Supplement Benefit Plans A, F, G and N.

Disclosures. Use this outline to compare benefits and premiums among policies.

Premium Information. Americo Financial Life and Annuity Insurance Company can only raise your premium if we raise the premium for all policies like yours in the same geographic area of the state where you live. Schedules of rates may vary depending upon your effective date.

Household Premium Discount. If for the past year you have resided with at least one, but no more than three, other Medicare-eligible adults who own or are issued a Medicare Supplement Policy from us, you will be eligible for a household premium discount. The discounted premium will be priced 10% lower than the rates illustrated. Your policy's household premium discount will be removed if the other policyholder no longer resides with you (other than in the case of his or her death).

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

Right to Return Policy. If you find that you are not satisfied with your policy, you may return it to us at our Medicare Supplement Administrative Offices PO Box 10812, Clearwater, FL 33257-8812. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

Policy Replacement. If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

Exceptions and Limitations. We will not pay benefits for: (a) expense incurred while this Policy is not in force, except as provided in the EXTENSION OF BENEFITS section; (b) Hospital or Skilled Nursing Facility confinement incurred during a Medicare Part A Benefit Period that begins while this Policy is not in force; (c) that portion of any expense incurred which is paid for by Medicare; (d) (d) any expense that duplicates payments made under any other provision of the Policy; (e) services for non-Medicare Eligible Expenses, including, but not limited to, routine exams, take-home drugs and eye refractions; (f) services for which a charge is not normally made in the absence of insurance; (g) loss or expense that is payable under any other Medicare Supplement Insurance policy or certificate; or (h expenses which are not determined to be Medicare Eligible Expenses by the Federal Medicare Program or its administrators, except to the extent provided in the Policy.

Notice. The policy may not fully cover all of your medical costs. Neither we nor our agents are connected with Medicare. This outline does not give all the details of Medicare coverage. Contact your local Social Security office or consult “Medicare & You” for more details.

Complete Answers Are Very Important. When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. We may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information. **Review the application carefully before you sign it. Be certain that all information has been properly recorded.**

No Health Review. No health review is required if you enroll within the first six months after you reach age 65 and enroll in Medicare Part B, or in other situations as required by law.

PLEASE REFER TO YOUR POLICY FOR DETAILS.

AMERICO

AMERICO FINANCIAL LIFE AND ANNUITY INSURANCE COMPANY
Outline of Coverage
Medicare Supplement Benefit Plans A, F, G and N.

Plan A

Medicare Part A – Hospital Services Per Benefit Period

A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

Services	Medicare Pays	Plan A Pays	You Pay
Hospitalization			
Semiprivate room and board, general nursing and miscellaneous services and supplies.			
First 60 days	All but $1,260	$0	$1,260 Part A Deductible
61st thru 90th day	All but $315 a day	$315 a day	$0
91st day and after			
- While using 60 lifetime reserve days	All but $630 a day	$630 a day	$0
- Once lifetime reserve days are used			
▪ Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
▪ Beyond the additional 365 days	$0	$0	All Costs
Skilled Nursing Facility Care			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st thru 100th days	All but $157.50 a day	$0	Up to $157.50 a day
101st day and after	$0	$0	All Costs
Blood			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
Hospice Care			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care.	Medicare copayment/coinsurance	$0

*When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

AMERICO

AMERICO FINANCIAL LIFE AND ANNUITY INSURANCE COMPANY
Outline of Coverage
Medicare Supplement Benefit Plans A, F, G and N.

Plan A

Medicare Part B – Medical Services per Calendar Year

Once you have been billed $147 of Medicare Eligible Expenses for covered services (which are noted with an asterisk), your Medicare Part B Deductible will have been met for the calendar year.

Services	Medicare Pays	Plan A Pays	You Pay
Medical Expenses In or out of the hospital and outpatient hospital treatment, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $147 of Medicare approved amounts*	$0	$0	$147 Part B Deductible
Remainder of Medicare approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (above Medicare approved amounts)	$0	$0	All costs
Blood			
First 3 pints	$0	All costs	$0
Next $147 of Medicare approved amounts*	$0	$0	$147 Part B Deductible
Remainder of Medicare approved amounts	80%	20%	$0
Clinical Laboratory Services – Tests for diagnostic services	100%	$0	$0

Parts A & B

Services	Medicare Pays	Plan A Pays	You Pay
Home Health Care Medicare Eligible Services			
- Medically necessary skilled care services and medical supplies	100%	$0	$0
- Durable medical equipment. First $147 of Medicare approved amounts*	$0	$0	$147 Part B Deductible
- Remainder of Medicare approved amounts	80%	20%	$0

AMERICO

AMERICO FINANCIAL LIFE AND ANNUITY INSURANCE COMPANY
Outline of Coverage
Medicare Supplement Benefit Plans A, F, G and N.

Plan F

Medicare Part A – Hospital Services Per Benefit Period

A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

Services	Medicare Pays	Plan F Pays	You Pay
Hospitalization Semiprivate room and board, general nursing and miscellaneous services and supplies.			
First 60 days	All but $1,260 a day	$1,260 Part A Deductible	$0
61st thru 90th day	All but $315 a day	$315 a day	$0
91st day and after			
- While using 60 lifetime reserve days	All but $630 a day	$630 a day	$0
- Once lifetime reserve days are used			
▪ Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
▪ Beyond the additional 365 days	$0	$0	All Costs
Skilled Nursing Facility Care You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st thru 100th days	All but $157.50 a day	Up to $157.50 a day	$0
101st day and after	$0	$0	All Costs
Blood			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
Hospice Care You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care.	Medicare copayment/coinsurance	$0

**When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

AMERICO

AMERICO FINANCIAL LIFE AND ANNUITY INSURANCE COMPANY
Outline of Coverage
Medicare Supplement Benefit Plans A, F, G and N.

Plan F

Medicare Part B – Medical Services per Calendar Year

Once you have been billed $147 of Medicare Approved amounts for covered services (which are noted with an asterisk), your Medicare Part B Deductible will have been met for the calendar year.

Services	Medicare Pays	Plan F Pays	You Pay
Medical Expenses In or out of the hospital and outpatient hospital treatment, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First $147 of Medicare approved amounts* Remainder of Medicare approved amounts	 $0 Generally 80%	 $147 Part B Deductible Generally 20%	 $0 $0
Part B Excess Charges (above Medicare approved amounts)	$0	100%	$0
Blood First 3 pints Next $147 of Medicare approved amounts* Remainder of Medicare approved amounts	 $0 $0 80%	 All costs $147 Part B Deductible $20%	 $0 $0 $0
Clinical Laboratory Services – Tests for Diagnostic services	100%	$0	$0

Parts A & B

Services	Medicare Pays	Plan F Pays	You Pay
Home Health Care Medicare Eligible Services - Medically necessary skilled care services and medical supplies - Durable medical equipment. First $147 of Medicare approved amounts* - Remainder of Medicare approved amounts	 100% $0 80%	 $0 $147 Part B Deductible 20%	 $0 $0 $0

Other Benefits Not Covered by Medicare

Services	Medicare Pays	Plan F Pays	You Pay
Foreign Travel Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA. First $250 each calendar year Remainder of charges	 $0 $0	 $0 80% to a lifetime maximum benefit of $50,000.	 $250 20% and amounts over the $50,000 lifetime maximum.

AMERICO

AMERICO FINANCIAL LIFE AND ANNUITY INSURANCE COMPANY
Outline of Coverage
Medicare Supplement Benefit Plans A, F, G and N.

Plan G

Medicare Part A – Hospital Services Per Benefit Period

A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

Services	Medicare Pays	Plan G Pays	You Pay
Hospitalization Semiprivate room and board, general nursing and miscellaneous services and supplies.			
First 60 days	All but $1,260	$1,260 Part A Deductible	$0
61st thru 90th day	All but $315 a day	$315 a day	$0
91st day and after			
- While using 60 lifetime reserve days	All but $630 a day	$630 a day	$0
- Once lifetime reserve days are used			
▪ Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
▪ Beyond the additional 365 days	$0	$0	All Costs
Skilled Nursing Facility Care You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st thru 100 days	All but $157.50 a day	Up to $157.50 a day	$0
101st day and after	$0	$0	All Costs
Blood			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
Hospice Care You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care.	Medicare copayment/coinsurance	$0

**When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

AMERICO

AMERICO FINANCIAL LIFE AND ANNUITY INSURANCE COMPANY
Outline of Coverage
Medicare Supplement Benefit Plans A, F, G and N.

Plan G
Medicare Part B – Medical Services per Calendar Year

Once you have been billed $147 of Medicare approved amounts for covered services (which are noted with an asterisk), your Medicare Part B Deductible will have been met for the calendar year.

Services	Medicare Pays	Plan G Pays	You Pay
Medical Expenses In or out of the hospital and outpatient hospital treatment, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $147 of Medicare approved amounts* Remainder of Medicare approved amounts	$0 Generally 80%	$0 Generally 20%	$147 Part B Deductible $0
Part B Excess Charges (above Medicare approved amounts)	$0	100%	$0
Blood First 3 pints Next $147 of Medicare approved amounts* Remainder of Medicare approved amounts	 $0 $0 80%	 All costs $0 $20%	 $0 $147 Part B Deductible $0
Clinical Laboratory Services – Tests for Diagnostic services	100%	$0	$0

Parts A & B

Services	Medicare Pays	Plan G Pays	You Pay
Home Health Care Medicare Eligible Services - Medically necessary skilled care services and medical supplies - Durable medical equipment. First $147 of Medicare approved amounts* - Remainder of Medicare approved amounts	 100% $0 80%	 $0 $0 20%	 $0 $147 Part B Deductible $0

AMERICO FINANCIAL LIFE AND ANNUITY INSURANCE COMPANY
Outline of Coverage
Medicare Supplement Benefit Plans A, F, G and N.

Plan G

Other Benefits Not Covered by Medicare

Services	Medicare Pays	Plan G Pays	You Pay
Foreign Travel Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA. First $250 each calendar year Remainder of Charges	 $0 $0	 $0 80% to a lifetime maximum benefit of $50,000.	 $250 20% and amounts over the $50,000 lifetime maximum.

AMERICO FINANCIAL LIFE AND ANNUITY INSURANCE COMPANY
Outline of Coverage
Medicare Supplement Benefit Plans A, F, G and N.

Plan N

Medicare Part A – Hospital Services Per Benefit Period
A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

Services	Medicare Pays	Plan N Pays	You Pay
Hospitalization			
Semiprivate room and board, general nursing and miscellaneous services and supplies.			
First 60 days	All but $1,260	$1,260 Part A Deductible	$0
61st thru 90th day	All but $315 a day	$315 a day	$0
91st day and after			
- While using 60 lifetime reserve days	All but $630 a day	$630 a day	$0
- Once lifetime reserve days are used			
▪ Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
▪ Beyond the additional 365 days	$0	$0	All Costs
Skilled Nursing Facility Care			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st thru 100 days	All but $157.50 a day	$All but $157.00	$0
101st day and after	$0	$0	All Costs
Blood			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
Hospice Care			
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care.	Medicare copayment/coinsurance	$0

**When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

AMERICO

AMERICO FINANCIAL LIFE AND ANNUITY INSURANCE COMPANY
Outline of Coverage
Medicare Supplement Benefit Plans A, F, G and N.

Plan N

Medicare Part B – Medical Services per Calendar Year

Once you have been billed $147 of Medicare Approved amounts for covered services (which are noted with an asterisk), your Medicare Part B Deductible will have been met for the calendar year.

Services	Medicare Pays	Plan N Pays	You Pay
Medical Expenses In or out of the hospital and outpatient hospital treatment, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $147 of Medicare approved amounts*	$0	$0	$147 Part B Deductible
Remainder of Medicare approved amounts	Generally 80%	Balance, other than up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
Part B Excess Charges (above Medicare approved amounts)	$0	$0	All costs
Blood			
First 3 pints	$0	All costs	$0
Next $147 of Medicare approved amounts*	$0	$0	$147 Part B Deductible
Remainder of Medicare approved amounts	80%	$20%	$0
Clinical Laboratory Services – Tests for diagnostic services	100%	$0	$0

Parts A & B

Services	Medicare Pays	Plan N Pays	You Pay
Home Health Care Medicare Eligible Services			
- Medically necessary skilled care services and medical supplies	100%	$0	$0
- Durable medical equipment. First $147 of Medicare approved amounts	$0	$0	$147 Part B Deductible
- Remainder of Medicare approved amounts	80%	20%	$0

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

Plan N

Other Benefits Not Covered by Medicare

Services	Medicare Pays	Plan N Pays	You Pay
Foreign Travel Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA. First $250 each calendar year Remainder of charges	 $0 $0	 $0 80% to a lifetime maximum benefit of $50,000.	 $250 20% and amounts over the $50,000 lifetime maximum.