MEDICO®
INSURANCE COMPANY
P.O. Box 10386, Des Moines, IA 50306-0386

MICHAEL I CHEIKIN
245 BRADFORD CIRCLE
BLUE BELL PA 19422-0

Your insurance identification cards are included at the bottom of this letter. As you know, you'll need to show your ID card to your health care providers when you receive services.

The back of the card gives information helpful to you and your health care providers:

- A toll-free number to contact our Customer Service Center

- An address for filing claims

Presenting your ID card to your health care providers so they have the information in their records helps make sure you receive all the benefits available under your insurance.

generic-id (4-17)

MEDICO®
INSURANCE COMPANY
www.GoMedico.com

ID: 000M1M105441
Effective Date: 01/01/2023
Insured: MICHAEL I CHEIKIN
Coverage type: Medicare Supplement Plan G

MEDICO®
INSURANCE COMPANY
www.GoMedico.com

ID: 000M1M105441
Effective Date: 01/01/2023
Insured: MICHAEL I CHEIKIN
Coverage type: Medicare Supplement Plan G

Mail Claims to:
Medico Insurance Company
P.O. Box 21660
Eagan, MN 55121-0660

USA Senior Care Network Toll-Free Number: 800-872-3860

http://usamco com/medico/

For benefits and eligibility information, contact Medico Insurance Company at 800-228-6080.

Preauthorization is not required. Benefits will be determined upon receipt of a claim.

Mail Claims to:
Medico Insurance Company
P.O. Box 21660
Eagan, MN 55121-0660

USA Senior Care Network Toll-Free Number: 800-872-3860

http://usamco.com/medico/

For benefits and eligibility information, contact Medico Insurance Company at 800-228-6080.

Preauthorization is not required. Benefits will be determined upon receipt of a claim.

MEDICO®
INSURANCE COMPANY
P.O. Box 10386, Des Moines, IA 50306-0386

December 20, 2022

Policy/Certificate Number: 000M1M105441
Coverage type: Medicare Supplement Plan G

Dear Michael I Cheikin,

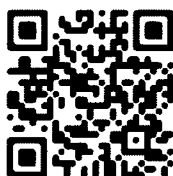
Welcome to the Medico® family. Thank you for choosing us for your insurance needs.

Your new policy is in this packet, and your effective date is 01/01/2023. Premiums will be paid monthly by automatic bank draft and will be withdrawn on the 1st of the month when the premium is due.

Please complete these steps:

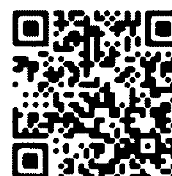
- ☐ Review the policy and application for accuracy. Notify us as soon as possible if any information has changed or is incorrect.
- ☐ Terminate any previous coverage with another insurance company if you are replacing existing coverage with this policy.
- ☐ Access the "Guide to Health Insurance for People with Medicare" on our website at www.GoMedico.com/products (scan QR code below).
- ☐ Register for the customer portal by visiting www.gomedico.com and clicking on "Member Login" at the top of the page or scanning the QR code below. You can then access policy information, download forms, check claim status, enroll in automatic payments through your bank account, and more.
- ☐ Download the MyMedico mobile app at GoMedico.com/mobile-app to review coverage, check claims, email your ID card, find providers, and more.

Customer portal
GoMedico.com,"Member Login"



MyMedico app
GoMedico.com/mobile-app

Medicare Guide
GoMedico.com/products



You may also call our Customer Success team at 800-228-6080, Monday through Friday, from 7:30 a.m. to 5 p.m. Central time with any questions. Thank you again for entrusting us with your insurance needs.

Sincerely,

Thomas A. Swank, President

Policyholders of Medico Insurance Company are members of American Enterprise Mutual Holding Company ("AEMHC"). Membership interests include the right to vote at an AEMHC annual or special meeting for the election of directors and on any proposition submitted to a vote of the members, as provided by AEMHC's Articles of Incorporation, its Bylaws, and other rights as provided by law. You can learn more about the organization by visiting www.americanenterprise.com.

MEDICO®

INSURANCE COMPANY

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Notice of Privacy Practices for American Enterprise Group Affiliated Covered Entity

MEDICAL

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices covers an affiliated covered entity. When the notice refers to "we," "our," or "us," it is referring to the following affiliated entities: American Republic Insurance Company, Medico Insurance Company, Medico Life and Health Insurance Company, American Republic Corp Insurance Company, and Medico Corp Life Insurance Company. For purposes of complying with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as amended by the Health Information Technology for Economic and Clinical Health Act (HITECH), the combined companies listed are designated as a single covered entity. The single covered entity shall be known as the "American Enterprise Group ACE." This designation may be amended from time to time to add new covered entities that are under common control and ownership with the American Enterprise Group ACE.

We respect the confidentiality of your health information and will protect your information in a responsible and professional manner. We are required by law to maintain the privacy of your health information and to send you this notice. This notice explains how we use information about you and when we can share that information with others. It also informs you of your rights with respect to your health information and how you can exercise those rights.

When we talk about "information" or "health information" in this notice we mean individually identifiable health information, as defined by HIPAA. Individually identifiable health information is health information that:

- Is created or received by the American Enterprise Group ACE's designated health care components;
- Relates to the past, present, or future physical or mental health condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual; and
- Identifies the individual, or with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

How We Use or Share Information

Subject to state and federal laws, we are permitted to use and/or share your information without your authorization in certain circumstances, such as:

- To use or disclose the information for payment purposes. For example, we may use the information to help pay medical bills that have been submitted to us by doctors and hospitals for payment or to contact your doctor to obtain medical records in order to make claim payment decisions.
- To use or disclose the information to perform health care operations. For example, we may use the information for activities relating to underwriting; customer service; legal services; and auditing functions, including fraud and abuse detection and compliance programs. We will not use or disclose genetic information, including family history, for underwriting purposes.
- To use or disclose your information to provide you with information about health related benefits and services that you may be interested in. We will not share your information with or sell it to telemarketing agencies or other agencies that market products other than those products provided or administered by the American Enterprise Group ACE or its business associates without your authorization.
- If you are available and do not object, we may disclose information to a member of your family, a friend, or other person you identify who is involved in your health care or the payment of a claim. If you are unavailable, incapacitated, or facing an emergency medical situation, and we determine that a limited disclosure is in your best interest, we may share limited information with such persons.
- To disclose information to a disaster relief organization in order for the organization to communicate with a family member or other person involved in your care.

State and federal laws may require or permit us to release your information to others without your authorization, such as:

- To use and disclose information to the extent required to comply with the law.
- To report information to state and federal agencies that regulate us, such as the U.S. Department of Health and Human Services and the Iowa Insurance Division.
- To share information for public health activities.
- To use or disclose information to avert a serious health or safety threat.
- To share information with a health oversight agency for certain oversight activities authorized by law such as audits, inspections, licensure, and disciplinary actions.
- To disclose information in the course of a judicial or administrative proceeding, such as pursuant to a subpoena.
- To report information for law enforcement purposes.
- To report information to a government authority regarding child abuse, neglect, or domestic violence.
- To share information with a coroner or medical examiner to identify a deceased person, determine a cause of death, or as
- To use or disclose information for research purposes, but only as permitted by law.
- To share information for specialized government functions, such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others.
- To report information on job-related injuries because of requirements of your state workers' compensation laws.

NOTICE OF PRIVACY PRACTICES—MEDICAL (continued)

In the event that an applicable law prohibits or materially limits one of the uses or disclosures of information described above, we will restrict the use or disclosure in accordance with the more stringent law. If one of the above reasons for a use or disclosure does not apply, **we must get your written permission, in the form of an authorization, to use or disclose your information.** In any case, we must obtain authorization for the use and disclosure of psychotherapy notes. If you give us written permission and change your mind you may revoke your authorization at any time except to the extent that we have taken action in reliance on the authorization or, if the authorization was obtained as a condition of obtaining insurance coverage, other law provides us with the right to contest a claim under the policy or the policy itself.

What Are Your Rights?

The following are your rights with respect to your information. If you would like to exercise the following rights, please contact our Customer Care Center. Contact information for our Customer Care Center is located at the end of this Notice.

- **You have the right to be notified** in the event there is a breach of your health information.
- **You have the right to ask us to restrict:** (a) how we use or disclose your information for payment or health care operations; (b) information that we have been asked to give to family members or to others who are involved in your health care or payment for your health care; and (c) uses and disclosures for disaster relief purposes. Please note that while we will try to accommodate reasonable requests, we are not required to agree to these restrictions.
- **You have the right to request confidential communications of information.** For example, if you believe that you would be harmed if we send your information to your current mailing address (for example, in situations involving domestic disputes or violence), you can ask us to send the information by alternative means (for example, by fax) or to an alternative address. We will accommodate your reasonable requests as explained above.
- **You have the right to copy and inspect certain components of your information that we maintain.** All requests for access must be made in writing and signed by you or your representative. Access request forms are available from our Customer Care Center at the address below. We may charge you a fee for copying and postage.
- **You have the right to request that certain components of your information be amended to correct an error or omission.** We are not obligated to make all requested amendments but will give each request careful consideration. All amendment requests must be in writing, signed by you or your representative, and must state the reasons for the requested amendment. Amendment request forms are available from our Customer Care Center.
- **You have the right to receive an accounting** of certain disclosures of your information. Accounting request forms are available from our Customer Care Center at the address below. The first accounting in any 12-month period is free; however, we may charge you a fee for each subsequent accounting you request in the same 12-month period. Please note that we are not required to release:
  - Any information collected prior to April 14, 2003.
  - Information disclosed or used for treatment, payment, and/or health care operations purposes.
  - Information disclosed to you or pursuant to your authorization.
  - Information that is incidental to a use or disclosure otherwise permitted.
  - Information disclosed for a facility's directory or to person involved in your care or other notification purposes.
  - Information disclosed for national security or intelligence purposes.
  - Information disclosed to correctional institutions, law enforcement officials, or health oversight agencies.
  - Information that was disclosed or used as part of a limited data set for research, public health, or health care operations purposes.

Exercising Your Rights

You have a right to receive a copy of this notice upon request at any time. We are required to abide by the terms of this notice. Should any of our privacy practices change, we reserve the right to change the terms of this notice and to make the new notice effective for all protected health information we maintain. Once revised, we will provide the new notice to you by mail. If you believe your privacy rights have been violated, you may file a complaint with us by contacting our Customer Care Center. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. **We will not take any action against you for filing a complaint.**

Contact Information

If you have any questions or complaints, please contact us at:

Notice of Privacy Practices
American Enterprise Group
P.O. Box 1
Des Moines, IA 50306-0001

You can call us at **800-247-2190** or visit **www.americanenterprise.com**.

Notice of Privacy Practices for American Enterprise Group Companies

FINANCIAL

THIS NOTICE APPLIES TO ALL PROSPECTS, APPLICANTS, CUSTOMERS AND FORMER CUSTOMERS WHO HAVE INQUIRED ABOUT OR PURCHASED INSURANCE PRODUCTS USED PRIMARILY FOR PERSONAL, FAMILY OR HOUSEHOLD PURPOSES.

At AmericanEnterprise Group Companies, including but not limited to American Republic Insurance Company, American Republic Corp Insurance Company, Medico Insurance Company, Medico Life and Health Insurance Company, and Medico Corp Life Insurance Company, ("Company") we keep your personal information confidential and share it only in a responsible manner as necessary to provide and service the products you purchase from us or to offer you additional products.

What Information Do We Collect?

To provide and administer products and services, we must refer to relevant personal information that can be identified to you or your household and that may not be available in public records ("nonpublic personal information"). We collect only the following information required to conduct business:

- Identity information received from your application, such as name, address, social security number, and age.
- Information about your transactions with us, including your identification and policy number(s), the type of products you buy, the premiums you pay, and how you purchased your coverage.
- Information received from a consumer reporting or credit agency or from public records (such as your driving record) as needed by our insurance underwriting practices.
- Information received from a third-party agency, such as consumer purchasing or census data.
- Information received from service providers regarding treatment of health conditions and payment for that treatment.

What Information Do We Share With Others?

To help us provide you with the best possible products and services, we maintain strong relationships with business associates. In the course of conducting business and as permitted or required by law, we may share any of the listed nonpublic personal information with our business associates for the following purposes:

- To process your application and issue your policy.
- To pay your claims.
- To make any policy changes you may request.
- To offer you additional opportunities to improve your financial security.

We may also disclose relevant portions of the information we collect, as described above, to companies that perform services on our behalf or with whom we have joint marketing agreements. We will not, however, disclose your health information for marketing purposes.

Other than the disclosures listed above, we do not release your information to nonaffiliated third parties. We will not for any reason share your information with or sell it to telemarketing agencies or other agencies that market products other than those products provided or administered by the Company or its business associates. Our business associates are bound by the same restrictions on the release and use of such information as the Company. Any future alliances with business associates which include personal information sharing will follow the same policy.

Fair Credit Reporting Act

We do not disclose information subject to the Fair Credit Reporting Act except as permitted or required by law. To the extent that we decide in the future to make any disclosures of your nonpublic personal financial information that are subject to the Act, we will follow the necessary requirements of the Act including providing you with the opportunity to restrict our ability to disclose information.

How Do We Protect Your Information?

We maintain appropriate physical, electronic and procedural safeguards to ensure the confidentiality of your nonpublic personal information. We follow security standards and procedures to help prevent unauthorized access to personal information. Only employees who need the information we collect from or about you to provide products or services to you may access that information. Employees are required to comply with our established policies.

What About Former Customers?

We do not disclose information about former customers unless permitted or required by law.

How Can You Correct Inaccurate Information?

We want to keep our records of your information accurate. If you discover inaccuracies in any communications from us, please call customer service at the number listed on your policy or certificate materials. We will respond promptly when we learn corrections are needed.

Questions?

If you have any questions, you can call us at **800-247-2190** or visit **www.americanenterprise.com**.

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SUMMARY OF THE LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT AND NOTICE CONCERNING LIMITATIONS AND EXCLUSIONS

INTRODUCTION

Residents of Pennsylvania who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Pennsylvania Life and Health Insurance Guaranty Association (PLHIGA). The purpose of this Association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in Pennsylvania and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Association is limited, however. As noted below, this protection is not a substitute for consumers' care in selecting companies that are well managed and financially stable. Insurance companies and their agents are prohibited by law from using the existence of the association to induce you to purchase any kind of insurance policy.

This Information is Provided By:

Pennsylvania Life and Health Insurance Guaranty Association
290 King of Prussia Road
Radnor Station Building 2, Suite 218
Radnor, PA 19087
(610) 975-0572

SUMMARY

The state law that provides for this safety-net coverage is called the Pennsylvania Life and Health Insurance Guaranty Association Act. Below is a brief summary of the law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the Association.

Coverage. Generally, individuals will be protected by the Pennsylvania Life and Health Insurance Guaranty Association if they live in this state and hold a life or health insurance contract, or an annuity, or if they hold certificates under a group life or health insurance contract or annuity, issued by a member insurer. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

Exclusions From Coverage. Persons holding such policies or contracts are not protected by this Association if:

- they are not residents of the State of Pennsylvania, except under certain very specific circumstances;
- the insurer was not authorized or licensed to do business in Pennsylvania at the time the policy or contract was issued;
- their policy was issued by a nonprofit hospital or health service corporation (e.g., a blue cross or blue shield plan), an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The Association also does not provide coverage for:

- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk;
- any policy of reinsurance (unless an assumption certificate was issued);
- plans of employers, associations or similar entities to the extent they are self-funded or uninsured (that is, not insured by an insurance company, even if an insurance company administers them);
- interest rate yields that exceed an average rate;
- dividends;
- experience rating credits;
- credits given in connection with the administration of a policy or contract;
- annuity contracts or group annuity certificates used by nonprofit insurance companies to provide retirement benefits for nonprofit educational institutions and their employees;
- policies, contracts, certificates or subscriber agreements issued by a prepaid dental care plan;
- sickness and accident insurance when written by a property and casualty insurer as part of an automobile insurance contract;

- unallocated annuity contracts issued to an employee benefit plan protected under the federal Pension Benefit Guaranty Corporation;

- financial guarantees, funding agreements or guaranteed investment contracts not containing mortality guarantees and not issued to or in connection with a specific employee benefit plan or governmental lottery;

- any kind of insurance or annuity, the benefits of which are exclusively payable or determined by a separate account required by the terms of such insurance policy or annuity maintained by the insurer or by a separate entity.

Limits On Amount of Coverage. The act also limits the amount the Association is obligated to pay out. The Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Association will pay a maximum of $300,000 – no matter how many policies and contracts there were with the same company, even if they provided different types of coverages.

Subject to the over-all $300,000 limit, the Association will pay up to $300,000 in life insurance death benefits, but not more than $100,000 in net cash surrender or withdrawal values. For annuities, the Association will pay up to $300,000 in annuity benefits, or $100,000 in net cash surrender or withdrawal benefits. For health insurance, the Association will pay up to $300,000, including any net cash surrender or withdrawal benefits.

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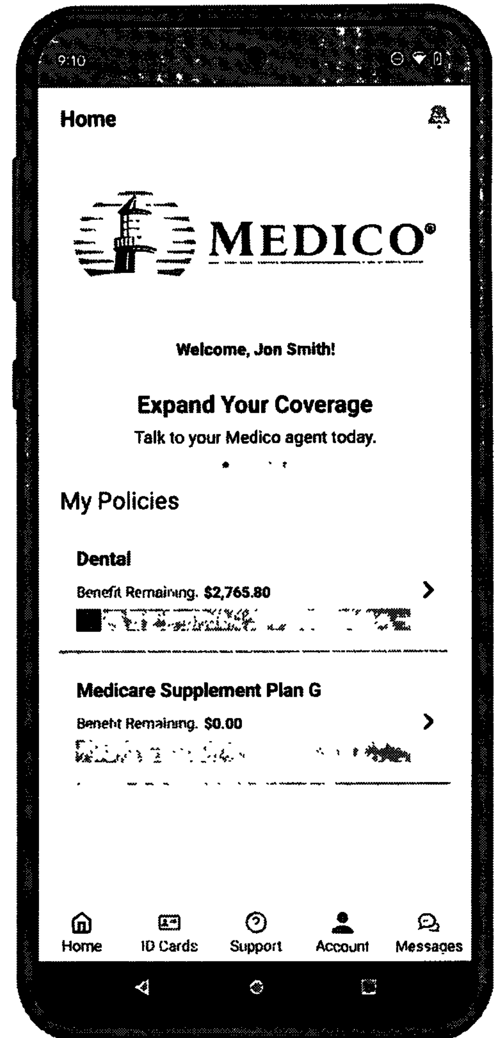


Your benefits are at your fingertips

The Medico customer portal and mobile app make it easy to get the most out of your Medico benefits. Get the answers you need in two easy steps:

Step 1. Register for Medico's customer portal at gomedico.com.

With Medico's secure customer portal, you can safely and conveniently manage your insurance policy online. You'll have 24/7 access to your policy information, including the ability to check claims status, view payment history, print Explanations of Benefits and proof of insurance, order a replacement ID card, make a one-time credit card payment, and more.

Step 2: Download the MyMedico mobile app.

With the free MyMedico mobile app, it's even easier to get the most out of your insurance benefits. Review your coverage, check claims, email your digital ID card, find providers, and more, all with a few taps on your mobile device. Learn more at gomedico.com/mobile-app.

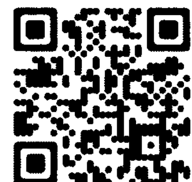
Questions? We are here to help.

Medico Customer Success
800-228-6080
Monday–Friday, 7:30 a.m. to 5 p.m. Central time

You can also contact Customer Success directly through the customer portal and mobile app.

1 **Customer portal**
Register today by visiting gomedico.com and clicking on "Member Login" at the top of the screen. Have your policy number available.

2 **Mobile app**
Using a mobile device, scan the QR code or visit GoMedico.com/Mobile-App to easily download from either the Apple or Android store.



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INSURANCE POLICY/CERTIFICATE

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A STOCK INSURANCE COMPANY
P.O. Box 10386, Des Moines, Iowa 50306-0386
1-800-228-6080

MEDICARE SUPPLEMENT INSURANCE POLICY
PLAN G

IMPORTANT NOTICE: The issuance of this policy is based upon the answers to all questions and any other information on your signed application. Please review the entire contract, including the copy of your application. Contact us at the address shown above within 10 days if any information on your application is not correct and complete. Omissions or misstatements in your application can cause denial of a claim or rescission of your policy. The best time to clear up any questions is now, before a claim arises.

The first premium **you**, the insured, pay and **your** signed application will put this policy in force as of the **policy date**. That date is shown in the **policy schedule**. The **policy schedule** is attached and is a part of this policy.

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, including, but not limited to, policy definitions, conditions, provisions, limitations and exclusions. 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.

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, less any claims paid. That will mean **your** policy was never in force.

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 by the **policy renewal date** or within the grace period. **We** do have the right to change **your** premium as stated in the Premium Change provision. **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. Premiums are based on **your** attained **age**.

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

Our President and Assistant Corporate Secretary sign this policy on **our** behalf.

Thomas A. Swank, President

Margaret A. Brown, Assistant Corporate Secretary

MEDICARE SUPPLEMENT POLICY

GUIDE TO YOUR POLICY

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POLICY SCHEDULE

POLICY NO. - 000M1M105441

INSURED - MICHAEL I CHEIKIN
245 BRADFORD CIRCLE
BLUE BELL, PA 19422

US

----- POLICY PREMIUM -----
MONTHLY $126.07

POLICY DATE..................01/01/2023
FIRST RENEWAL DATE...........01/01/2023
TOTAL FIRST PREMIUM......... $126.07
AGE AT ISSUE........................ 67
FIRST POLICY ANNIVERSARY.....01/01/2024

This policy schedule is not comprehensive; please refer to the Benefits section.

BASIC BENEFITS:

Inpatient Hospital Confinement Benefit (Medicare Part A)
- Medicare's Part A daily coinsurance - 61st - 90th day
- Part A Medicare eligible expenses for Medicare lifetime inpatient reserve days
- 100% of Medicare eligible expenses for hospitalization after Medicare lifetime reserve days have been exhausted for an additional 365 days in your lifetime

Hospice Care Benefit (Medicare Part A)
- Cost sharing for all Part A Medicare eligible expenses for hospice care and respite care

Blood Benefit (Medicare Part A or Part B)
- First three (3) pints of blood each calendar year

Medical Expenses Benefit (Medicare Part B)
- Part B coinsurance (generally 20% of Medicare approved expenses) or copayments for hospital outpatient services

PLAN G ADDITIONAL BENEFITS:

Inpatient Hospital Confinement Deductible Benefit (Medicare Part A)
- 100% of Medicare Part A deductible

Skilled Nursing Facility Confinement Benefit (Medicare Part A)
- Medicare Part A skilled nursing daily facility coinsurance - 21st - 100th day

Medicare Part B Excess Charges Benefit
- 100% of Medicare Part B excess charges (above Medicare approved amounts)

Emergency Care in a Foreign Country Benefit
- 80% of the billed charges for Medicare eligible expenses for medically necessary emergency care received in a foreign country

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SECTION A: DEFINITIONS

Some of the terms found in this policy are defined below and bolded where used. Additional terms may be defined throughout this policy where they are used. Section titles and provision titles may also be capitalized to help you easily recognize them.

Age: Your age on **your** last birthday.

Benefit period: The way that original **Medicare** measures **your** use of **hospital** and skilled nursing facility (SNF) services. A **benefit period** begins the day **you** are admitted as an inpatient in a **hospital** or SNF. The **benefit period** ends when **you** have not gotten any inpatient **hospital** care (or skilled care in a SNF) for 60 days in a row. If **you** go into a **hospital** or a SNF after one **benefit period** has ended, a new **benefit period** begins. **You** must pay the inpatient **hospital** deductible for each **benefit period**. There is no limit to the number of **benefit periods**.

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

Hospice care: A special way of caring for people who are terminally ill. **Hospice care** involves a team-oriented approach that addresses the medical, physical, social, emotional, and spiritual needs of the patient. **Hospice care** also provides support to the patient's family or caregiver.

Hospital: An institution that is approved or eligible to be approved to receive payments from **Medicare** and is accredited by the Joint Commission on Accreditation of Hospitals.

Immediate relative: Your spouse, parent, child, sibling, or any person living with **you**.

Injury: Accidental bodily **injury** that results in loss, independent of **sickness** or other causes. This loss must begin while **your** coverage under this policy is in force.

Medicaid: Title XIX of the Social Security Amendments of 1965, as then constituted or later amended.

Medically necessary: Health care services or supplies needed to diagnose or treat an illness, **injury**, condition, disease, or its symptoms and that meet accepted standards of medicine.

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 and legally entitled to practice in the state or jurisdiction in which services are performed, other than an **immediate relative**.

Policy date: The date on which this policy first became effective. That date is shown in the **policy 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 in the **policy schedule**.

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

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

Residence/reside: The physical location where **you** live. If **you** live in more than one location, and **you** file a United States income tax return, the physical address (not a P.O. Box) shown on **your** United States income tax return as **your** home address will be deemed **your residence**. If **you** do not file a United States income tax return, the current primary address **we** have on file will be deemed **your residence**.

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

Sickness: An illness or disease that **you** have or acquire after the **policy date** and while this insurance is in force.

We, us or our: Medico Insurance Company.

You or your: The insured named in the **policy schedule**.

SECTION B: BASIC BENEFITS

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.

We will pay benefits for the following **Medicare eligible expenses you** incur while **your** policy is in force. In determining benefits to be paid, **we** will consider **you** to be enrolled in and eligible for **Medicare** Parts A and B.

Inpatient Hospital Confinement Benefit (Medicare Part A):

Coinsurance Benefit: We will pay 100% of the Part A **Medicare eligible expenses** for each day of hospitalization to the extent not covered by **Medicare** from the 61st through 90th day of each **benefit period**.

Lifetime Inpatient Reserve Days Benefit: After **you** have been confined in a **hospital** for 90 days in a **Medicare benefit period, we** will pay 100% of the Part A **Medicare eligible expenses** for hospitalization to the extent not covered by **Medicare** for each **Medicare** lifetime inpatient reserve day used. Lifetime reserve days are nonrenewable and limited to 60 days during **your** lifetime.

Medicare Exhaustion Benefit: Upon exhaustion of all **Medicare hospital** inpatient coverage, including the lifetime inpatient reserve days, **we** will pay 100% of the Part A **Medicare eligible expenses** for hospitalization. Benefits are payable at the applicable prospective payment system (PPS) rate, or other appropriate **Medicare** standard of payment. **Medicare** exhaustion benefits are 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.

Hospice Care Benefit (Medicare Part A):

We will pay the cost sharing for all Part A **Medicare eligible expenses** for **hospice care** and **respite care** expenses.

Blood Benefit (Medicare Part A or Part B):

We will pay the reasonable cost under **Medicare** Parts A and B for the first three (3) pints of blood (or equivalent quantities of packed red blood cells as defined under federal regulations) unless replaced in accordance with federal regulations.

Medical Expenses Benefit (Medicare Part B):

After the **Medicare** Part B **calendar year** deductible has been satisfied, **we** will pay the coinsurance amount not paid by **Medicare** applicable to Part B **Medicare eligible expenses** regardless of **hospital** confinement. In the case of **hospital** outpatient department services under a PPS, **we** will pay the copayment amount.

SECTION C: ADDITIONAL BENEFITS

We will pay benefits for the following **Medicare eligible expenses you** incur while this policy is in force. In determining benefits to be paid, **we** will consider **you** to be enrolled in and eligible for **Medicare** Parts A and B. These additional benefits are subject to the same terms and conditions as Basic Benefits.

Inpatient Hospital Confinement Deductible Benefit (Medicare Part A):

Medicare Part A Deductible: We will pay 100% of the **Medicare** Part A inpatient **hospital** confinement deductible amount for each **benefit period.**

Skilled Nursing Facility Confinement Benefit (Medicare Part A):

When **you** are confined to a skilled nursing facility for post-**hospital** care eligible under **Medicare** Part A, **we** will pay the actual billed charge, up to the daily coinsurance amount, for each day of confinement from the 21st day through the 100th day for each **benefit period.**

Medicare Part B Excess Charges Benefit:

We will pay 100% of the difference between the actual charges billed to **Medicare** Part B for **your** medical expenses and the amount approved by **Medicare** Part B. If the provider accepts **Medicare's** assignment, no excess charges will be payable by **us.** If the provider does not accept **Medicare's** assignment, the excess charges **we** will pay may not exceed any charge limitation established by **Medicare** or state law.

Emergency Care in a Foreign Country Benefit:

We will pay 80% of the billed charges for **Medicare eligible expenses** for **medically necessary** emergency care received while in a foreign country to the extent such expenses are not covered by **Medicare,** subject to the following limitations:

1. Such care would have been covered by **Medicare** if provided in the United States;
2. Such care began during the first 60 consecutive days of each trip outside the United States;
3. Benefits are subject to a $250 **calendar year** deductible; and
4. Benefits are subject to a lifetime maximum benefit of $50,000.

For this benefit, emergency care means **medically necessary** medical care received by a **physician** or in a **hospital** that is needed immediately because of an **injury** or **sickness** of sudden and unexpected onset.

We reserve the right to review for **medically necessary** services.

SECTION 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;
4. Loss that occurs while this policy is not in force; and
5. Any expense incurred that duplicates any benefit paid by **Medicare.**

SECTION E: PREMIUM PROVISIONS

Premium Change: We can change **your** premium only if **we** do the same to all policies of this form which are issued to persons of **your** class. **Your** premium is based on the geographic area of **your** state of **residence** when coverage is issued. If **you** have a change of **residence,** premiums may change to reflect **your** current geographic area. **Your** premium may also change due to:

1. **Age;**

2. A change in **your** premium payment method;
3. A new rate table being applied;
4. A rating classification change; or
5. A misstatement on **your** application that results in the proper amount due not being charged.

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 send **you** written notice in advance of the change in premium.

Change of Residence: If **you** change **your residence**, **you** must notify **us** of **your** new address. **Your** premium may be based on **your** new **residence** and may change to reflect **your** current geographic area. If **your** premium changes, **your** new premium amount will be due beginning on the first premium due date after the change.

Premium Payments: Premiums are payable based on a frequency of payment selected by **you** and agreed to by **us**. Premiums must be paid to **us** or to **our** authorized representative. The payment of the premium due will keep the coverage under **your** policy in force to the next premium due date, subject to the Grace Period provision.

Grace Period: A grace period of 31 days will be allowed for the payment of each premium due after the first premium is paid. **Your** coverage will stay in force during this time. The coverage under **your** policy will terminate at the end of the grace period if the premium has not been paid.

Unpaid Premium: When a claim is paid, any premium due and unpaid may be deducted from the claim payment.

Reinstatement: If any renewal premium is not paid within the time allowed for payment, a subsequent acceptance of premium by **us** or by **our** representative authorized to accept such premium, without requiring a reinstatement application, will reinstate **your** policy. However, if **we** or **our** authorized representative require an application for reinstatement and issues a conditional receipt for any premium paid, **your** policy will be reinstated upon **our** approval of **your** reinstatement application or, lacking such approval, upon the 45th day following the date of such conditional receipt unless **we** have previously notified **you** in writing of **our** disapproval of such application.

The reinstated policy will cover only losses due to conditions that begin after the date of reinstatement. In all other respects **you** and **we** will have the same rights under this policy that **we** had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed on or attached to the policy in connection with the reinstatement. Any premium **we** accept in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement.

Misstatement of Age: If **your age** has been misstated on **your** application, the benefits will be those the premium paid would have purchased at the correct age.

Misstatement of Residence: If **your** state of **residence** is misstated on **your** application, **we** will correct **your** state of **residence** and apply the correct premium amount. If **your** corrected state of **residence** is in a state in which **we** do not offer this policy, **we** reserve the right to cancel, rescind or reform **your** coverage.

Household Discount: You may be eligible for a household discount if **you** are living at the same address in a legal relationship recognized by the state.

SECTION F: 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.

SECTION G: 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 (as defined in Section 1862(b)(1)(A)(v) of the Social Security Act). **We** must receive **your** written notice 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 and payment of the premium attributable to the period, effective as of the date of termination of enrollment in the group health plan.

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.

SECTION H: HOW TO FILE A CLAIM

Notice of Claim: You must give **us** written notice of a claim within 20 days after covered 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 include **your** name and **your** policy number. The notice should be sent to **us** at: Medico Insurance Company, P.O. Box 21660, Eagan, Minnesota 55121-0660, 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 one (1) year after the time proof is otherwise required, except in the absence of legal capacity.

SECTION I: PAYMENT OF CLAIMS

Time of Payment of Claims: Indemnities payable under this policy will be paid immediately upon receipt of due written proof of loss.

Payment of Claims: All benefits are payable to **you** unless **you** assign **your** benefits. If **you** assign **your** benefits, all or any portion of any benefits provided may be paid directly to the **physician** or institution rendering the service. **We** are not responsible for verifying the validity of the assignment.

Benefits unpaid at **your** death will be paid to **your** estate. If no estate exists, **we** may pay such indemnity to any relative by blood or connection by marriage of the insured, in accordance with the probate laws of the state in which this policy was issued; or a beneficiary who is deemed by **us** to be equitably entitled thereto. Any payment made by **us** in good faith pursuant to this provision shall fully discharge **us** to the extent of the payment.

Right to Collect Information: Any investigation of a claim will be completed within 30 days of receipt of proof of loss, unless an investigation cannot reasonably be completed within that time. If this happens, **we** will provide **you** with a written explanation and continue providing a written explanation every 45 days thereafter. To determine **our** liability, **we** may request additional information from **you**, a provider, facility, or other individual or entity. **You** must cooperate with **us** and assist **us** by obtaining the following information within 30 days of **our** request. **We** will not pay benefits for a particular claim if **we** are unable to determine **our** liability because **you**, a provider, facility, or other individual or entity fails to do any of the following:

1. Authorize the release of all medical records to **us** and/or fails to authorize the release of other information **we** request;
2. Provide **us** with information **we** request about pending claims;
3. Provide **us** with information that is accurate and complete;
4. Have any examination completed as requested by **us** at **our** expense; or
5. Reasonably cooperate with any requests made by **us**.

Such claims will be considered for benefits upon receipt of the requested information, provided that **we** receive all necessary information.

Review of Claims: We reserve the right to initiate, conduct and maintain, or to contract for, various programs and procedures directed at ensuring that claims were appropriate. Such programs and procedures include, but are not limited to:

1. Retrospective review; and
2. Auditing of expenses that may include review of:
    a. Charges that are billed separately as professional services when the procedure requires only a technical component;
    b. Charges that are billed incorrectly or billed separately but are an integral part of another billed service;
    c. Other claims that are improperly billed;
    d. Duplicates of previously received or processed claims; or
    e. Charges billed for secondary and/or tertiary procedures.

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.

SECTION 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 **your** policy, unless **you** request a later termination date (the grace period will not apply);
2. The end of the grace period if sufficient premium has not been paid before the end of the grace period;
3. The date of **your** death; or
4. **You** commit fraud or misrepresentation of a material fact, as determined by **us**, subject to the Time Limit on Certain Defenses provision. If **we** terminate **your** coverage, **we** have the right to recover any claim payments **we** made, less any premiums paid.

Refund of Unearned Premium: If the termination date occurs within a period for which **we** have accepted a premium, or if **we** accept a premium after such date, **your** policy will continue in effect until the end of the period for which premiums have been accepted. This does not apply where the acceptance of premium was a result of misstatement of **age** or **residence** by **you.** In that case, **we** will follow the Misstatement of Age or Misstatement of Residence provisions. In the event of **your** death, **we** will return the unearned portion of any premium paid beyond **your** date of death.

Claims Incurred Prior to Termination: Termination of **your** policy will not apply to a valid claim for benefits regarding a covered loss which occurs before the termination date. Benefits under this policy will stop the day **your** coverage is terminated.

SECTION K: GENERAL PROVISIONS

Entire Contract; Changes: This policy, with attachments (and a copy of **your** application), is the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of **ours** and unless such approval is endorsed hereon or attached hereto. No **producer** has authority to change this policy or to waive any of its provisions.

Time Limit on Certain Defenses: After two years from the **policy date**, no misstatements, except fraudulent misstatements, made by the applicant 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 two-year period.

No claim for loss incurred or disability commencing after two years from the **policy date** can be reduced or denied on the grounds that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the **policy date**.

Pre-Existing Conditions: We will not reduce or deny a claim under this policy because a **sickness** or **injury** existed before the **policy date**.

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

Change of Beneficiary; Assignment: Unless the insured makes an irrevocable designation of beneficiary, the right to change of beneficiary is reserved to the insured, and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this policy, or to any change of beneficiary or beneficiaries, or to any other changes in this policy.

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, less any claims 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 reside**. 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 and Federal Law: Any provision of this policy which, on its **policy date**, is in conflict with the law of federal government or the state in which **you reside** on such date is hereby amended to conform to the minimum requirements of such law.

Annual Meeting Information: The annual meeting of the members of American Enterprise Mutual Holding Company will be held at the mutual holding company's principal office at nine o'clock a.m. on the first Tuesday in March of each year. Each such meeting will be for the purpose of electing a director or directors and transacting any other business properly coming before the annual meeting. At every annual meeting, each member of the mutual holding company who is a member as of the record date fixed by the board of directors, which record date shall not be more than 90 days prior to the date of the meeting, shall have one vote upon any proposition coming before such meeting, which vote may only be cast in person or by ballot furnished by the mutual holding company. In order to vote by ballot, a member as of the record date must request a ballot from the Secretary of the mutual holding company at least 15 days prior to the annual meeting.

Medico Insurance Company
601 Sixth Ave., Des Moines, IA 50309
P.O. Box 10386, Des Moines, IA 50306

www.GoMedico.com
Phone (toll-free): 800-228-6080

Application for Medicare Supplement Insurance

Requested effective date of new policy (optional)

01/01/2023
MM/DD/YYYY

Requested effective date must be after the application date. If no effective date is requested, the effective date will be the day the application is approved by the company.

Policy delivery

Upon approval of this application, the policy will be delivered to the applicant by mail.

Part A: Applicant information (please print)

Michael I Cheikin	12/06/1955	67	Male
Full name of applicant: *first, middle, last, suffix*	Date of birth (MM/DD/YYYY)	Age	Gender

134427813	(610) 639-6034	cheikinm@msn.com
Social Security number	Phone number	Email address

245 BRADFORD CIRCLE	BLUE BELL	PA	19422
Residence address *(include Apt/Bldg/Unit Nbr if applicable)*	City	State	ZIP code
Mailing address *(if different than residence address)*	City	State	ZIP code

Are you eligible for Open Enrollment? ☐ Yes ☑ No

If "Yes," skip Parts C and D.

Part B: Insurance information

If you lost other health insurance coverage and received a notice from your previous insurer that said you were eligible for guaranteed issue of a Medicare Supplement insurance policy or you had certain rights to buy such a policy, you may be guaranteed acceptance in one of Medico's Medicare Supplement plans. Please include a copy of the notice from your previous insurer with your application.

Please answer the following questions to the best of your knowledge.

1. Please enter your Medicare claim number: 5D71CC5TV31
2. a. Are you within 6 months of your 65th birthday? ☐ Yes ☑ No
   b. Did you enroll in Medicare Part B in the last 6 months? ☐ Yes ☑ No
   c. What is your Part B effective date? 12/01/2020
   d. What is your Part A effective date? 12/01/2020
3. Are you covered for medical assistance through the state Medicaid program? (If you are participating in a "spend-down program" and have not met your "share of cost," please answer "No" to this question.) ☐ Yes ☑ No
   If "Yes,"
   a. Will Medicaid pay your premiums for this Medicare Supplement policy? ☐ Yes ☐ No
   b. Do you receive any benefits from Medicaid **other than** payments toward your Medicare Part B premium? ☐ Yes ☐ No
4. a. If you had coverage from any Medicare plan other than original Medicare within the past 63 days, such as Medicare Advantage, Medicare HMO, or Medicare PPO, provide your start and end dates. (If you are still covered under the policy, leave "End" blank.) Start: ____________ End: ____________
   b. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy? ☐ Yes ☐ No
   c. Was this your first time in this type of Medicare plan? ☐ Yes ☐ No
   d. Did you cancel a Medicare Supplement policy to enroll in this Medicare plan? ☐ Yes ☐ No

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Part B: Insurance information (continued)

5. a. Do you have another Medicare Supplement policy in force? ☑ Yes ☐ No
   b. If "Yes," please provide the following information.

LUMICO	2001036607	G
Company name	Policy number	Plan

   c. Do you intend to replace your current Medicare Supplement policy with this policy? ☑ Yes ☐ No

If you are replacing another Medicare or Medicare Supplement plan, please complete and submit the Notice to Applicant Regarding Replacement of Medicare Supplement Insurance or Medicare Advantage.

6. Are you eligible for guaranteed issue? ☐ Yes ☑ No
   If "Yes," please provide documentation and skip Parts C and D.
7. Have you had coverage under any other health insurance within the past 63 days (such as an employer, union, or individual plan)? ☐ Yes ☑ No
   a. If "Yes," please list the company and policy type.

   Company name ______ Policy type ______

   b. What are the dates of coverage under your other policy? (If you are still covered under the other policy, leave "End" blank.) Start: ______ End: ______
8. If you have lost or are losing other health insurance coverage, did you receive notice from that insurance company stating you were eligible for guaranteed issue of a Medicare Supplement insurance policy or that you had certain rights to buy a policy? (If you answered, "Yes," and you are unable to provide a termination notice, please complete all sections of this form.) ☐ Yes ☐ No
   If "No," please provide an explanation:

   ______

Part C: General health information

Note: These questions should not be answered if you apply during Open Enrollment or if you are eligible for guaranteed issue.

Please list your current height and weight. Height: 5'9" Weight: 185

Have you used tobacco in any form, electronic cigarettes, or other nicotine products in the past 24 months? ☐ Yes ☑ No

Qualifying information

(If any answer to questions 1 through 4 is "Yes," you are not eligible for coverage.)

Please answer the following questions to the best of your knowledge.

1. Within the past 5 years, have you:
   a. Had, been treated for, or diagnosed with diabetes that required insulin, required three or more medications for control, or had complications? ☐ Yes ☑ No
   b. Had, been treated for, or advised to have a bone marrow or organ transplant? ☐ Yes ☑ No
   c. Had, been treated for, or diagnosed by a member of the medical profession with acquired immune deficiency syndrome (AIDS) or AIDS-related complex (ARC), or tested positive for human immunodeficiency virus (HIV)? ☐ Yes ☑ No
2. Within the past 24 months have you:
   a. Had, been treated for, or diagnosed with internal cancer, leukemia, melanoma, Hodgkin's disease, myeloma, or lymphoma? ☐ Yes ☑ No
   b. Had, been treated for, or diagnosed with amyotrophic lateral sclerosis (ALS), Parkinson's disease, or multiple or lateral sclerosis? ☐ Yes ☑ No
   c. Had, been treated for, or diagnosed with cirrhosis of the liver, Hepatitis B or C, chronic renal/ kidney failure, or had dialysis? ☐ Yes ☑ No
   d. Had, been treated for, or diagnosed as having had a stroke or transient ischemic attack (TIA)? ☐ Yes ☑ No

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Part C: General health information (continued)

e. Had, been treated for, or diagnosed with peripheral vascular disease (poor circulation in your extremities), had angioplasty, stent placement of any vessel, bypass surgery, heart attack, heart surgery, or congestive heart failure? ☐ Yes ☑ No

f. Had, been treated for, or diagnosed with emphysema, chronic obstructive pulmonary disease (COPD), or other chronic pulmonary disease? ☐ Yes ☑ No

g. Had, been treated for, or diagnosed with a connective tissue disease (such as systemic lupus), degenerative bone disease, rheumatoid arthritis, or arthritis that is disabling? ☐ Yes ☑ No

h. Had any fractures due to osteoporosis or amputation due to disease? ☐ Yes ☑ No

i. Been or are you now bedridden or permanently confined to a wheelchair? ☐ Yes ☑ No

j. Had, been treated for, or diagnosed with schizophrenia or bipolar disease? ☐ Yes ☑ No

k. Been confined to a hospital for a mental or nervous condition? ☐ Yes ☑ No

l. Been treated for abuse of or diagnosed with addiction to alcohol, drugs, or opioids? ☐ Yes ☑ No

3. Do you have or have you been told by a medical professional that you have Alzheimer's disease, dementia, organic brain disorder, or a cognitive disorder? ☐ Yes ☑ No
4. Are you currently using oxygen? ☐ Yes ☑ No

Part D: Medical health information

Note: These questions should not be answered if you apply during Open Enrollment or if you are eligible for guaranteed issue.

If you answer "Yes" to any of the following questions, please provide details in the space allotted after question 4. If you need additional space, attach a separate page that you have signed and dated.

1. Do you require assistance or supervision to perform any of the following activities of daily living: dressing, eating, bathing, toileting (including use of a catheter), or walking (including use of a cane, walker, motorized scooter/mobility aid, or wheelchair)? ☐ Yes ☑ No
2. Has a member of the medical profession recommended that you have medical tests, treatment, therapy, or surgery, including cataract surgery or joint replacement, that has not yet been performed? ☐ Yes ☑ No
3. Have you been hospitalized within the last 60 days? Has a member of the medical profession recommended that you be hospitalized, confined to a nursing facility or assisted living facility, or received home health care within the last 60 days? Have you been hospitalized or in the emergency room three or more times within the past 24 months? ☐ Yes ☑ No
4. Have you had a seizure within the past 24 months? ☐ Yes ☑ No

Question details (list 1, 2, 3, or 4) ______________________________

Have you taken any medication in the last 12 months, including injections or infusions? ☑ Yes ☐ No

If "Yes," please provide the following information.

Medication name	Dosage	Quantity taken each time	Frequency taken	Diagnosis/Condition	Start date
See Overflow Page					

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Part D: Medical health information (continued)

Primary physician

Timothy Reekie	11/19/2019
Name of physician	Date of last visit (MM/DD/YYYY)
(267) 440-2050	Wyndmoor, PA
Office phone number	City and state

Specialists seen in the past 24 months

Name of physician	Specialty	Date of last visit (MM/DD/YYYY)
Name of physician	Specialty	Date of last visit (MM/DD/YYYY)

Part E: Benefit options

Choose your plan:

☐ Plan A ☐ Plan B ☑ Plan G ☐ High-deductible Plan G ☐ Plan N

If your Medicare Part A eligibility date is before Jan. 1, 2020, these additional plans are also available:

☐ Plan F ☐ High-deductible Plan F

Household premium discount: Complete the following section to determine eligibility for the household premium discount. If you answer "NO" to any of the questions in this section, you are not eligible for the household premium discount.

Are you part of a legal relationship recognized by the state? (Including but not limited to relationships such as marriages, domestic partnerships and civil unions.) ☑ Yes ☐ No

Do you both live at the same address? ☑ Yes ☐ No

Please provide the full name of the other member of the relationship.

Patti Cheikin

Full name: *first, middle, last, suffix*

Method of payment:	**Frequency of payment:**			
☑ Automatic bank withdrawal	☑ Monthly	☐ Quarterly	☐ Semi-annually	☐ Annually
☐ Credit/Debit card	☐ Monthly	☐ Quarterly	☐ Semi-annually	☐ Annually

Part F: Notices

You do not need more than one Medicare Supplement policy.

If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

You may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy.

If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare Supplement policy (or if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing Medicaid eligibility. If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but it will otherwise be substantially equivalent to your coverage before the date of the suspension.

If you are eligible for, and have enrolled in, a Medicare Supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare Supplement policy under these circumstances and later lose your employer or union-based group health plan, your suspended Medicare Supplement policy (or if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare Supplement policy provided coverage for outpatient

Part F: Notices (continued)

prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but it will otherwise be substantially equivalent to your coverage before the date of the suspension.

Counseling services may be available in your state to provide advice concerning your purchase of Medicare Supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

Part G: Application agreement

I hereby apply to Medico Insurance Company (the Company) for a **Medicare Supplement insurance policy** to be issued solely and entirely in reliance on my answers to the questions. This application will become a part of any policy to which this form is attached. If I am not applying during Open Enrollment or not eligible for guaranteed issue, I do not have a right to have this policy issued to me if I have answered "Yes" to any of questions 1 through 4 in the "General health information" part or have answered "Yes" to any of questions 1 through 4 in the "Medical health information" part. I have read, or had read to me, the complete application.

I have read and agree:

- **No insurance exists unless and until coverage is approved by the Company, the first premium is paid, and a policy is delivered.**
- The information furnished is complete, true, and correctly recorded to the best of my knowledge.
- If requested, I will complete a recorded telephone call with a Company representative as part of the underwriting process.
- No portion of the premium will be paid, during the period the policy is in force, by or on behalf of a third party (not to include an immediate family member), either directly, through wage adjustments, or other means of reimbursement.

I have received the Notice of Privacy Practices and the Outline of Coverage for the policy.

I have received a link to the Medicare Supplement Buyers Guide, "A Guide to Health Insurance for People With Medicare," on the Company website at www.GoMedico.com/products.

CAUTION: If your answers on this application are incorrect or untrue, the Company may have the right to deny benefits or rescind your policy if the misrepresentation was material to our acceptance of the risk.

NOTICE: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

I acknowledge that in states where it is required, the producer made the necessary inquiries concerning my insurance needs and proposed a program of insurance that is suitable for my needs. I am applying for this Medicare Supplement insurance policy.

X MICHAEL I CHEIKIN — 12/17/2022

Applicant's signature eSignature — Date (MM/DD/YYYY)

Part H: Producer's section

Have you personally sold any other health insurance policies to the proposed insured that are still in force OR sold any policies no longer in force in the past 5 years? ☑ Yes ☐ No

If "Yes," please list policies:

Policy type and number	In force?
MEDICARE SUPPLEMENT 2001036607	☑ Yes ☐ No
	☐ Yes ☐ No

Is the insurance applied for intended to replace any medical or health insurance coverage? ☑ Yes ☐ No

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Part H: Producer's section (continued)

Producer's certification: I certify the information in this application was provided by the applicant and correctly recorded. I have no information to add that could affect the acceptance or rejection of the risk. Any intention to replace coverage is reflected in the application. I have provided the applicant a link to the Medicare Supplement Buyers Guide at www.GoMedico.com/products.

Gordon Conwell	105107WCEL
Producer's printed name	Producer's number
X Gordon Conwell	12/16/2022
Producer's signature eSignature	Date (MM/DD/YYYY)

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MEDICO®
INSURANCE COMPANY
P.O. Box 10386, Des Moines, Iowa 50306-0386

December 20, 2022

Michael I Cheikin
245 Bradford Circle
Blue Bell, PA 19422

Application: 132-0006-041064

Dear Michael I Cheikin :

Thank you for selecting Medico Insurance Company to be a part of your overall plan for health and financial well-being. After completing a thorough review of your application, Medico has issued the following coverage:

Michael   Issued at a preferred rate.

If you are replacing other coverage with this plan, it is your responsibility to notify your existing insurer to cancel the policy.

If a signed HIPAA Authorization was submitted with your application, a copy is enclosed for your records.

To protect your confidentiality, please send any questions regarding the underwriting decision to Medico in writing. Questions may be submitted to the following address:

Medico Insurance Company
Attention: Underwriting Department
PO Box 10386
Des Moines, IA 50306-0386

If you have any questions, please call Medico's Customer Care Center, 1-800-228-6080, Monday - Friday, 7:30 a.m. to 5 p.m. Central time.

Thank you for the opportunity to serve you.

New Business

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General Information
Company: Medico, Medico Corp and/or Medico Life and Health
Distribution: ME
Agent Number: 105107WCEL
Bank Draft Bill Day: 1

Replacement Information

Medical Health Information (Medicare Supplement Application)	
Questions	Details

Medications taken within the past 12 months (Medicare Supplement Application)	
Medication #1	
Medication	DIFLUCAN (Fluconazole)
Dosage	150MG TABS
Quantity	1
Diagnosis	Skin Issue
Frequency	1 Daily
Start Date	08/05/2017

Links to Medicare Supplement guides, including "A Guide to Health Insurance for People with Medicare," can be found at
https://www.gomedico.com/products/medicare-supplement-insurance

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HIPAA Authorization

I authorize any physician, hospital, pharmacy, pharmacy benefit manager, health insurance plan, or any other entity that possesses any diagnosis, treatment, prescription, or other medical information about me to furnish such health information to Medico Insurance Company, Medico Corp Life Insurance Company, and/or Medico Life and Health Insurance Company and the entities with which it contracts to administer insurance applications (collectively the "Company"), and their agents and representatives, for the purpose of evaluating my eligibility for insurance. This medical or health information may include information on the diagnosis and treatment of mental illness, alcohol, and drug use. This also includes information on the diagnosis, treatment, and testing results related to HIV, AIDS, and sexually transmitted diseases, unless otherwise restricted by state law. This authorization overrides any restrictions that I may have in place with any entity regarding the release of my medical information. Health information obtained will not be re-disclosed without my authorization unless permitted by law, in which case it may not be protected under federal privacy rules. This authorization shall be valid for two years from this date and may be revoked by sending written notice to the Company.

Non-health information is all other information. It may be about employment, other insurance owned, or motor vehicle, consumer, or credit reports. It may also be information used to confirm questions and answers on the application for insurance.

I authorize disclosure of this information to the Company by any of the following sources: doctors, medical practitioners, hospitals, clinics, or other medical or medically related facilities or professionals; the Company's legal representatives or agents; insurers or reinsurers; health plans; consumer reporting agencies; public records; employers; Pharmacy Benefit Manager (PBM); or the Medical Information Bureau (MIB).

I authorize the Company or it's reinsurers to make a brief report of my personal health information to the MIB.

I understand:

- I can refuse to sign this Authorization. If I refuse, the Company will not be able to consider my application(s).
- I can revoke this Authorization at any time, except to the extent that the Company has acted in reliance upon it or other law that gives the Company the right to contest a claim under the policy/certificate or the policy/certificate itself.
- Revoking this Authorization means the Company will not be able to consider my application(s). Requests to revoke must be in writing and sent to: Medico Insurance Company and/or Medico Life and Health Insurance Company, P.O. Box 10386, Des Moines, Iowa 50306-0386 and/or Medico Corp Life Insurance Company, P.O. Box 10482, Des Moines, Iowa 50306-0482.
- Subject to state and federal laws, information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and may no longer be protected.
- I (or my authorized personal representative) am entitled to and will be sent a copy of this Authorization.
- This Authorization expires 24 months from the date I sign it.
- I may request to be interviewed in connection with the preparation of a consumer report and, upon written request, receive a copy of the report.

I agree that a copy of this Authorization is as valid as the original.

Michael I Cheikin 12/17/2022

Your name (Please print) Date

X MICHAEL I CHEIKIN

Your signature eSignature

Spouse's name (If applying, please print) Date

X

Your signature

Authorization to Disclose Information (MIB)

I authorize Medico Insurance Company, Medico Corp Life Insurance Company, and/or Medico Life and Health Insurance Company (the "Company") to disclose health and non-health information that they may obtain about me to the Medical Information Bureau (MIB). The purpose of the disclosure is fraud prevention.

I understand that I do not have to authorize this disclosure to MIB. Issuance of coverage will not be conditioned on me signing this authorization. ☐ **Yes** ☐ **No**

I understand that, subject to state and Federal laws, information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected.

I understand that I have the right to revoke this authorization at any time except to the extent that the Company has acted upon this authorization. I further understand that if I revoke this authorization I must do so in writing and must send my written request to: Medico Insurance Company and/or Medico Life and Health Insurance Company, P.O. Box 10386, Des Moines, Iowa 50306-0386 and/or Medico Corp Life Insurance Company, P.O. Box 10482, Des Moines, Iowa 50306-0482.

I understand that this authorization will expire 24 months from the date I sign it.

I acknowledge that I, or my authorized personal representative, am entitled to and have received a copy of this form.

Your name (Please print) Date

X

Your signature

Spouse's name (If applying, please print) Date

X

Your signature

If you are signing as a personal representative for an individual to be insured, read and sign below

I hereby certify and attest that I am the duly authorized personal representative of these persons to be insured.

Personal representative (Please print)

X

Personal representative signature

Person(s) to be insured (Please print):

1.

2.

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

1.

2.

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Medico Insurance Company
601 Sixth Ave., Des Moines, IA 50309
P.O. Box 10386, Des Moines, IA 50306

www.GoMedico.com
Phone (toll-free): 800-228-6080

Replacement Notice

Notice to Applicant Regarding Replacement of Medicare Supplement or Medicare Advantage

Save this notice! It may be important to you in the future.

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

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

STATEMENT TO APPLICANT BY ISSUER OR PRODUCER:

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

☐ Additional benefits.

☑ No change in benefits, but lower premiums.

☐ Fewer benefits and lower premiums.

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

☐ Disenrollment from a Medicare Advantage plan. (please explain reason for disenrollment)

____

☐ Other (please specify)

____

____

____

If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

Gordon Conwell eSignature	Gordon Conwell PO BOX 227
Signature of producer	Typed name and address of issuer or producer
MICHAEL I CHEIKIN eSignature	12/17/2022
Applicant's signature	Date

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