AMERICO FINANCIAL LIFE AND ANNUITY INSURANCE COMPANY

Medicare Supplement Administrative Offices: PO Box 10812, Clearwater, FL 33757-8812 1-877-212-2346

MEDICARE SUPPLEMENT INSURANCE

Outline of Coverage for Policy Form AWI500

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

NEITHER AMERICO FINANCIAL LIFE AND ANNUITY INSURANCE COMPANY, NOR ITS AGENTS, ARE CONNECTED WITH MEDICARE.

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

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. Until you are age 99, your premium may change each year. This change will only be made on the first renewal date that coincides with or follows each anniversary of the effective date. Schedules of rates may vary depending upon your effective date.

Household Premium Discount. If you resided with at least one, but no more than three, other adults who are age 60 or older for the past year, 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 adult 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 33757-8812. 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 you are sure you want to keep it.

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.

MEDICARE SUPPLEMENT INSURANCE

Outline of Coverage for Policy Form AWI500

Medicare Part A – Hospital Services Per Benefit Period

***NOTICE:** When your Medicare part A hospital benefits are exhausted, we stands in the place of Medicare and will pay whatever amount Medicare would have paid up to an additional 365 days as provided in the Policy's "Core Benefits."

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

Services	Medicare Pays	This Policy Pays	You Pay
Hospitalization Semiprivate room and board, general nursing and miscellaneous services and supplies.			
First 60 days	All but $1,556	$0 or ☐ Optional Part A Deductible Rider **	$1,556 Part A Deductible or $0
61st thru 90th day	All but $389 a day	$389 a day	$0
91st day and after			
- While using 60 lifetime reserve days;	All but $778 a day	$778 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 $194.50 a day	Up to $194.50 a day	$0
101st day and after	$0	$0	All Costs
Inpatient Psychiatric Care Inpatient psychiatric care in a participating psychiatric hospital.	190 days per lifetime	175 days per lifetime	All charges not covered by policy nor Medicare.
Blood			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
Hospice Care			

MEDICARE SUPPLEMENT INSURANCE

Outline of Coverage for Policy Form AWI500

Medicare Part A – Hospital Services Per Benefit Period

***NOTICE:** When your Medicare part A hospital benefits are exhausted, we stands in the place of Medicare and will pay whatever amount Medicare would have paid up to an additional 365 days as provided in the Policy's "Core Benefits."

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

Services	Medicare Pays	This Policy Pays	You Pay
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

Medicare Part B – Medical Services – Per Calendar Year

*Once you have been billed $233 of Medicare Eligible Expenses for covered services, your Medicare Part B Deductible will have been met for the calendar year.

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

Services	Medicare Pays	This Policy 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 $233* of Medicare approved amounts	$0	$0 or ☐ Optional Part B Deductible Rider[1] ** or ☐ Optional Medicare Copayment Rider **	$233* Part B Deductible or $0 or Up to $20 per office visit and up to $50 per emergency room visit

[1]This is an optional rider only available to applicants first eligible for Medicare prior to 1/1/2020.

MEDICARE SUPPLEMENT INSURANCE

Outline of Coverage for Policy Form AWI500

Medicare Part B – Medical Services – Per Calendar Year

***Once you have been billed $233 of Medicare Eligible Expenses for covered services, your Medicare Part B Deductible will have been met for the calendar year.

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

Services	Medicare Pays	This Policy Pays	You Pay
Remainder of Medicare approved amounts	Generally 80%	Generally 20% or ☐ Optional Medicare Part B Excess Charges Rider **	Charges in excess of 20% up to the limiting charge or Balance, if any, or expense if not covered by Medicare or this policy.
Blood			
First 3 pints	$0	All costs	$0
Next $233 of Medicare approved amounts	$0	$0 or ☐ Optional Part B Deductible Rider[1] **	$233* or $0
Remainder of Medicare approved amounts	80%	20%	Charges not covered by the policy or Medicare
Clinical Laboratory Services – Tests for diagnostic services	100%	$0	$0
Home Health Care	100% of charges for visits considered Medically necessary by Medicare	40 visits or ☐ Optional Additional Home Health Care Rider **	Charges not covered by the policy or Medicare.

[1]This is an optional rider only available to applicants first eligible for Medicare prior to 1/1/2020.

MEDICARE SUPPLEMENT INSURANCE

Outline of Coverage for Policy Form AWI500
Basic Plan
Other Benefits – Not Covered by Medicare

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

Services	Medicare Pays	This Policy Pays	You Pay
Preventative Medical Care Benefit – Not Covered by Medicare Some Annual physical and preventative tests and services administered or ordered by your Physician when not covered by Medicare			
First $120 each calendar year	$0	$120	Charges not covered by the policy or Medicare.
Additional Charges	$0	$0	
Foreign Travel – Not Covered by Medicare Medically necessary emergency care services beginning during the first 60 days of each trip outside of the USA.			
First $250 each calendar year.	$0	$0	$250
Remainder of charges	$0	$0 or ☐ Optional Foreign Travel Emergency Rider** 80% to a lifetime maximum benefit of $50,000	All cost or 20% and amounts over the $50,000 lifetime maximum.

MEDICARE SUPPLEMENT INSURANCE

Outline of Coverage for Policy Form AWI500

THE FOLLOWING BENEFITS ARE REQUIRED BY THE STATE OF WISCONSIN

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

Benefits are not payable for services provided by or paid for by the Veterans Administration or custodial care or skilled nursing facility confinement certified by Medicare.

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

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

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

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

HOSPITAL AND AMBULATORY SURGICAL CENTER CHARGES - We will pay the usual and customary charges incurred, and anesthetics provided, in conjunction with dental care that is provided to a covered individual in a hospital or ambulatory surgical center, if any of the following applies:

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

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

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

MEDICARE SUPPLEMENT INSURANCE

Outline of Coverage for Policy Form AWI500

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

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

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

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

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

MEDICARE SUPPLEMENT INSURANCE

Outline of Coverage for Policy Form AWI500

Renewability of the Policy - We will renew the policy each time you send us the premium. It must be paid on or before the date it is due or during the 31 days that follow. Your premium will change on the first renewal date that coincides with or follows the anniversary date of the policy.

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

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

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

MEDICARE SUPPLEMENT INSURANCE

Outline of Coverage for Policy Form AWI500

MEDICARE SUPPLEMENT PREMIUM INFORMATION

ANNUAL PREMIUM

$_____ Basic Medicare Supplement Coverage

OPTIONAL Benefits for Medicare Supplement Policy – Each of these riders may be purchased separately.

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

$_____ ☐ MEDICARE PART B DEDUCTIBLE RIDER - 100% of Part B Deductible.
Available only to those first eligible for Medicare prior to 1/1/2020.

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

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

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

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

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

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

Monthly EFT: $_____ Quarterly: $_____ Semi-annual: $_____

AMERICO

AMERICO FINANCIAL LIFE AND ANNUITY INSURANCE COMPANY

Medicare Supplement Administrative Offices: PO Box 10812, Clearwater, FL 33757-8812 1-877-212-2346

MEDICARE SUPPLEMENT INSURANCE

Outline of Coverage for Policy Form AWI500

FEMALE Monthly Rates by Plan – Wisconsin Zip Codes: All Zip Codes that start with 530-534

Female / Non-Tobacco Rates								Female / Tobacco Rates						
Basic Policy	Part A Ded.	Part B Ded.	Part B Excess	Foreign Travel	Home Health	Part B Copay	Attained Age	Basic Policy	Part A Ded.	Part B Ded.	Part B Excess	Foreign Travel	Home Health	Part B Copay
462.01	85.00	19.42	5.81	4.25	7.22	-93.70	0-64	531.31	97.74	19.42	6.68	4.88	8.30	-107.75
154.00	28.33	19.42	1.94	1.42	2.41	-31.23	65	177.10	32.58	19.42	2.23	1.63	2.77	-35.92
154.00	28.33	19.42	1.94	1.42	2.41	-31.23	66	177.10	32.58	19.42	2.23	1.63	2.77	-35.92
154.00	28.33	19.42	1.94	1.42	2.41	-31.23	67	177.10	32.58	19.42	2.23	1.63	2.77	-35.92
154.00	28.33	19.42	1.94	1.42	2.41	-31.23	68	177.10	32.58	19.42	2.23	1.63	2.77	-35.92
160.62	29.68	19.42	2.01	1.47	2.51	-32.82	69	184.71	34.13	19.42	2.32	1.69	2.88	-37.75
167.08	30.58	19.42	2.09	1.53	2.60	-34.23	70	192.14	35.17	19.42	2.40	1.76	2.99	-39.37
172.79	32.07	19.42	2.16	1.58	2.68	-35.40	71	198.70	36.88	19.42	2.48	1.81	3.08	-40.71
178.49	33.55	19.42	2.22	1.63	2.77	-36.58	72	205.27	38.59	19.42	2.56	1.87	3.18	-42.06
184.20	35.04	19.42	2.29	1.67	2.85	-37.75	73	211.83	40.30	19.42	2.63	1.93	3.27	-43.41
189.91	36.53	19.42	2.36	1.72	2.93	-38.92	74	218.39	42.01	19.42	2.71	1.98	3.37	-44.76
195.71	38.03	19.42	2.42	1.77	3.01	-40.11	75	225.07	43.74	19.42	2.79	2.04	3.47	-46.13
200.43	39.67	19.42	2.48	1.81	3.08	-40.91	76	230.50	45.62	19.42	2.85	2.08	3.55	-47.05
205.20	41.32	19.42	2.54	1.86	3.15	-41.71	77	235.98	47.52	19.42	2.92	2.13	3.63	-47.97
210.11	43.01	19.42	2.60	1.90	3.23	-42.54	78	241.62	49.46	19.42	2.99	2.18	3.71	-48.92
215.07	44.72	19.42	2.66	1.94	3.30	-43.38	79	247.33	51.42	19.42	3.05	2.23	3.79	-49.89
220.18	46.46	19.42	2.72	1.99	3.38	-44.25	80	253.21	53.43	19.42	3.12	2.28	3.88	-50.89
225.38	48.14	19.42	2.76	2.02	3.43	-44.87	81	259.19	55.36	19.42	3.17	2.32	3.95	-51.60
230.75	49.87	19.42	2.81	2.05	3.49	-45.52	82	265.37	57.34	19.42	3.23	2.36	4.01	-52.35
236.18	51.61	19.42	2.85	2.08	3.55	-46.18	83	271.61	59.35	19.42	3.28	2.40	4.08	-53.11
241.68	53.37	19.42	2.90	2.12	3.60	-46.85	84	277.93	61.38	19.42	3.34	2.44	4.14	-53.87
247.23	55.16	19.42	2.95	2.15	3.66	-47.52	85	284.31	63.43	19.42	3.39	2.48	4.21	-54.64
252.53	56.52	19.42	2.99	2.19	3.72	-48.13	86	290.41	64.99	19.42	3.44	2.52	4.28	-55.35
257.90	57.89	19.42	3.04	2.22	3.78	-48.75	87	296.59	66.58	19.42	3.50	2.56	4.35	-56.06
263.35	59.29	19.42	3.09	2.26	3.84	-49.37	88	302.85	68.18	19.42	3.55	2.60	4.42	-56.78
268.75	60.68	19.42	3.14	2.30	3.90	-49.98	89	309.06	69.78	19.42	3.61	2.64	4.49	-57.48
274.08	62.05	19.42	3.19	2.33	3.96	-50.57	90	315.19	71.36	19.42	3.66	2.68	4.56	-58.16
278.49	63.09	19.42	3.21	2.35	3.99	-50.94	91	320.26	72.56	19.42	3.69	2.70	4.59	-58.58
282.95	64.14	19.42	3.23	2.36	4.02	-51.30	92	325.39	73.76	19.42	3.72	2.72	4.62	-59.00
287.17	65.14	19.42	3.25	2.38	4.04	-51.62	93	330.24	74.91	19.42	3.74	2.74	4.65	-59.37
291.42	66.15	19.42	3.27	2.39	4.07	-51.94	94	335.14	76.07	19.42	3.76	2.75	4.68	-59.74
295.72	67.16	19.42	3.29	2.41	4.09	-52.27	95	340.08	77.24	19.42	3.79	2.77	4.71	-60.11
298.67	67.84	19.42	3.33	2.43	4.14	-52.79	96	343.48	78.01	19.42	3.83	2.80	4.76	-60.71
301.66	68.51	19.42	3.36	2.46	4.18	-53.31	97	346.91	78.79	19.42	3.86	2.83	4.80	-61.31
304.68	69.20	19.42	3.39	2.48	4.22	-53.85	98	350.38	79.58	19.42	3.90	2.85	4.85	-61.93
307.73	69.89	19.42	3.43	2.51	4.26	-54.39	99	353.88	80.37	19.42	3.94	2.88	4.90	-62.55

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

AMERICO

AMERICO FINANCIAL LIFE AND ANNUITY INSURANCE COMPANY

Medicare Supplement Administrative Offices: PO Box 10812, Clearwater, FL 33757-8812 1-877-212-2346

MEDICARE SUPPLEMENT INSURANCE

Outline of Coverage for Policy Form AWI500

MALE Monthly Rates by Plan – Wisconsin Zip Codes: All Zip Codes that start with 530-534

Male / Non-Tobacco Rates								Male / Tobacco Rates						
Basic Policy	Part A Ded.	Part B Ded.	Part B Excess	Foreign Travel	Home Health	Part B Copay	Attained Age	Basic Policy	Part A Ded.	Part B Ded.	Part B Excess	Foreign Travel	Home Health	Part B Copay
531.31	97.74	19.42	6.68	4.88	8.30	-107.75	0-64	611.01	112.41	19.42	7.68	5.61	9.55	-123.92
177.10	32.58	19.42	2.23	1.63	2.77	-35.92	65	203.67	37.47	19.42	2.56	1.87	3.18	-41.31
177.10	32.58	19.42	2.23	1.63	2.77	-35.92	66	203.67	37.47	19.42	2.56	1.87	3.18	-41.31
177.10	32.58	19.42	2.23	1.63	2.77	-35.92	67	203.67	37.47	19.42	2.56	1.87	3.18	-41.31
177.10	32.58	19.42	2.23	1.63	2.77	-35.92	68	203.67	37.47	19.42	2.56	1.87	3.18	-41.31
184.71	34.13	19.42	2.32	1.69	2.88	-37.75	69	212.42	39.25	19.42	2.67	1.95	3.31	-43.41
192.14	35.17	19.42	2.40	1.76	2.99	-39.37	70	220.96	40.44	19.42	2.77	2.02	3.44	-45.27
198.70	36.88	19.42	2.48	1.81	3.08	-40.71	71	228.51	42.41	19.42	2.85	2.09	3.55	-46.82
205.27	38.59	19.42	2.56	1.87	3.18	-42.06	72	236.06	44.38	19.42	2.94	2.15	3.66	-48.37
211.83	40.30	19.42	2.63	1.93	3.27	-43.41	73	243.61	46.34	19.42	3.03	2.21	3.76	-49.92
218.39	42.01	19.42	2.71	1.98	3.37	-44.76	74	251.15	48.31	19.42	3.12	2.28	3.87	-51.47
225.07	43.74	19.42	2.79	2.04	3.47	-46.13	75	258.83	50.30	19.42	3.21	2.34	3.99	-53.05
230.50	45.62	19.42	2.85	2.08	3.55	-47.05	76	265.07	52.46	19.42	3.28	2.40	4.08	-54.10
235.98	47.52	19.42	2.92	2.13	3.63	-47.97	77	271.37	54.65	19.42	3.36	2.45	4.17	-55.16
241.62	49.46	19.42	2.99	2.18	3.71	-48.92	78	277.87	56.88	19.42	3.43	2.51	4.27	-56.26
247.33	51.42	19.42	3.05	2.23	3.79	-49.89	79	284.42	59.14	19.42	3.51	2.57	4.36	-57.37
253.21	53.43	19.42	3.12	2.28	3.88	-50.89	80	291.19	61.45	19.42	3.59	2.63	4.46	-58.52
259.19	55.36	19.42	3.17	2.32	3.95	-51.60	81	298.07	63.67	19.42	3.65	2.67	4.54	-59.34
265.37	57.34	19.42	3.23	2.36	4.01	-52.35	82	305.17	65.95	19.42	3.71	2.71	4.61	-60.20
271.61	59.35	19.42	3.28	2.40	4.08	-53.11	83	312.35	68.25	19.42	3.77	2.76	4.69	-61.07
277.93	61.38	19.42	3.34	2.44	4.14	-53.87	84	319.62	70.59	19.42	3.84	2.80	4.77	-61.95
284.31	63.43	19.42	3.39	2.48	4.21	-54.64	85	326.96	72.95	19.42	3.90	2.85	4.84	-62.84
290.41	64.99	19.42	3.44	2.52	4.28	-55.35	86	333.97	74.74	19.42	3.96	2.89	4.92	-63.65
296.59	66.58	19.42	3.50	2.56	4.35	-56.06	87	341.07	76.56	19.42	4.02	2.94	5.00	-64.47
302.85	68.18	19.42	3.55	2.60	4.42	-56.78	88	348.28	78.41	19.42	4.09	2.99	5.08	-65.30
309.06	69.78	19.42	3.61	2.64	4.49	-57.48	89	355.42	80.24	19.42	4.15	3.04	5.16	-66.10
315.19	71.36	19.42	3.66	2.68	4.56	-58.16	90	362.47	82.06	19.42	4.21	3.08	5.24	-66.88
320.26	72.56	19.42	3.69	2.70	4.59	-58.58	91	368.30	83.44	19.42	4.24	3.10	5.28	-67.37
325.39	73.76	19.42	3.72	2.72	4.62	-59.00	92	374.20	84.83	19.42	4.28	3.13	5.32	-67.85
330.24	74.91	19.42	3.74	2.74	4.65	-59.37	93	379.78	86.15	19.42	4.30	3.15	5.35	-68.27
335.14	76.07	19.42	3.76	2.75	4.68	-59.74	94	385.41	87.48	19.42	4.33	3.16	5.38	-68.69
340.08	77.24	19.42	3.79	2.77	4.71	-60.11	95	391.09	88.82	19.42	4.36	3.19	5.42	-69.12
343.48	78.01	19.42	3.83	2.80	4.76	-60.71	96	395.00	89.71	19.42	4.40	3.22	5.47	-69.81
346.91	78.79	19.42	3.86	2.83	4.80	-61.31	97	398.95	90.61	19.42	4.44	3.25	5.52	-70.51
350.38	79.58	19.42	3.90	2.85	4.85	-61.93	98	402.94	91.51	19.42	4.49	3.28	5.58	-71.22
353.88	80.37	19.42	3.94	2.88	4.90	-62.55	99	406.97	92.43	19.42	4.53	3.31	5.64	-71.93

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

AMERICO

AMERICO FINANCIAL LIFE AND ANNUITY INSURANCE COMPANY

Medicare Supplement Administrative Offices: PO Box 10812, Clearwater, FL 33757-8812 1-877-212-2346

MEDICARE SUPPLEMENT INSURANCE

Outline of Coverage for Policy Form AWI500

FEMALE Monthly Rates by Plan – Wisconsin Zip Codes: All Zip Codes that start with 535-549

Female / Non-Tobacco Rates								Female / Tobacco Rates						
Basic Policy	Part A Ded.	Part B Ded.	Part B Excess	Foreign Travel	Home Health	Part B Copay	Attained Age	Basic Policy	Part A Ded.	Part B Ded.	Part B Excess	Foreign Travel	Home Health	Part B Copay
399.45	73.49	19.42	5.02	3.67	6.24	-81.01	0-64	459.37	84.51	19.42	5.78	4.22	7.18	-93.16
133.15	24.50	19.42	1.67	1.23	2.08	-27.00	65	153.12	28.17	19.42	1.93	1.41	2.39	-31.05
133.15	24.50	19.42	1.67	1.23	2.08	-27.00	66	153.12	28.17	19.42	1.93	1.41	2.39	-31.05
133.15	24.50	19.42	1.67	1.23	2.08	-27.00	67	153.12	28.17	19.42	1.93	1.41	2.39	-31.05
133.15	24.50	19.42	1.67	1.23	2.08	-27.00	68	153.12	28.17	19.42	1.93	1.41	2.39	-31.05
138.87	25.66	19.42	1.74	1.27	2.17	-28.38	69	159.70	29.51	19.42	2.00	1.47	2.49	-32.63
144.45	26.44	19.42	1.81	1.32	2.25	-29.59	70	166.12	30.41	19.42	2.08	1.52	2.58	-34.03
149.39	27.73	19.42	1.87	1.36	2.32	-30.61	71	171.79	31.88	19.42	2.14	1.57	2.67	-35.20
154.32	29.01	19.42	1.92	1.41	2.39	-31.62	72	177.47	33.36	19.42	2.21	1.62	2.75	-36.37
159.26	30.30	19.42	1.98	1.45	2.46	-32.64	73	183.14	34.84	19.42	2.28	1.66	2.83	-37.53
164.19	31.58	19.42	2.04	1.49	2.53	-33.65	74	188.82	36.32	19.42	2.34	1.71	2.91	-38.70
169.21	32.88	19.42	2.10	1.53	2.61	-34.68	75	194.59	37.82	19.42	2.41	1.76	3.00	-39.88
173.29	34.30	19.42	2.14	1.57	2.67	-35.37	76	199.29	39.44	19.42	2.47	1.80	3.07	-40.68
177.41	35.73	19.42	2.19	1.60	2.73	-36.06	77	204.02	41.08	19.42	2.52	1.84	3.14	-41.47
181.65	37.19	19.42	2.24	1.64	2.79	-36.78	78	208.90	42.76	19.42	2.58	1.89	3.21	-42.30
185.94	38.66	19.42	2.30	1.68	2.85	-37.51	79	213.83	44.46	19.42	2.64	1.93	3.28	-43.13
190.37	40.17	19.42	2.35	1.72	2.92	-38.26	80	218.92	46.20	19.42	2.70	1.97	3.36	-44.00
194.86	41.62	19.42	2.39	1.74	2.97	-38.80	81	224.09	47.87	19.42	2.74	2.01	3.41	-44.61
199.51	43.11	19.42	2.43	1.77	3.02	-39.36	82	229.43	49.58	19.42	2.79	2.04	3.47	-45.26
204.20	44.62	19.42	2.47	1.80	3.07	-39.93	83	234.83	51.31	19.42	2.84	2.07	3.53	-45.92
208.95	46.15	19.42	2.51	1.83	3.12	-40.50	84	240.29	53.07	19.42	2.88	2.11	3.58	-46.58
213.75	47.69	19.42	2.55	1.86	3.17	-41.08	85	245.81	54.84	19.42	2.93	2.14	3.64	-47.24
218.33	48.86	19.42	2.59	1.89	3.22	-41.61	86	251.08	56.19	19.42	2.98	2.18	3.70	-47.85
222.98	50.05	19.42	2.63	1.92	3.27	-42.15	87	256.42	57.56	19.42	3.03	2.21	3.76	-48.47
227.69	51.26	19.42	2.67	1.95	3.32	-42.69	88	261.84	58.95	19.42	3.07	2.25	3.82	-49.09
232.35	52.46	19.42	2.72	1.98	3.38	-43.21	89	267.21	60.33	19.42	3.12	2.28	3.88	-49.70
236.96	53.65	19.42	2.76	2.01	3.42	-43.73	90	272.51	61.70	19.42	3.17	2.32	3.94	-50.28
240.78	54.55	19.42	2.77	2.03	3.45	-44.04	91	276.89	62.73	19.42	3.19	2.33	3.97	-50.65
244.63	55.46	19.42	2.80	2.04	3.48	-44.36	92	281.33	63.78	19.42	3.21	2.35	4.00	-51.01
248.28	56.32	19.42	2.81	2.06	3.50	-44.63	93	285.52	64.77	19.42	3.23	2.37	4.02	-51.33
251.96	57.19	19.42	2.83	2.07	3.52	-44.91	94	289.75	65.77	19.42	3.25	2.38	4.05	-51.65
255.67	58.07	19.42	2.85	2.08	3.54	-45.19	95	294.02	66.78	19.42	3.27	2.39	4.07	-51.97
258.23	58.65	19.42	2.88	2.10	3.58	-45.64	96	296.96	67.45	19.42	3.31	2.42	4.11	-52.49
260.81	59.24	19.42	2.90	2.12	3.61	-46.10	97	299.93	68.12	19.42	3.34	2.44	4.15	-53.01
263.42	59.83	19.42	2.93	2.15	3.65	-46.56	98	302.93	68.80	19.42	3.37	2.47	4.20	-53.54
266.05	60.43	19.42	2.96	2.17	3.68	-47.02	99	305.96	69.49	19.42	3.41	2.49	4.24	-54.08

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

AMERICO

AMERICO FINANCIAL LIFE AND ANNUITY INSURANCE COMPANY

Medicare Supplement Administrative Offices: PO Box 10812, Clearwater, FL 33757-8812 1-877-212-2346

MEDICARE SUPPLEMENT INSURANCE

Outline of Coverage for Policy Form AWI500

MALE Monthly Rates by Plan – Wisconsin Zip Codes: All Zip Codes that start with 535-549

Male / Non-Tobacco Rates								Male / Tobacco Rates						
Basic Policy	Part A Ded.	Part B Ded.	Part B Excess	Foreign Travel	Home Health	Part B Copay	Attained Age	Basic Policy	Part A Ded.	Part B Ded.	Part B Excess	Foreign Travel	Home Health	Part B Copay
459.37	84.51	19.42	5.78	4.22	7.18	-93.16	0-64	528.27	97.18	19.42	6.64	4.85	8.25	-107.14
153.12	28.17	19.42	1.93	1.41	2.39	-31.05	65	176.09	32.40	19.42	2.21	1.62	2.75	-35.71
153.12	28.17	19.42	1.93	1.41	2.39	-31.05	66	176.09	32.40	19.42	2.21	1.62	2.75	-35.71
153.12	28.17	19.42	1.93	1.41	2.39	-31.05	67	176.09	32.40	19.42	2.21	1.62	2.75	-35.71
153.12	28.17	19.42	1.93	1.41	2.39	-31.05	68	176.09	32.40	19.42	2.21	1.62	2.75	-35.71
159.70	29.51	19.42	2.00	1.47	2.49	-32.63	69	183.65	33.93	19.42	2.30	1.68	2.86	-37.53
166.12	30.41	19.42	2.08	1.52	2.58	-34.03	70	191.04	34.97	19.42	2.39	1.75	2.97	-39.14
171.79	31.88	19.42	2.14	1.57	2.67	-35.20	71	197.56	36.67	19.42	2.47	1.80	3.07	-40.48
177.47	33.36	19.42	2.21	1.62	2.75	-36.37	72	204.09	38.37	19.42	2.54	1.86	3.16	-41.82
183.14	34.84	19.42	2.28	1.66	2.83	-37.53	73	210.62	40.07	19.42	2.62	1.91	3.25	-43.16
188.82	36.32	19.42	2.34	1.71	2.91	-38.70	74	217.14	41.77	19.42	2.69	1.97	3.35	-44.50
194.59	37.82	19.42	2.41	1.76	3.00	-39.88	75	223.78	43.49	19.42	2.77	2.03	3.45	-45.87
199.29	39.44	19.42	2.47	1.80	3.07	-40.68	76	229.18	45.36	19.42	2.84	2.07	3.53	-46.78
204.02	41.08	19.42	2.52	1.84	3.14	-41.47	77	234.62	47.25	19.42	2.90	2.12	3.61	-47.69
208.90	42.76	19.42	2.58	1.89	3.21	-42.30	78	240.24	49.18	19.42	2.97	2.17	3.69	-48.64
213.83	44.46	19.42	2.64	1.93	3.28	-43.13	79	245.91	51.13	19.42	3.04	2.22	3.77	-49.60
218.92	46.20	19.42	2.70	1.97	3.36	-44.00	80	251.76	53.13	19.42	3.11	2.27	3.86	-50.60
224.09	47.87	19.42	2.74	2.01	3.41	-44.61	81	257.71	55.05	19.42	3.16	2.31	3.92	-51.31
229.43	49.58	19.42	2.79	2.04	3.47	-45.26	82	263.85	57.02	19.42	3.21	2.35	3.99	-52.05
234.83	51.31	19.42	2.84	2.07	3.53	-45.92	83	270.05	59.01	19.42	3.26	2.38	4.05	-52.80
240.29	53.07	19.42	2.88	2.11	3.58	-46.58	84	276.33	61.03	19.42	3.32	2.42	4.12	-53.56
245.81	54.84	19.42	2.93	2.14	3.64	-47.24	85	282.68	63.07	19.42	3.37	2.46	4.19	-54.33
251.08	56.19	19.42	2.98	2.18	3.70	-47.85	86	288.74	64.62	19.42	3.42	2.50	4.26	-55.03
256.42	57.56	19.42	3.03	2.21	3.76	-48.47	87	294.89	66.19	19.42	3.48	2.54	4.32	-55.74
261.84	58.95	19.42	3.07	2.25	3.82	-49.09	88	301.12	67.79	19.42	3.53	2.58	4.39	-56.46
267.21	60.33	19.42	3.12	2.28	3.88	-49.70	89	307.29	69.38	19.42	3.59	2.62	4.46	-57.15
272.51	61.70	19.42	3.17	2.32	3.94	-50.28	90	313.38	70.95	19.42	3.64	2.66	4.53	-57.83
276.89	62.73	19.42	3.19	2.33	3.97	-50.65	91	318.43	72.14	19.42	3.67	2.68	4.56	-58.24
281.33	63.78	19.42	3.21	2.35	4.00	-51.01	92	323.53	73.34	19.42	3.70	2.70	4.60	-58.66
285.52	64.77	19.42	3.23	2.37	4.02	-51.33	93	328.35	74.48	19.42	3.72	2.72	4.62	-59.03
289.75	65.77	19.42	3.25	2.38	4.05	-51.65	94	333.22	75.63	19.42	3.74	2.74	4.65	-59.39
294.02	66.78	19.42	3.27	2.39	4.07	-51.97	95	338.13	76.80	19.42	3.77	2.75	4.68	-59.76
296.96	67.45	19.42	3.31	2.42	4.11	-52.49	96	341.51	77.56	19.42	3.80	2.78	4.73	-60.36
299.93	68.12	19.42	3.34	2.44	4.15	-53.01	97	344.92	78.34	19.42	3.84	2.81	4.78	-60.96
302.93	68.80	19.42	3.37	2.47	4.20	-53.54	98	348.37	79.12	19.42	3.88	2.84	4.82	-61.57
305.96	69.49	19.42	3.41	2.49	4.24	-54.08	99	351.86	79.91	19.42	3.92	2.86	4.87	-62.19

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