Lumico

insurance made clear

AGENT UNDERWRITING GUIDE

MEDICARE SUPPLEMENT

Updated 9/7/18

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IMPORTANT CONTACT INFORMATION

New business, claims, administration, and overnight mailing address:

New Business Mailing Address:	For Overnight Mail:
Lumico Life Insurance Company Medicare Supplement Underwriting P.O. Box 10874 Clearwater, FL 33757-8874	17757 US HWY 19 N Suite 660 Clearwater FL 33764
Policy Administration Mailing Address:	
Lumico Life Insurance Company Medicare Supplement Administration P.O. Box 10875 Clearwater, FL 33757-8875	

Telephone Numbers:	
Customer Service, New Business, Claims, Underwriting	1-855-774-4491
Commissions	1-855-774-4491
Fax Numbers:	
Underwriting	1-855-774-4492
New Business	1-833-522-4001
Policyowner Services	1-816-701-2549

WELCOME TO LUMICO

We are committed to providing your customers with what they should expect from insurance—a high quality product, reasonable price, and an easy process—all achieved with great ease.

You can feel confident that you are working with an insurance company that has the experience of being in business for over 50 years - and recognizes that insurance needs to be different than it was 50 years ago.

Backed by Swiss Re

We are rated “A” by A.M. Best. “A” is excellent and is the second highest rating that can be awarded and means that Lumico is financially stable and secure[1].

We are backed by Swiss Re, a global reinsurance company with $74 trillion in assets under management.

[1] These ratings reflect claims paying ability but are not a guarantee of future performance

SUBMITTING AN APPLICATION

There are several ways that an application for Lumico Medicare Supplement can be submitted. Our easiest and quickest process is by using our electronic application (e-App).

e-App Process

You can access our e-app through Lumico's Agent Health Portal https://agenthealthportal.lumico.com. The e-app will walk you through all the required sections that must be completed within the e-app.

If all Underwriting criteria is met, the applicant will be provided their policy number and information pertaining to the first draft of their premium.

Upload to Agent Portal

The Upload function can be found within the Agent Portal. This function may be used to upload applications and other forms rather than mailing or faxing them. The Upload function accepts most file formats, such as PDF and JPEG.

Agent Health Portal

In order to issue your clients' Medicare Supplement insurance policies as quickly and efficiently as possible, while assuring proper evaluation of each risk, the Agent Health Portal will be used as the primary means of communicating the status of your submitted business. You can access the Agent Portal via https://agenthealthportal.lumico.com

Some of the things you can do on the Agent Portal include:

- Print a temporary ID card
- Access your customer's policy for electronically delivered policies
- Submit an updated address, phone number or email address
- View HIPAA Privacy and GLB notices
- Print forms for:
    - Address Change
    - Electronic Payment Authorization Form
    - Release of Personal and Medical Information
- Name Change
- View Agent alerts regarding application delays
- Check the status of submitted applications

POLICY ISSUE GUIDELINES

All applicants must be covered under Medicare Part A & Part B to be eligible for Lumico Medicare Supplement Insurance. The policy issued is specific to the state of residence. The applicant's state of residence controls the application, forms, premium, and policy issue. If an applicant has more than one residence, the state where the Federal Income Taxes are filed should be considered the state of residence. Please refer to your introductory materials for required forms specific to your state. Also refer to the Appendix for state-specific guidelines for application dates.

Underwritten Policies

Applicants over the age of 65 and at least six (6) months beyond enrollment in Medicare Part B (or those that do not qualify for a GI reason) will be underwritten. In addition, disabled applicants that are not applying during open enrollment or who do not qualify for guaranteed issue will be underwritten also. All health questions must be answered, including providing all prescription history on the application. The answers to the health questions on the application will determine eligibility for coverage. Both the drugs listed on the application and any prescription drug information returned from the prescription drug screen will be used to verify eligibility.

- Underwritten cases may be submitted up to 60 days prior to the requested coverage effective date. For Annual Enrollment Period (4th quarter of the calendar year), underwritten cases may be submitted beginning September 15 of that year.
- Individuals whose employer group plan health coverage is ending can apply up to 60 days prior to the requested effective date.

Open Enrollment

To be eligible for Open Enrollment, an applicant must be at least 64 ½ years of age (in most states) and be within six (6) months of enrollment in Medicare Part B.

Applicants covered under Medicare Part B prior to age 65 are eligible for a six (6) month Open Enrollment period upon reaching age 65.

Special Enrollment Windows

Certain states have special enrollment windows. Refer to the Appendix for additional details.

Guaranteed Issue

In some states, loss of Medicaid health benefits qualifies Medicare beneficiaries for Guaranteed Issue into a Medicare Supplement product. Refer to the Appendix for where such situations apply.

The rules for qualification under Guaranteed Issue determined by Federal requirements. These rules can also be found in the Centers for Medicare & Medicaid Services (CMS) annual

publication, “Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare.”

Applicant has a guaranteed issue right if...	**Applicant has the right to buy...**	**Applicant can/must apply for a Medigap policy...**
He/she is in a Medicare Advantage Plan (like an HMO or PPO), and their plan is leaving Medicare or stops giving care in their area, or they move out of the plan’s service area.	Medigap Plan A, B, C, F, K, or L that’s sold in their state by any insurance company. They only have this right if they switch to Original Medicare rather than join another Medicare Advantage Plan.	As early as 60 calendar days before the date their health care coverage will end, but no later than 63 calendar days after their health care coverage ends. Medigap coverage can’t start until their Medicare Advantage Plan coverage ends.
He/she has Original Medicare and an employer group health plan (including retiree or COBRA coverage) or union coverage that pays after Medicare pays and that plan is ending. **Note:** In this situation, they may have additional rights under state law.	Medigap Plan A, B, C, F, K, or L that’s sold in their state by any insurance company. If they have COBRA coverage, they can either buy a Medigap policy right away or wait until the COBRA coverage ends.	No later than 63 calendar days after the latest of these 3 dates: 1. Date the coverage ends 2. Date on the notice they get telling them that coverage is ending (if they get one) 3. Date on a claim denial, if this is the only way they know that their coverage ended
He/she has Original Medicare and a Medicare SELECT policy. They move out of the Medicare SELECT policy’s service area. Call the Medicare SELECT insurer for more information about options.	Medigap Plan A, B, C, F, K, or L that’s sold by any insurance company in their state or the state they’re moving to.	As early as 60 calendar days before the date their Medicare SELECT coverage will end, but no later than 63 calendar days after their Medicare SELECT coverage ends.
(Trial right) They joined a Medicare Advantage Plan (like an HMO or PPO) or Programs of All-inclusive Care for the Elderly (PACE) when they were first eligible for Medicare Part A	Any Medigap policy that’s sold in your state by any insurance company.	As early as 60 calendar days before the date their coverage will end, but no later than 63 calendar days after their coverage ends.

at 65, and within the first year of joining, they decide they want to switch to Original Medicare.		**Note:** Rights may last for an extra 12 months under certain circumstances.
(Trial right) They dropped a Medigap policy to join a Medicare Advantage Plan (or to switch to a Medicare SELECT policy) for the first time, they've been in the plan less than a year, and they want to switch back.	The Medigap policy they had before they joined the Medicare Advantage Plan or Medicare SELECT policy, if the same insurance company they had before still sells it. If their former Medigap policy **isn't** available, they can buy Medigap Plan A, B, C, F, K, or L that's sold in their state by any insurance company.	As early as 60 calendar days before the date their coverage will end, but no later than 63 calendar days after their coverage ends. **Note:** Rights may last for an extra 12 months under certain circumstances.
Their Medigap insurance company goes bankrupt and they lose their coverage, or their Medigap policy coverage otherwise ends through no fault of their own.	Medigap Plan A, B, C, F, K, or L that's sold in their state by any insurance company.	No later than 63 calendar days from the date their coverage ends.
They leave a Medicare Advantage Plan or drop a Medigap policy because the company hasn't followed the rules, or it misled them.	Medigap Plan A, B, C, F, K, or L that's sold in their state by any insurance company.	No later than 63 calendar days from the date their coverage ends.

FIELD UNDERWRITING GUIDELINES

Unless an application is completed during an Open Enrollment or Guarantee Issue period, the applicant will be underwritten for coverage. This includes:

1. Tobacco use status
2. Answering all health questions on the application, including the question regarding prescription medication,
3. Disclosure of height and weight,
4. Validation of pharmaceutical information, and
5. Telephone interview at the underwriter's discretion.

Build Chart

Use the following chart to determine the eligibility of the applicant based upon height and weight. If the height and weight combination is in a range under the "Decline" column, the applicant is not eligible for coverage.

	Decline	Proceed	Decline
Height	Weight	Weight	Weight
4' 2"	< 54	54 – 145	146 +
4' 3"	< 56	56 – 151	152 +
4' 4"	< 58	58 – 157	158 +
4' 5"	< 60	60 – 163	164 +
4' 6"	< 63	63 – 170	171 +
4' 7"	< 65	65 – 176	177 +
4' 8"	< 67	67 – 182	183 +
4' 9"	< 70	70 – 189	190 +
4' 10"	< 72	72 – 196	197 +
4' 11"	< 75	75 – 202	203 +
5' 0"	< 77	77 – 209	210 +
5' 1"	< 80	80 – 216	217 +
5' 2"	< 83	83 – 224	225 +
5' 3"	< 85	85 – 231	232 +
5' 4"	< 88	88 – 238	239 +
5' 5"	< 91	91 – 246	247 +
5' 6"	< 93	93 – 254	255 +
5' 7"	< 96	96 – 261	262 +
5' 8"	< 99	99 – 269	270 +
5' 9"	< 102	102 – 277	278 +
5' 10"	< 105	105 – 285	286 +
5' 11"	< 108	108 – 293	294 +
6' 0"	< 111	111 – 302	303 +
6' 1"	< 114	114 – 310	311 +
6' 2"	< 117	117 – 319	320 +
6' 3"	< 121	121 – 328	329 +
6' 4"	< 124	124 – 336	337 +
6' 5"	< 127	127 – 345	346 +
6' 6"	< 130	130 – 354	355 +
6' 7"	< 134	134 – 363	364 +
6' 8"	< 137	137 – 373	374 +
6' 9"	< 140	140 – 382	383 +

6' 10"	< 144	144 – 392	393 +
6' 11"	< 147	147 – 401	402 +
7' 0"	< 151	151 – 411	412 +
7' 1"	< 155	155 – 421	422 +
7' 2"	< 158	158 – 431	432 +
7' 3"	< 162	162 – 441	442 +
7' 4"	< 166	166 – 451	452 +

Health Questions

The tobacco question must be answered for all applications, even for Open Enrollment and Guaranteed Issue, unless a state variation exists.

Any "Yes" answer to Section IV will be automatically declined.

UNINSURABLE HEALTH CONDITIONS

While not all-inclusive, the following conditions would be considered declinable during the underwriting process:

AIDS/HIV	Crippling/disabling arthritis
ALS (Amyotrophic Lateral Sclerosis)/ Lou Gehrig's Disease	Diabetes with >50 units insulin per day
Alzheimer's disease	More than two blood pressure medications (diabetics only)
ARC (AIDS related complex)	Lupus – systemic
Chronic Hepatitis	Multiple Sclerosis (MS)
Chronic Kidney Disease or Renal Failure Requiring Dialysis	Muscular Dystrophy
Chronic obstructive pulmonary disease (COPD)	Myasthenia Gravis
Other chronic pulmonary disorders, including:	Organ transplant (stem cells included, corneal transplants excluded)
Bronchiectasis	Osteoporosis with fracture
Chronic asthma	Parkinson's disease
Chronic bronchitis	Scleroderma
Chronic interstitial lung disease	Senile Dementia
Chronic pulmonary fibrosis	Other cognitive disorders, including:
Cystic fibrosis	Mild cognitive impairment (MCI)
Emphysema	Delirium
Sarcoidosis	Dementia
Cirrhosis	Organic brain disorder
More than two (2) diabetes medications	

In addition to the conditions noted above, the following will also lead to a decline in coverage:

- Use of a nebulizer more than once per month
- Use of oxygen
- An implanted cardiac defibrillator or pacemaker/defibrillator combination unit.
- Any medication administered in a physician's office (including, but not limited to, injectables).
- An applicant does not meet height and weight requirements listed in the Build Chart.
- Any applicant who has been referred for further diagnostic testing or consultation with an additional physician that has not been completed

Applicants with Arthritis

Crippling/disabling arthritis is determined by many factors. Some factors for consideration include:

- Can the applicant perform their activities of daily living such as, dressing, eating, bathing, housework and shopping without limitations?
- Does the applicant require any assistance in walking, such as, use of a cane, walker, wheelchair, or does another person provide assistance?
- Is the applicant currently receiving, considering or have they been advised by a physician to have physical therapy, surgery or injections?
- Has the applicant received any injections or infusions within the past 12 months for arthritis or degenerative bone disease?

Applicants with well-controlled diabetes and hypertension

Consideration for coverage may be given to those persons with well-controlled cases of diabetes with hypertension. A case is considered well-controlled if the person is taking less than 50 units of insulin daily, **or** no more than two oral or injectable medications for diabetes and no more than two medications for hypertension. We consider hypertension stable if recent average high blood pressure readings are 150/90 or lower, treated or untreated.

Applicants with diabetes that have ever required more than 50 units of insulin daily, or applicants with diabetes (insulin dependent or treated with oral medications) who also have one or more of the complication conditions listed in this question of the application, are not eligible for coverage.

Consideration Health Questions

In general, if an applicant answers "Yes," to Question 9, they ***may*** be eligible for coverage. The underwriter will conduct a phone interview to obtain further information regarding the condition(s) listed below:

- Coronary artery disease, angina, aortic or cardiac aneurysm, cardiomyopathy, congestive heart failure, heart valve disorder, atrial fibrillation, or other heart rhythm disorder
- Peripheral artery disease, peripheral vascular disease, peripheral venous thrombotic disease, or carotid artery disease
- Degenerative bone disease, spinal stenosis, or rheumatoid arthritis
- Any mental or nervous disorder requiring treatment by a psychiatrist

Pharmaceutical Information

Lumico has implemented a process to support the collection of pharmaceutical information for underwritten Medicare Supplement applications. In order to obtain the pharmaceutical information, the Release of Personal and Medical Information form must be signed by the applicant.

Medication Guidelines

Use of the following drugs will result in an automatic decline. (Note, this list is **not** all inclusive.) The same drugs may have other names (generic or brand names) or they may be included with other drugs with a combination name.

3TC	Hydrea	Procrit
Adriamycin	Hydergine	Prolixin
Akineton	Imuran	Razadyne
Aldesleukin	Interferon	Remicade
Alkeran	Indinavir	Reminyl
Amantadine	Invirase	Requip
Apokyn	Kemadrin	Retrovir
Aricept (Donepezil)	Lasix (Furosemide)	Rebif
Artane	(>60 mg/day)	Ridaura (Auroanofin)
Avonex	L-Dopa (Levodoopa)	Ribavirin
Azilect	Leukeran	Riluzole
AZT	Lioresal	Risperdal (Risperidone)
Baclofen	Lithium	Ritonavir
Betaseron	Lomustine	Sandimmune
Cerefolin	Lupron	Seroquel
Carbidopa	Megace (Megestrol)	Sinemet
Clozapine	Mellaril (Thioridazine)	Stalevo
Cogentin	Melphalan	Stelazine
Cognex	Memantine	Sustiva
Comantan	Mtrifonate	Symmetrel
Copaxone	Mirapex	Tacrine
Cytoxan	Moban	Tasmar
D4T	Myleran	Teslac
DDC	Namenda	Thiotepa
DES	Navane (Thiothixene)	Thorazine
Dopar	Nelfinavir	Tysabri
Eldepryl	Neoral	VePesid
Enbrel	Neupro	Vincristine
Epogen	Oncovin	Viramune
Ergoloid	Paraplatin	Zanosar
Exelon (Rivastigmine)	Parlodel	Zelapar
Falantamine	Permax	Zoladex
Gold	Prednisone (>10 mg/day)	Zyprexa
Haldo (Haloperidol)		
Herceptin		

Replacements

A replacement takes place when an applicant wishes to exchange a new Lumico Medicare Supplement policy for:

1. an existing Lumico Life Medicare Supplement policy of lesser or greater value, or
2. a policy with an external company.

Internal and external replacements are processed in the same manner and both require a newly completed application with full Underwriting.

All applications submitted as a result of a replacement must include all answers to Section VII of the application (Replacement Questions) for the state in which the application is signed. One copy is to be provided to the applicant, and one copy should accompany the application.

COMPLETING THE REPLACEMENT SECTION OF THE APPLICATION (SECTION VII)

- Applications may be submitted for applicants that have just enrolled in Medicare Part B even though they have not yet received their Medicare ID card.
- The Part B enrollment date must be provided, as it is used to determine if the applicant is in an Open Enrollment period.
- Question 2 pertains to state Medicaid programs:
    - If the applicant is covered by the Medicaid-QMB program, the applicant is not eligible for coverage. The application will be processed as a non-medical decline.
    - If the applicant is covered by the Medicaid-SLMB program, there are no special restrictions on buying a Medicare Supplement policy. If the applicant is covered by a program other than Medicaid-SLMB, additional documentation or information is required to determine whether the applicant can purchase a Medicare Supplement policy.
- Question 3 pertains to the replacement of a Medicare Advantage, Medicare PPO/HMO policy or certificate. Lumico will verify on Medicare's website if the applicant has been dis-enrolled from the Medicare Advantage policy. Lumico cannot issue a policy without confirmation of this information.
- Question 4 pertains to the replacement of an existing Medicare Supplement policy. If this question is answered "Yes", the Replacement form must also be completed.
- Question 5 pertains to coverage under any other health insurance within the past 63 days (for example, an employer, union, or individual plan). Note that maintaining a non-Medicare group plan and a Medicare supplement is not considered double coverage.

Telephone Interviews

A telephone interview may be conducted at the discretion of the Underwriter. Please be sure to advise your clients that we may be contacting them to conduct an interview. Telephone interviews for health information is only conducted for Underwritten policies; for Open Enrollment and Guarantee Issue applications, health questions will not be asked of the applicant. If we are unable to complete the telephone interview, we will decline the application.

Processing Delays

If an application is submitted with incomplete, unclear, or missing information that is critical to policy issuance, we may conduct a phone interview. If we are able to issue the policy as a result, we may issue an amendment to the application. Critical information includes, but is not limited to:

- Plan type
- Complete residential address
- Date of birth
- Any health question left blank (if not Open Enrollment or Guaranteed Issue).
- Prescription medication section left incomplete (if not Open Enrollment or Guaranteed Issue)
- Tobacco use
- Applicant's signature
- Agent's signature
- Medical coverage replacement section is not completed
- The application is received at the administrative office more than 30 days from the signature date, or if the signature date is in the future
- Authorization and Certification Form was not completed and signed
- Release of Personal and Medical Information was not signed and submitted for an underwritten application
- Replacement forms not submitted when applicable
- Medicare Part B enrollment date and/or Medicare Number (MBI/Claim #) were left blank. This number is critical for the proper processing of claims.
- Payor information – a third party payor that has no immediate family OR business relationship to the applicant will be reviewed by the Underwriter, even if the application is during Open Enrollment or Guaranteed Issue.

Declined Applications

Applications will be declined for the following reasons, although this list is not all-inclusive:

- The applicant does not recall filling out the application.
- An underwritten application was signed by a Power of Attorney
- If a telephone interview is required and cannot be properly conducted
- If additional forms requested by the underwriter are not submitted within the allotted time frame
- If the applicant is replacing a Medicare Advantage Plan and we are unable to verify disenrollment from the plan
- If the applicant is deemed uninsurable after completing our underwriting process

DECLINE PROCESS

If the Applicant is declined for coverage, we will send the applicant a letter informing them of where and how they can obtain specific information about the decline.

DECLINE APPEALS

If the applicant wishes to appeal his/her declined application, a written request must be submitted by the applicant to the Underwriting Manager within 60 days of the decision. If more than 60 days have passed since the decline, the applicant will be required to submit a new application and a telephone interview will be completed.

All appeals require medical records pertaining to the condition for which the applicant was declined. It is the responsibility of the applicant to obtain his/her medical records. Medical records must be submitted to the Underwriting Department directly from the physician's office and *will not be accepted if submitted by the applicant or agent*. Please note that Lumico does not reimburse any fees associated with obtaining medical records or other supporting documentation pertaining to the requested appeal.

The written request and medical records may be faxed to 1-855-774-4492 and directed to the attention of the Medicare Supplement Underwriting Manager. The request and records may also be mailed to the physical address or post office box noted on page 3 of this Guide.

Amendments

An Amendment to the application will be generated for the following reasons:

- Any question left blank or answered incorrectly (as determined by a telephone interview).
- An error or unclear answer for the plan selection and/or underwriting risk classification.
- An error or unclear answer for the date of birth, sex, and/or address.
- An error or unclear answer for the modal premium.

In Kentucky, the use of amendments are not permitted. Any corrections needed to an application will need to be made prior to policy issuance.

Free Look Cancellation

Applicants who wish to cancel an issued policy during the 30-day Right to Examine period must provide written notice of their request. The request can be in the form of a returned insurance policy appropriately marked indicating they do not wish to keep the insurance policy or may be in the form of a signed letter or other signed written statement. Lumico requests that the original policy be returned to Lumico within 30 days of receipt. The policy fee and any premium paid, less any claim paid, will be refunded. A letter confirming the insurance policy was cancelled will be mailed to the applicant. A message through the Agent Portal will be sent to the writing agent.

Any commission paid will be reversed.

PLANS

Lumico offers four standard Medicare Supplement plans. Available choices are: A, F, G, and N. The plan selection must be indicated on the application in the space provided. Please note plan availability may vary by state. Refer to the Appendix for state availability by plan.

Premium Calculations

The following steps outline how to calculate a premium for a given client:

1. Determine the ZIP code where the client resides and find the correct rate page for that ZIP code.
2. Determine plan the applicant has chosen.
3. Determine if tobacco or non-tobacco rates apply
4. Locate age and gender, and verify that the age and date of birth are the exact age as of the effective date.
5. This will be your annual base premium.
6. Apply the Household Discount, if applicable.
7. If you are paying a premium modal other than monthly, divide the annual base premium by the applicable mode.

Example:
A client just turned 65 and is applying for Medicare Supplement for the first time. She is applying with her husband and a Household Discount is available in her state.

Step 1: Zip code	85003
Step 2: Plan	Plan F
Step 3: Tobacco use	Non-Tobacco
Step 4: Age/Gender	Female, Age 65
Step 5: Annual Base Premium	$1,406
Step 6: Household Discount	$1,406 X (100% - 7%) = $1,307.58
Step 7: Apply premium mode	Monthly: $1,307.58 ÷ 12 = $108.97

In addition, there is a one-time policy fee of $25 (or as determined by state variation), payable at the time of application. The above example does not reflect addition of this policy fee.

Household Discount

If an applicant resides in a state where a Household Discount is available and meets the criteria noted below, he or she may be eligible for a household discount upon coverage approval.

In order for an individual to qualify for a Household Discount, the applicant must meet **one** of the following criteria:

a) married and residing with their spouse; ***OR***,
b) must have resided in the same household with an individual that is at least 50 years old for the last 12 months.

Ohio and Illinois applicants applying for the household discount must meet the following criteria:

a) Married and residing w/legal spouse or reside with the person named on the form for at least 12 months, ***AND***
b) the person named on the form must currently be applying for, or have an active Lumico Medicare Supplement policy.

Kentucky applicants applying for the household discount must meet the following criteria:

a) married and residing with their spouse; ***OR***,
b) must have resided in the same household with an individual for the last 12 months.

Individuals applying for the household discount must complete the Household Discount request form and submit it along with the completed application.

Telephone interviews may be conducted to confirm that the applicant qualifies for the household discount.

Tobacco Class

Unless otherwise determined by state law, the underwriting class is determined by the applicant's use of any form of tobacco, including e-cigarettes, nicotine patches, cigars, chewing tobacco or a pipe in the past twelve months. If tobacco has been used during this time frame, the class selected and the premium noted should be Standard. If there has been no usage of any form of tobacco in the past twelve months, the Preferred (non-tobacco) premium should be noted.

Methods of Payment

The method of premium payment should be selected on the application with the modal premium indicated in the designated field. Please note, the modal premium does not include the insurance policy fee.

Bank Draft

A completed Electronic Bank Draft Authorization form must accompany the application. If the applicant wishes to draft from a savings account, the Electronic Bank Draft Authorization form must be filled out in its entirety. If the information provided is incomplete or unclear, Lumico will require proof of the routing number and account number from the financial institution.

The initial premium may be drafted upon approval of coverage. If a specified date (e.g. preferred payment date) for drafting of renewal premiums is not selected by the applicant, the effective date will be the draft date.

Preferred Payment Dates

The applicant may select any day between the 1st and the 28th of the month for drafting of renewal premiums. If the date falls on a weekend or a holiday, the draft will occur on or about the next business day.

If the customer would like to have their draft dates coincide with their Social Security deposit date, they may elect to do so. The chart below outlines how to specify a date for this case:

	Benefits Paid On
*Birth Date on 1st - 10th	Second Wednesday**
*Birth Date on 11th - 20th	Third Wednesday**
*Birth Date on 21st - 31st	Fourth Wednesday**
Supplemental Security Income (SSI)	1st of the Month**
Beneficiaries who started receiving Social Security Benefits prior to May 1997 or who are receiving both SSI and Social Security	3rd of the Month**

*For beneficiaries who first started receiving Social Security May 1997 or later
**If date falls on weekend or holiday, the draft will occur on the prior business day.

Insurance Policy Effective Date

For underwritten applications, we will honor requests for effective dates starting from the date the application was signed up to 60 days in the future. During Annual Enrollment Period (4th Quarter), we will allow signatures dated September 15 for a January 1 effective date. For replacements, the effective date cannot be prior to the end date of the Medicare Supplement or Medicare Advantage policy that is being replaced.

For Open Enrollment applications received before the applicant's 65th birthday, the effective date of the insurance policy must be within the 6-month Open Enrollment window.

Applications may not be backdated prior to the application signature date for any reason, including to save age.

Insurance policies may not be effective on the 29th, 30th, or 31st of the month. Applications written on these days will be made effective on the 1st of the following month (unless otherwise requested; see below).

For applications submitted during the Oregon Annual Enrollment period, the earliest effective date is the applicant's date of birth, and the latest available effective date is 30 days after their birthday, to the day.

For applications submitted during the Missouri Annual Enrollment period, the latest available effective date is 60 days from the sign date.

POLICY SERVICES

Claims

Please call 1-855-774-4491 for Claims to assist with any questions regarding claims. NOTE: All claims submitted to Medicare by the health care provider will automatically be filed with us electronically once Medicare has released payment.

Application Assistance

If you have any questions about the application or about how to answer any of the questions on the application, please contact your marketing agency for assistance.

To check on the status of an application submitted, you may access the Agent Portal at any time.

Policy Reinstatement

If any renewal premium is not paid following 31 days from the premium due date, the policy will lapse and coverage will terminate. Within 60 days of the last paid to date, coverage may be reinstated, based upon meeting the underwriting requirements.

If coverage was voluntarily cancelled by the policyholder, or the policy has lapsed and it is more than 90 days beyond the last paid to date, the coverage cannot be reinstated. The client may, however, apply for new coverage. All underwriting requirements must be met before a new policy can be issued.

APPENDIX

STATE SPECIFIC REQUIREMENTS

Enrollment Windows

For both MO and OR, documentation verifying plan information for prior coverage should be provided. The current insurer's policy schedule page containing (at a minimum) the policyholder name, plan and policy effective date. If the policy being replaced has been inforce more than 2 years ago, we will also need proof showing the current paid to date of the policy.

Missouri
Annual Open Enrollment lasting 90 days, beginning 60 days before and ending 30 days after the Individual's policy anniversary date, during which time a person may replace any Medicare supplement plan with the same plan. If the individual is covered under a Medicare discontinued plan design, Plans A, F, G or N may be available.

Oregon
During annual Birthday Enrollment which lasts 60 days, beginning 30 days before and ending 30 days after the individual's birthday, a person may replace any Medicare Supplement policy with a policy of equal or lesser benefits. Coverage will not be made effective prior to the individual's birthday. Please include documentation verifying plan information for prior coverage. A replacement form must also accompany the completed application.

Plans issued prior to January 1, 1990 are not eligible under this rule.

OREGON ANNUAL ENROLLMENT

I have a:	I can replace it with:								
	A	B	C	D	G	K	L	M	N
1990 or 2010 Medicare Supplement Plan A	X								
1990 or 2010 Medicare Supplement Plan B	X	X							
1990 or 2010 Medicare Supplement Plan C	X	X	X	X		X	X	X	X
1990 or 2010 Medicare Supplement Plan D	X	X		X		X	X	X	X
1990 Medicare Supplement Plan E	X	X		X		X	X	X	X
1990 or 2010 Medicare Supplement Plan F (not a high deductible plan F)	Any 2010 Medicare Supplement Plan (except for inovative Plan F)*								
1990 or 2010 Medicare Supplement High Deductible Plan F	2010 Medicare Supplement High Deductible Plan F								
1990 or 2010 Medicare Supplement Plan G	X	X		X	X	X	X		X
1990 Medicare Supplement Plan H	X	X		X		X	X	X	X
1990 Medicare Supplement Plan I	X	X		X	X	X	X		X
1990 Medicare Supplement Plan J	Any 2010 Medicare Supplement Plan								
1990 Medicare Supplement High Deductible Plan J	2010 Medicare Supplement High Deductible Plan F								
1990 or 2010 Medicare Supplement Plan K						X			
1990 or 2010 Medicare Supplement Plan L						X	X		
2010 Medicare Supplement Plan M								X	X
2010 Medicare Supplement Plan N									X

APPLICATION DATES

- For applications submitted during the Oregon Annual Enrollment period, the earliest effective date is the applicant's date of birth, and the latest available effective date is 30 days after their birthday, to the day.
- For applications submitted during the Missouri Annual Enrollment period, the latest available effective date is 60 days from the sign date.
- Wisconsin applications may be taken up to 90 days prior to the month the applicant turns age 65.

Guaranteed Issue

State	Qualifications	Plans Offered
KS	The individual must no longer be eligible to receive Medicaid health benefits.	A, C, F, N
TN	Client, age 65 and older covered under Medicare Part B, enrolled in Medicaid (TennCare) and the enrollment involuntarily ceases, is in a Guaranteed Issue beginning with notice of termination and ending 63 days after the termination date. Client, under age 65, losing Medicaid (TennCare) coverage has a 6 month Open Enrollment period beginning on the date of involuntary loss of coverage.	A, C F Any Medigap plan offered by an insurer
TX	The individual must no longer be eligible to receive Medicaid health benefits.	A, B, C, F
UT	Medicaid health benefits must involuntarily terminate.	A, C, F
WI	Individual is eligible for benefits under Medicare Parts A and B and is covered in the medical assistance program and loses eligibility in the medical assistance program	All Plans and riders

NOTE: The individual must apply within 63 days of loss of coverage with appropriate documentation.

For persons **voluntarily** leaving their employer group coverage, Guaranteed Issue rights are only available in the following states:

CO,ID,IL,IN, MT,NJ,NV, OH,PA,TX	If the employer sponsored plan is primary to Medicare.	A, *B, C F
NM, OK, VA, WV	If the Employer sponsored plan's benefits are reduced substantially.	A, C, F
AR, KS, LA, MO, SD	No conditions – always qualifies	A, *B, C F

**Please note: Plan B is not available in all states.*

For purposes of determining GI eligibility due to a Voluntary termination of an employer sponsored group welfare plan, a reduction in benefits will be defined as any increase in the insured's deductible amount or their coinsurance requirements (flat dollar co-pays or coinsurance %). A premium increase without an increase in the deductible or coinsurance requirement will not qualify for GI eligibility. This definition will be used to satisfy NM, OK, VA and WV requirements. Proof of coverage termination is required. For most states, plans A, B, C or F are available for Guarantee issue applications.

State Specific Forms

Illinois – Medicare Supplement Checklist: this form must be signed by the applicant and agent and submitted along with the application. This is a state required form and must show a valid benefit comparison for each item listed on the form.

Kentucky – Medicare Supplement Comparison Statement: this statement must be completed for any application replacing a Medicare Supplement or Medicare Advantage plan. The form must be signed by the applicant, and submitted along with the application. This is a state required form and must show a valid benefit comparison for each item listed on the form.

Ohio – Agent Medicare Supplement Insurance Solicitation Notice: this notice must be completed, signed by the agent and broker, and submitted along with the application.

State Availability by Product

The chart below shows current state availability by product:

State	Tobacco Rates during OE?
Arizona	**Y**
Georgia	**Y**
Illinois	**N**
Indiana	**Y**
Kentucky	**N**
Louisiana	**N**
Michigan	**N**
Mississippi	**Y**
North Carolina	**N**
Nebraska	**Y**
Ohio	**N**
Pennsylvania	**N**
South Carolina	**N**
Tennessee	**N**
Texas	**Y**