Physicians Select Insurance Company®
a member of the Physicians Mutual family

Physicians Mutual®
Insurance for all of us.®

Physicians Select Insurance Company Product & Underwriting Guidelines For Medicare Supplement Plans

Revised 07/01/2023

For Agent Use Only

PHYSICIANS SELECT INSURANCE COMPANY

PRODUCT & UNDERWRITING GUIDELINES
MEDICARE SUPPLEMENT PLANS

Note: Wisconsin Product & Underwriting Guidelines available separately

TABLE OF CONTENTS

PRODUCT & UNDERWRITING GUIDELINES
MEDICARE SUPPLEMENT
PHYSICIANS SELECT PLANS

CONTACTS

For questions concerning possible eligibility of a Medicare Supplement applicant:

Email **askmedsupp@physiciansmutual.com** (For general questions only. Please DO NOT include personal information or case specific inquiries.)

Field personnel and agents need to refer to previously released Agency field memos for state regulation Medicare Supplement Open Enrollment & Guaranteed Issue Rules and Product & Underwriting Guidelines located in S3 – Select your state – Medicare Supplement – Underwriting.

Home Office employees can locate the state guidelines in MS Word:

- I:\DEPTS\XG&I\Common\xOPNENRL & GUARISS.doc

PRODUCT INFORMATION

A Medicare Supplement policy is an Individual Health Insurance policy that can help pay some of the healthcare costs that original Medicare doesn't cover.

Listed in the grid below are the Medicare Supplement plans offered by Physicians Select Insurance Company on or after July 1, 2019, and a brief description of each plan. *Starting in 2020, Congress will no longer allow Medicare Supplement (Medigap) Plan F to be sold to those first eligible for Medicare on or after January 1, 2020.

See the Medicare Supplement application or brochure to see what plans are available in your state.

See the **Outline of Coverage** for more product details.

☐ Plan A [S060]	☐ Plan G [S066]
☐ Innovative Plan G [S066+F018]	☐ High Deductible Plan G [S068]

For those first eligible for Medicare <u>prior to January 1, 2020:</u>

☐Plan F [S065]

PLAN A:

Pays the following costs of Part A hospital expenses and Part B medical services and supplies:

- Hospitalization - covers and pays hospital co-insurance for days 61- 90. Once lifetime reserve days are used, the plan will pay 100% of Medicare eligible hospitalization expenses an additional 365 days.
- Hospice Care copayment/co-insurance.
- Part B Medical Services – remainder of Medicare approved amounts, generally 20%.
- First three pints of blood.

PLAN F: (*for those first eligible for Medicare prior to January 1, 2020)

Pays all costs of Part A hospital expenses (covers Part A deductible and pays hospital co-insurance for days 61- 90 and 91-150; once lifetime reserve days are used, the plan will pay 100% of Medicare eligible hospitalization expenses for an additional 365 days) and Part B medical services and supplies, except:

- Hospitalization beyond the additional 365 days.
- Foreign Travel Deductible and 20% co-insurance.

PLAN G:

Pays all costs of Part A hospital expenses (covers Part A deductible and pays hospital co-insurance for days 61- 90 and 91-150; once lifetime reserve days are used, the plan will pay 100% of Medicare eligible hospitalization expenses for an additional 365 days) and Part B medical services and supplies, except:

- Hospitalization beyond the additional 365 days.
- Part B deductible (subject to change annually).
- Foreign Travel Deductible and 20% co-insurance.

INNOVATIVE G:

The Innovative Plan G, which includes a Deductible Discount Rider, adds a temporary calendar year plan deductible (subject to change annually) and a discount off of our Plan G premium. Once the plan deductible has been met, the plan provides the same benefits as our Plan G (see *Plan G*). This plan deductible will apply until the deductible elimination date of January 1st following the second policy anniversary. At that time the Rider remains continuing to provide the discount off of our Plan G premium; however, the temporary calendar year plan deductible will no longer need to be met and the plan will provide full Plan G benefits for all remaining years.

The Deductible Discount Rider can be removed from the policy at any time prior to the deductible elimination date. A signed and dated request from the policyholder needs to be sent to Customer Service. The Rider will be removed on the monthly renewal date following our receipt of the request. At that time the benefits will be that of our full Plan G at the current Plan G premium without the discount.

HIGH DEDUCTIBLE G:

This High Deductible Plan G has a calendar year deductible (subject to change annually). Once the calendar year deductible is paid, the plan provides the same benefits as Plan G (see *Plan G*).

Preventive Benefits Plus Rider (F019):

The Preventive Benefits Plus Rider (F019) is available for all plans except Plan A and provides additional benefits for Preventive Health Care, plus Additional Goods and Services with no dollar maximum, subject to plan exclusions and limitations. This optional rider will be made available at the time of the application. Customers may also receive offers to add the rider after their coverage is effective.

Note: Applicants first eligible for Medicare prior to January 1, 2020, who first became eligible due to disability rather than turning age 65, will need to provide a copy of their Medicare ID card with the application if they are applying for Plan F. Form PM2434 is not acceptable for this situation.

UNDERWRITING GUIDELINES

These are general guidelines and do not address state special regulations that may apply unless specifically stated.

ELIGIBILITY

A person that carries both Medicare Part A and Medicare Part B is eligible and therefore may apply for Medicare Supplement Insurance, also called a Medigap policy.

Information is available at www.medicare.gov to help one make decisions about joining Medicare Part B. (Refer to *PMA3265 Enrollment Periods for Medicare*)

An eligible individual can apply for Medicare Supplement (Medigap) coverage under three scenarios:

- **OPEN ENROLLMENT –** Page 6
- **GUARANTEED ISSUE –** Page 9
- **UNDERWRITTEN FOR HEALTH –** Page 10

All Underwriting eligibility guidelines indicate the probable action of the Home Office Underwriting Department. Variation from these rules, including state mandates, will be made at the judgment of the Home Office Underwriter.

Applicants who are currently eligible for any type of state Medicaid benefits (except the payment of Medicare Part B and/or D premiums only) are not eligible for this policy (except for residents of Arizona, Kentucky, South Carolina, South Dakota, Texas and Virginia where Medicaid does not make a person ineligible).

OPEN ENROLLMENT

Open enrollment is a one-time only; six-month period when a person, typically turning 65, can buy any Medicare Supplement policy they want that is sold in their state (subject to new eligibility rules under MACRA, see Product Information). It starts the first month a person is covered under Medicare Part B and extends five additional months. In some states, this includes those under age 65 if they are disabled and enrolled in Medicare Part B. Proof will be required with the application.

When a person is applying during open enrollment, insurance companies must offer coverage without regard to the person's health. Coverage cannot be denied or higher premiums charged due to past or present health problems. Tobacco use rates may apply, see *General Information*. Open enrollment applicants do not have to answer the health questions on the application. However, application questions pertaining to other insurance or Medicaid still must be answered.

Turning 65 "T-65" – Open Enrollment

We will allow a person turning 65 to apply as early as seven months prior to their Medicare Part B effective date (three months in Wisconsin) when applying under open enrollment at 65. In these cases, the policy will be effective on the 1st day of their birthday month, when first becoming eligible for Medicare. If their birthday falls on the 1st of the month, the effective date is the 1st of the previous month.

When Can a T-65 Open Enrollment Application be Taken and Effective?

If Applying Before Age 65:

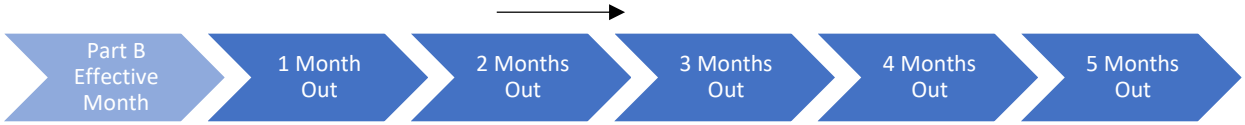
Taking an Application:
A Medicare Supplement application can be taken up to 7 months prior to the customer's Part B effective date.

Application can be Effective:
The Medicare Supplement policy will be effective on the 1st of the customer's birthday month.
*If the customer's birthday is the 1st of the month, the Part B effective date will be the 1st of the prior month

If Applying After Age 65:

Taking an Application:
A Medicare Supplement application can be taken any time beginning with the first of the month the customer is both age 65 and enrolled in Medicare Part B, and extends for six months. If an application is taken outside of the 6-month window, it is no longer considered open enrollment.

Application can be Effective:
The Medicare Supplement policy can be effective up to 6 months out from the Medicare Part B effective date.



Example: Applying at age 65 and 2 months up to 4 months out to be effective.

Requirements - We will require a completed application.

Beyond Age 65½ – Open Enrollment

If a person applies beyond age 65½, and they are enrolling in Medicare Part B, this is also considered open enrollment. Applications for Part B are accepted by Medicare no more than 90 days prior to the requested Part B effective date.

When Can a Beyond Age 65½ Open Enrollment Application be Taken and Effective?

When Applying Beyond Age 65½ and Enrolling in Part B:

Taking an Application:

A Medicare Supplement application can be taken no sooner than 90 days* prior to the customer's requested Medicare Part B effective date.

*See *Household Member Exception*

Application can be Effective:

The Medicare Supplement application must be effective within 6 months of the customer's Part B effective date to be considered open enrollment; however, the application can only be taken 90 days prior to the requested effective date of the policy.

What Proof is Required?

- We will require a completed application.
- We will require proof of the customer's Medicare Part B effective date (and, if the customer was born on or after 1/2/1955, proof of Medicare Part A)

  Acceptable proof of Medicare Part A and B can include any one of the following:

  - A copy of the Medicare ID card
  - A completed PM2434 form with Part B effective date, taken from the applicant's Medicare card
  - The application for Medicare Part B showing the Part B effective date

Household Member Exception:

When one household member is in their turning 65 Open Enrollment period and the second household member is age 65½ or older and enrolling for the first time in Medicare Part B, we will accept an application more than 90 days prior to the Part B effective date. In order to process this exception, we will need the following:

- Both applications must be taken during the same household visit
- A paper application is required for the customer who is beyond age 65½ and the name of the other household member's name must be indicated at the top of the application. This assists with identifying these exceptions.
- Both applications will be processed as Open Enrollment

For the beyond 65½ applicant, we will require proof of group coverage when they are applying more than 90 days from their requested Medicare Part B effective date, and they must be applying with another household member who is in their turning 65 Open Enrollment period. Proof of group coverage can include any one of the following:

- A copy of the group insurance card (with names of applicant(s)),
- Credible coverage documentation (e.g. letter from their Human Resources department or certificate of group health plan coverage
- A recent insurance claim/EOB (with the applicant's name displayed).

Note: Proof of Part B must be submitted to the Home Office when received. It is the agent's responsibility to assure that proof is submitted. Underwriting will assist and send a letter requesting proof 30 days prior to the policy effective date if not already received. If proof is not submitted prior to the policy effective date, the status will be changed to guarantee issue and compensation will be adjusted accordingly.

GUARANTEED ISSUE

A person is eligible in certain situations, outside of open enrollment, to purchase a guaranteed issue Medicare Supplement policy. By law, an insurance company cannot deny a person insurance coverage or place conditions on a policy, deny a person for any pre-existing health conditions or charge a person more for a policy because of past or present health problems. An insurance company is required to sell or offer a policy in seven situations.

Individuals who qualify for guaranteed issue status under Federal or State Laws (refer to the G&I Open enrollment & guaranteed issue Guidelines for specific state guidelines), must provide valid proof of guaranteed issue rights with their application for coverage.

One common Guarantee Issue right is when a person is leaving their employer group coverage. Proof of group coverage can include any one of the following in this situation:

- A copy of the group insurance card (with names of applicant(s)),
- Credible coverage documentation (e.g. letter from their Human Resources department or certificate of group health plan coverage
- A recent insurance claim/EOB (with the applicant's name displayed).

All plans are available in Guaranteed Issued situations, except: for those who have a Medicare Supplement plan and drop it to enroll in a Medicare Advantage (or similar managed care) plan for the first time, and then want to return to Medicare Supplement within the twelve-month trial period. For this twelve-month trial situation, the following rules apply.)

- The prior Medicare Supplement carrier must offer the same plan an individual previously owned if that plan is still available.
- As long as the prior carrier still issues the same plan, then other carriers are not required to offer plans to these individuals.

- Only if the prior carrier no longer issues the same plan then other carriers must offer other plans (we would offer all plans). The prior carrier must also offer other plans currently sold, if any, if they no longer sell the same plan.

Note: Any prior insurance carrier must offer the same Medicare Supplement plan an individual previously owned if that Plan is still available for those exercising their twelve-month Medicare Advantage trial. If Physicians Select is the prior carrier for an individual exercising their twelve-month Medicare Advantage right, we will only offer their same prior plan, if available.

Information regarding the seven eligible guaranteed issue situations can be found in the *Buyer's Guide.*

UNDERWRITTEN FOR HEALTH

If a person is not eligible for open enrollment or does not qualify for guaranteed issue, we will underwrite the application to determine eligibility. We will accept applications no more than 90 days prior to the requested coverage effective date.

The application identifies impairments that make an applicant ineligible for coverage. Coverage is either approved or declined. No elimination riders, rate-ups or other modifications to the contract are permitted for health reasons. All applicants will complete an initial set of questions regarding insurability. Applicants who will be age 69 years or older, as of the requested policy effective date, will be fully Underwritten and will complete additional questions regarding insurability. See All Applicants and Additional Only for Applicants 69 years of age or older as of requested effective date section.

A telephone interview on underwritten Medicare Supplement applications may be required. It is best to prepare your client for the personal health interview. Advise them to use the page provided by you that lists information needed, such as physician's name and current medications.

When a policy is issued as underwritten, and appears that the customer may qualify for guaranteed issue status, we will send the customer a letter indicating they may qualify for guaranteed issue, which prevents insurance companies from taking action because of misstatements, if any, in responses to the health questions. They can send valid documentation (30 days from the date of the letter) of proof of prior coverage. Once valid proof is received, the application status will be changed from underwritten to guaranteed issue status.

> Note: It is in the best interest of the customer to provide proof of guarantee issue even if they are able to qualify for coverage through underwriting.

If the applicant does not qualify for guaranteed issue status or we do not receive the valid documentation, the policy will remain as fully underwritten.

If we believe the applicant could qualify for guaranteed issue, and after full underwriting the applicant does not qualify for coverage, the application will be pended. The Division Office*

will be notified, requesting valid guaranteed issue documentation. Once valid proof is received, the application will be issued under their guaranteed issue right. If valid proof is not received within 30 days of the application submit date, the case will be declined as fully underwritten. *For Direct Medicare Supplement Sales, a letter will be sent directly to the applicant requesting valid proof.

A pharmaceutical drug and health data check will be performed on underwritten Medicare Supplement applications. This may result in an underwritten electronic application to jet issue.

If the applicant has used nicotine products such as tobacco products, cigarettes, electronic cigarettes, patches or other nicotine products, within the past 12 months, additional premium will be charged, except in those states that do not allow for this when open enrollment and guarantee issue cases.

Height and weight will be considered and must also be answered. A person's build below the minimum height of 4' 10" or weight range or over our maximum acceptable upper limit will not be eligible for coverage.

Physicians Select Medicare Supplement Height/Weight Chart

Build Chart			
Height	**Weight**		
	Decline if Under Minimum	**Accept**	**Decline if Over Maximum**
4' 10"	86	86 – 194	194
4' 11"	89	89 – 201	201
5' 0"	92	92 – 208	208
5' 1"	95	95 – 215	215
5' 2"	98	98 – 222	222
5' 3"	101	101 – 229	229
5' 4"	105	105 – 236	236
5' 5"	108	108 – 243	243
5' 6"	112	112 – 251	251
5' 7"	115	115 – 258	258
5' 8"	119	119 – 266	266
5' 9"	122	122 – 274	274
5' 10"	126	126 – 282	282
5' 11"	130	130 – 290	290

Build Chart			
Height	**Weight**		
	Decline if Under Minimum	**Accept**	**Decline if Over Maximum**
6' 0"	133	133 – 298	298
6' 1"	137	137 – 306	306
6' 2"	141	141 – 315	315
6' 3"	145	145 – 323	323
6' 4"	149	149 – 332	332
6' 5"	153	153 – 340	340
6' 6"	157	157 – 349	349
6' 7"	161	161 – 358	358
6' 8"	165	165 – 367	367
6' 9"	170	170 – 376	376
6' 10"	174	174 – 386	386
6' 11"	178	178 – 395	395
7' 0"	183	183 – 404	404

All Applicants

Within the past 24 months, any applicant if they have had, been treated for, or been told by a medical professional that they have any of the following, they will not qualify for coverage and the application should not be submitted:

- Chronic kidney disease (stage 3, 4, or 5)
- Kidney failure
- Kidney disease for which they are currently receiving dialysis or have been recommended to receive dialysis
- Internal cancer
- Any type of blood cancer(s), leukemia, or lymphoma
- Melanoma
- Any cancer that is under surveillance or watchful waiting (such as prostate cancer)
- Cancer in the past 2 years that has gone into remission. Therefore, the cancer was active within the past 24 months
- A non-routine medical test to rule out or confirm the presence of cancer that has not been completed, or pending results.
    - A non-routine medical test is recommended because of a symptom that requires further evaluation. While both a mammogram and colonoscopy can be completed as part of routine preventive care when a person becomes a certain age, a non-routine medical test is recommended because of a concerning symptom that requires further evaluation.
        - Example – a mammogram was recommended because a lump was found.
        - Example – a colonoscopy was recommended because of a change in bowel habits.
- Diabetes and use insulin (e.g. Humulin, Novolin, Levemir)
- Any diabetes (diet controlled, using oral medication or insulin) and also have heart disease (excluding high blood pressure)
- Severe Arthritis - For underwriting purposes, arthritis is considered severe when any of the following are true:
    - Arthritis restricts mobility or daily activities; such as walking, going up stairs or bending to get in or out of a chair.
    - A cane, walker, or wheelchair is used due to restricted mobility or pain due to arthritis.
    - Arthritis requires or the following has been recommended or discussed: physical therapy, or joint injections in the hip, knee or shoulder.
    - Major joint (hip, knee or shoulder) replacement has been advised by a medical professional.
    - Major joint (hip, knee or shoulder) replacement surgery has been done within in the past six months or have not been released from doctor's or therapist's care after surgery.
- Rheumatoid Arthritis
- Liver Disease

- Cirrhosis
- Alcoholism or drug abuse
- Bipolar Disease
- Schizophrenia, or other psychotic disorders
- Have received drugs administered by intravenous (IV) infusion, other than during an emergency room visit, hospitalization, or surgery

If any of the following apply, they will not qualify for coverage and the application should not be submitted:

- Use of oxygen as a treatment for a diagnosed medical condition
- Admitted (inpatient or outpatient) to the hospital within the past three months
- Surgery (including cataract surgery) has been advised or discussed as a treatment option and the surgery has NOT been completed

Treatment will be viewed as any consultation, referral or other exchange of information to manage a patient's care, including a treatment plan. This definition is meant to be a guide, and is subject to the medical condition being evaluated. Once present, some medical conditions never "go away," and continue through various stages of progression. Underwriting will review medications taken, treatment protocol and severity of a disease to determine insurability.

Note: Treatment/Treatment Option may include, but is not limited to: surgery, radiation, hormone or chemotherapy, cardiac rehabilitation, physical or occupational therapy or any treatment prescribed by a medical professional.

Additional Only for Applicants 69 years of age or older as of the requested effective date

Within the past 24 months if they have had, been treated for, or been told by a medical professional that they have any of the following, they will not qualify for coverage and the application should not be submitted:

- Coronary Artery Disease
- Heart Attack
- Heart Surgery (includes angioplasty or bypass, balloon surgery or placement of a heart stent)
- Congestive Heart Failure
- Cardiomyopathy
- Heart valve disorder or Valvular Heart Disease
- Atrial Fibrillation or other Heart Rhythm Disorder - requiring medication for irregular heartbeat, or to slow/regulate the heart rate
- Implanted Cardiac Defibrillator
- Pulmonary Hypertension
- Unoperated aneurysm
- Peripheral Vascular Disease
- Stroke
- Transient Ischemic Attack (TIA), a mini stroke
- Carotid Artery Disease
- Cerebral Vascular Disease
- Osteoporosis with fracture
- Degenerative Bone Disease
- Amputation or fracture caused by disease
- Chronic Obstructive Pulmonary Disease (COPD)
- Chronic Bronchitis
- Emphysema or any chronic pulmonary disorder (included, but not limited to pulmonary fibrosis, asbestosis, pneumonitis, occupational lung disease)
- Myasthenia Gravis
- Grave's Disease
- Systemic Lupus Erythematosus (SLE)
- Multiple Sclerosis
- Amyotrophic Lateral Sclerosis (ALS/Lou Gehrig's Disease)
- Parkinson's Disease
- Alzheimer's Disease
- Dementia or any other cognitive disorder and/or use of Aricept or other memory-enhancing drugs
- Acquired Immune Deficiency Syndrome (AIDS), Positive HIV, or AIDS Related Complex (ARC)

If any of the following apply, they will not qualify for coverage and the application should not be submitted:

- Hospitalized or confined to a nursing home or residing in an assisted-living facility within the past 90 days
- Hospitalized two or more times in the past 12 months
- Confined to a bed
- Require the use of a wheelchair or any motorized mobility device.
- Had or been recommended to have an organ or stem cell transplant (excluding cornea transplants)
- Advised or discussed as a treatment option a non-routine medical procedure will be needed within the next 12 months
- Have **both** High Blood Pressure and Diabetes, **and** any of the following are true:
    - Take three or more oral medications for either condition. Or, takes more than two oral medications for either high blood pressure or diabetes.
        - Non-insulin injectable medication used to treat diabetes will be treated the same as an oral medication for underwriting purposes. An example of a non-insulin injectable medication would include Byetta or Trulicity.
        - Diuretic/water pills used for high blood pressure will not be considered the same as an oral medication for high blood pressure. Examples of diuretic/water pills would include Hydrochlorothiazide/HCTZ, Indapamide, Furosemide, Spironolactone, or Triamterene.
        - Review the medications taken for both high blood pressure and diabetes and confirm this requirement is met.

		High Blood Pressure Oral Medication			
	Number of daily oral medications	0	1	2	3+
Diabetes Oral & Non-insulin Injectable Medication	0	Insurable	Insurable	Insurable	Will not qualify for coverage
	1	Insurable	Insurable	Insurable	Will not qualify for coverage
	2	Insurable	Insurable	Insurable	Will not qualify for coverage
	3+	Will not qualify for coverage	Will not qualify for coverage	Will not qualify for coverage	Will not qualify for coverage

    - The medication dosage has increased or been newly prescribed for either condition in the past two years
        - Ask the customer if they have had changes in either medication and, if so, when either the medication or the dosage of medication was changed.
        - If the medication or the dosage has been changed in the past two years, the customer will not qualify for coverage. This would not

include an elimination of medication or a decrease in dosage because of improvement in disease control.

- Have diabetic complications (peripheral neuropathy; diabetic retinopathy)
  - Ask the customer if they have any complications of their diabetic disease. Do they have peripheral neuropathy or numbness or tingling in their feet or toes? Do they have diabetic retinopathy, or damage to the blood vessels in the back of the eye? If they have these complications of their diabetes, they will not qualify for coverage.
  - Ask the customer if they take medications for peripheral neuropathy. An example of medication to treat nerve damage from peripheral neuropathy would include Gabapentin, Neurontin, Lyrica, Gralise or Duloxetine.

Treatment will be viewed as any consultation, referral or other exchange of information to manage a patient's care, including a treatment plan. This definition is meant to be a guide, and is subject to the medical condition being evaluated. Once present, some medical conditions never "go away," and continue through various stages of progression. Underwriting will review medications taken, treatment protocol and severity of a disease to determine insurability.

Note: Treatment/Treatment Option may include, but is not limited to: surgery, radiation, hormone or chemotherapy, cardiac rehabilitation, physical or occupational therapy or any treatment prescribed by a medical professional.

SOME MEDICATIONS ASSOCIATED WITH UNINSURABLE HEALTH CONDITIONS

Applicants taking certain medication or disclosing certain conditions will automatically be declined. We do not suggest submitting applications for these individuals. Here is a list of some generally uninsurable medications:

Auto – Decline List All Applicants	
Medications	Conditions
Abilify	Bipolar Disease, Schizophrenia, Psychotic Disorder
Dialysis	Kidney Disease
Embrel	Rheumatoid Arthritis
Humira	Rheumatoid Arthritis
Insulin or any Insulin for Diabetes: (Apidra, Humalog, Humulin, Lantus, Levemir, Novolin, Novolog)	Diabetes
Interferon (IV infusion)	Hepatitis, Leukemia, malignant melanoma
Imuran (oral tablet, IV infusion)	Prevention of transplant rejection, Rheumatoid Arthritis, Systemic Lupus, Crohn's Disease
Methotrexate	Cancer, Severe Arthritis, Rheumatoid Arthritis
Oxygen	Oxygen used as treatment for a diagnosed medical condition
Remicade (IV infusion)	Crohn's Disease, Ulcerative Colitis, Rheumatoid Arthritis, Psoriatic Arthritis, Ankylosing Spondylitis, Plaque, Psoriasis
Remodulin (IV infusion)	Pulmonary Hypertension
Rituximab (IV infusion)	Non-Hodgkin's Lymphoma, Chronic Lymphocytic Leukemia, Rheumatoid Arthritis, Granulomatosis, Pemphigus Vulgaris
Seroquel	Bipolar Disease, Schizophrenia, Psychotic Disorder
Soliris (IV infusion)	Myasthenia Gravis
Xeljanz	Rheumatoid Arthritis

Auto – Decline List Additional Only for Applicants 69 years of age or older as of effective date	
Medications	Conditions
Advair	COPD, Emphysema, chronic bronchitis
Aricept or other memory-enhancing drugs (Namenda, Razadyne, Exelon)	Alzheimer's or dementia
Benlysta	System Lupus Erythematosus (SLE)
Breo Ellipta	COPD, Emphysema, chronic bronchitis
Carbidopa-levodopa	Parkinson's Disease
Coumadin, Eliquis, Heparin, Pradaxa, Warfarin, Xarelto (blood thinner oral tablet/injection)	Atrial Fibrillation, Heart Valve Replacement, risk of blood clots after surgery, Congenital Heart Defects, certain heart or blood vessel diseases, Deep Vein Thrombosis (DVT), Pulmonary Embolism (PE)
Dialysis	Kidney Disease
Digoxin	Atrial Fibrillation, Heart Rhythm Disorder
Flecainide	Atrial Fibrillation, Heart Rhythm Disorder
Flolan	Pulmonary Hypertension
Interferon (IV infusion)	Multiple Sclerosis (MS)
Nitroglycerin or Isosorbide Mononitrate	Coronary Artery Disease
Reclast (maintain bone density)	Degenerative Bone Disease (osteoporosis)
Saphnelo	System Lupus Erythematosus (SLE)
Sinemet	Parkinson's Disease
Symbicort	COPD, Emphysema, chronic bronchitis
Soliris (IV infusion)	Myasthenia Gravis
Tepezza	Grave's Disease, thyroid eye disease
Trelegy Ellipta	COPD, Emphysema, chronic bronchitis
Quinidine	Atrial Fibrillation, Heart Rhythm Disorder
Veletri	Pulmonary Hypertension
Voclosporin	System Lupus Erythematosus (SLE)

COMPLETING THE APPLICATION

The Medicare Supplement application can be completed via an electronic application "eApp" (iPad or remote electronic application). Signature requirements are as follows:

- Mobile Quote eApp – Obtain an electronic signature face-to-face
- Remote electronic application – Obtain a signature via voice-recorded IVR or DocuSign. If DocuSign, a valid email address from the client is required.

A Medicare Supplement paper application packet is also available and contains the application, rate quote sheets, plus all forms required in the applicant's state of residence.

Here are some guidelines to assist you with completing the application:

Use the correct application. The applications must be from the applicant's state of residence. The state of residence is considered to be their primary residence, where they are registered to vote and pay their taxes.

Spouse/partners must complete separate applications. This is individual coverage only.

The application will identify the sections requiring completion based on the applicant's age and their eligibility for Open Enrollment, Guaranteed Issue or Underwritten for Health status. Fully complete the sections identified.

If a question is answered in error, draw a single line through the error and have the correction initialed by the applicant. Please avoid scribbling and the use of white out. Applications with multiple alterations not initialed by the applicant will be returned for a new currently dated application.

Automatic Bank Withdrawal (ABW) draft date can be requested to be any day between the 1st and the 28th of the month. The draft date, however, should not be more than 10 calendar days past the effective date, which may result in two payments being made in the first month. Verify the routing and account numbers are correct (verify with the customer's check).

Do not backdate or postdate applications. Do not backdate coverage effective dates.

Only the applicant for insurance may complete and sign the application. Each application must have an original signature. Power-of-Attorney (POA) signatures are not acceptable (except during open enrollment and guaranteed issue: in this case, we must receive a copy of the power-of-attorney document with the application). Note: For customers with a POA, a paper application must be used. Electronic applications cannot be accepted.

Applications must reach our Home Office within 10 days of the application date. We recommend the application reach the Division Office within seven days of the application date for processing to begin. Stale applications will be withdrawn, and the agent must submit a new, currently-dated application to include a new rate quote sheet and required forms.

GENERAL INFORMATION

Effective Dates Range from the 1st – 28th of any month: This policy is intended as comprehensive Medicare Supplement coverage. An insured may carry only one Medicare Supplement policy with all companies. When replacing coverage with another company, the effective date of our policy should correspond with the termination date of the previous policy. An applicant who intends to replace another company's Medicare Supplement policy should never do so until their Physicians Mutual policy has been issued, delivered, reviewed with their agent and accepted. Effective dates range from the 1st - 28th of any month.

Example: The customer provides us documentation that their current plan ends on April 30, 2022. We will issue with an effective date of May 1, 2022.

Example: The customer provides us documentation that their current plan ends on April 11, 2022. We will issue with an effective date of April 12, 2022.

If a customer is coming off of another Medicare Supplement Plan, Medicare Advantage Plan or an employer group health plan, and does not have proof of the plan terminating prior to the last day of the month, the effective date will be the 1st of the following month.

Example: The customer does not provide us documentation that the plan ends on April 11, 2022. We will issue with an effective date of May 1, 2022.

Plan or Effective Date Change Requests: If a customer requests a change, the request will need to be sent to the Home Office with a new rate quote sheet. We will review the request to determine if the requested change is allowable or if additional underwriting or a new application is required.

Underwriting will determine if the request meets our 31-day review period "free look" and New Business Rule Timeframe for handling.

> New Business Rule Timeframe:
> Open Enrollment applications allow up to seven, or in certain circumstances six months between the application date and policy effective date for changes.
>
> Guarantee Issue and Underwritten applications allow 90 days between application dates and policy effective dates for changes.

Note: Changes beyond the New Business Rule Timeframes, or beyond the 31-day review period "free look" will not be allowed. A new, currently dated application will be required. Customers enrolling in Medicare Part B later than originally planned should be advised their Medicare Supplement policy will pay claims as though they had Part B.

For Effective Date Change Requests			
Their previous coverage type:	Request must be received within **Free Look Period*** *31 days from the policy effective date	New Effective Date must be within **New Business Rule Timeframe** OE – up to 7 months GI/UW 90 days	**Proof** of termination date needed from previous carrier
Medicare Advantage or Med Supp (no overlap in coverage)	Yes	Yes	Yes
Medicare Advantage or Med Supp – with unintended overlap in coverage	No	Yes	Yes
Group/Individual	Yes	Yes	No

- A new policy number will be created and a new policy will be printed if the original policy was already issued. The new policy and ID cards will be mailed to the customer. The original policy will be voided. Any premiums paid will be transferred to the new policy.

- An Amendment will be created, for original application changes, if we do not have a signed request for changes from the customer.

- Changes may result in premium differences. Premiums are determined based on the rate in effect on the application date and the customers age on the policy effective date. If a new application is required, rate changes may have been implemented and the premium will reflect the new application rate.

- For **plan change requests**, we will review to determine if the plan type can be changed.

  If the request is received prior to the end of the "free look" period and the change will be made as of the policy effective date, we can use the original application. All other requests require a newly completed and currently dated application. This will be processed as an internal replacement. Changes beyond the New Business Rule Timeframes require a new, currently-dated application.

  Note: Removing the Innovative Rider may be done with a signed request for changes from the customer at any time, a new application is not required.

- For **effective date change requests**, we will review to determine if we can change the original effective date to the newly requested effective date.

  In addition to a request to change the effective date, documentation from the previous carrier will be required showing the termination date for external replacements, and/or documentation of Medicare's effective date.

Requests to avoid an overlap in coverage with a previous policy are only changed to a date later than the original effective date requested on the application.

- Some common Open Enrollment examples (Documentation of Medicare's effective date will be required):
    - Part B starting later than expected
        - App date 1/15 - Effective date 3/1
        - Request for the change is dated 3/18 - the customer's Part B won't start until 4/1
        - We will reissue with 4/1 as the effective date

        - App date 3/15 - Effective date 7/1
        - Request for the change is dated 7/18 - the customer's Part B won't start until 8/1
        - We will move the policy effective date because the request was made during the new business rule timeframe and 31-day review period

        - App date 1/15 - Effective date 7/1
        - Request for the change is dated 7/18 - the customer's Part B won't start until 8/1
        - We will not move the policy effective date because the request was made beyond the new business rule timeframe
        - A new application will be required
    - Part B starting earlier than expected
        - App date 1/15 - Effective date 5/1
        - Request for the change is dated 3/18 - the customer's Part B started 4/1
        - We will move the effective date if they are still in their Open Enrollment period

        - App date 1/15 - Effective date 5/1
        - Request for the change is dated 3/18 - the customer's Part B started 3/1
        - We will not move the effective date earlier than the request date

- Some common Guarantee Issue and Underwritten examples when the customer doesn't want to stay with the effective date they listed on the application (Documentation will be required showing previous carrier's coverage termination date):
        - App date 1/15 - Effective date 5/1
        - Request dated 3/18 - the customer would like to start coverage on 4/1
        - We will move the effective date as long as they have Part A & B, and are still in their Guarantee Issue right
        - A new application will be required if Underwritten

- App date 1/15 - Effective date 2/1
- Request dated 3/18 - the customer would like to start coverage on 4/1
- We will not move the policy effective date because the request was made beyond the 31-day review period (except for when there is an overlap in coverage)
- A new application will be required

- App date 3/1 – Effective date is 4/1
- Request dated 4/18 - the customer would like to start coverage on 5/1
- We will move the policy effective date because the request was made during the 31-day review period and before the end of the new business rule timeframe

- App date 1/1 – Effective date is 4/1
- Request dated 4/18 - the customer would like to start coverage on 5/1
- We will not move the policy effective date because the request was made beyond the new business rule timeframe
- A new application will be required

Other Coverage: This policy may not be issued in addition to any other coverage, including some types of group coverage or Medicaid other than the coverages indicated below:

- Group or Individual Major Medical coverage with a high deductible ($3,000.00 and above, unless eligible for Open Enrollment);
- Cancer coverage, or;
- Hospital Indemnity coverage, or;
- Long-Term Care coverage, Nursing Home coverage, Short-Term Nursing coverage, Home Health Care coverage or Accident coverage.

Note: Rule does not apply to TX.

Tobacco Use Rates: All states have tobacco use rates for underwritten applicants. However, some states do not allow for tobacco use rates on Open Enrollment and Guaranteed Issue. Tobacco rate is applied when any form of nicotine, an electronic cigarette or other tobacco product has been used in the prior 12 months of the application.

Third Party Payers: Premium payments will not be accepted from third party organizations or groups. Premium payments from third party payers will be accepted only from the following:

- A relative (next of kin).
- A family owned business/family business employer - If premium is being paid from a family business, a Business Waiver form (PM-1902A) must be completed and submitted with the application.
- A family owned farm account – If premium is being paid from a farm account, a Business Waiver form (PM-1902A) must be completed and submitted with the application.
- Power of Attorney.

Missing Underwriting Requirements: An application will be withdrawn 30 days after receipt if an underwriting determination cannot be made due to missing requirements, including telephone interview, missing application corrections that have not been received or we have not received proof of guaranteed issue status in a guaranteed issue scenario.

Appealing Incorrect or Incomplete Health History: If a customer believes the information we had to underwrite their application was incorrect or incomplete, they have the right to appeal our decision. At the customer's expense, they may request their physician send to us the past two years of their medical records. Medical records must include all office notes and test results. After review of the medical records the underwriter will determine insurability. We will advise both the applicant and agent of our final decision.

Refunding Time Period: There is a 20-calendar day time period, from the time the applicant's check is deposited at the Home Office until a refund will process on withdrawn or declined applications.

Proof of Guarantee Issue Requirement Handling: An application indicating a guarantee issue status will be handled as follows:

- A requirement will be added requesting proof of guarantee issue, when it is not received with the application. See *Guarantee Issue* for acceptable documents.
- A 21-calendar day period will be given to communicate that proof will or will not be submitted to underwriting. If it is communicated that proof will not be submitted, underwriting will pivot to underwritten (with answered health questions) and conduct a telephone interview with the applicant. See *Underwritten for Health*.
- If proof of documentation is not provided, and/or underwriting cannot be completed, the application will be withdrawn 30 days from the application submit date. A new and currently dated application with valid proof of guaranteed issue will be required for further consideration.

PHYSICIANS SELECT DISCOUNT & REPLACEMENT RULES

Discounts for Physicians Select
(Discounts subject to state approval and may vary by state)

Non-tobacco (10%): A 12-month nicotine free period is required to obtain this discount.

Payment by Automatic Bank Withdrawal (ABW) $5.00: $5.00 less than the monthly direct payment method.

Medicare Supplement Household Discount (10%): Applies to Physicians Select policies only. If the applicant has continuously resided in the last 12 months with at least one but no more than three other individuals, that are 60 or older or reside with their spouse.

Note: A household resident will need to be identified at the time of application to obtain any available household discounts.

Physicians Select Two Year Selection Guarantee

Two Year Selection Guarantee: For first-time Physicians Select, Physicians Life or Physicians Mutual plan buyers the policyowner has a one-time option to switch plans, either to upgrade their plan in the first two years without underwriting or to downgrade their plan. The effective date of the new policy must be on the same date of the month as the first policy's effective date. (See Disclosure F020 for full details).

The two-year period begins on the policy effective date, and this option ends two years from that date. Once this one-time option has been used, normal replacement rules apply and a new application is needed. See below.

Replacement Handling

Replacing existing Medicare Supplement coverage, either internally or externally, requires the applicant to certify the following statement (state application versions may differ slightly):

This statement applies only to the Medicare Supplement application: The Undersigned applicant and agent certify the applicant has read, or had read to him or her, the completed application, and the applicant realizes any false statement or misrepresentation in the application may result in loss of coverage under the Medicare Supplement policy.
I represent and agree that all information stated in this application is complete and correct to the best of my knowledge. I understand no coverage is in force until the Company issues a policy showing a Policy Effective Date and the first full premium has been paid.

Internal Replacement – Replacing an in-force Medicare Supplement policy with a new Medicare Supplement policy from Physicians Select or Physicians Life Insurance Company. A paper application is required. If we receive a new application and we determine there was a prior policy in force with our Company, within 180- days, we will handle as an internal replacement. The 180- days is measured from the prior policy's paid to date to the new application date.

External Replacement – Replacing a Medicare Supplement policy/Medicare Advantage or any policy currently in-force with another insurance carrier with a new underwritten Medicare Supplement policy from Physicians Select Insurance Company.

Note: Loss of coverage due to any false statement or misrepresentation may occur on both the previously in-force (canceled when the new policy was issued) and new policy due to rescission, leaving the customer without Medicare Supplement coverage.

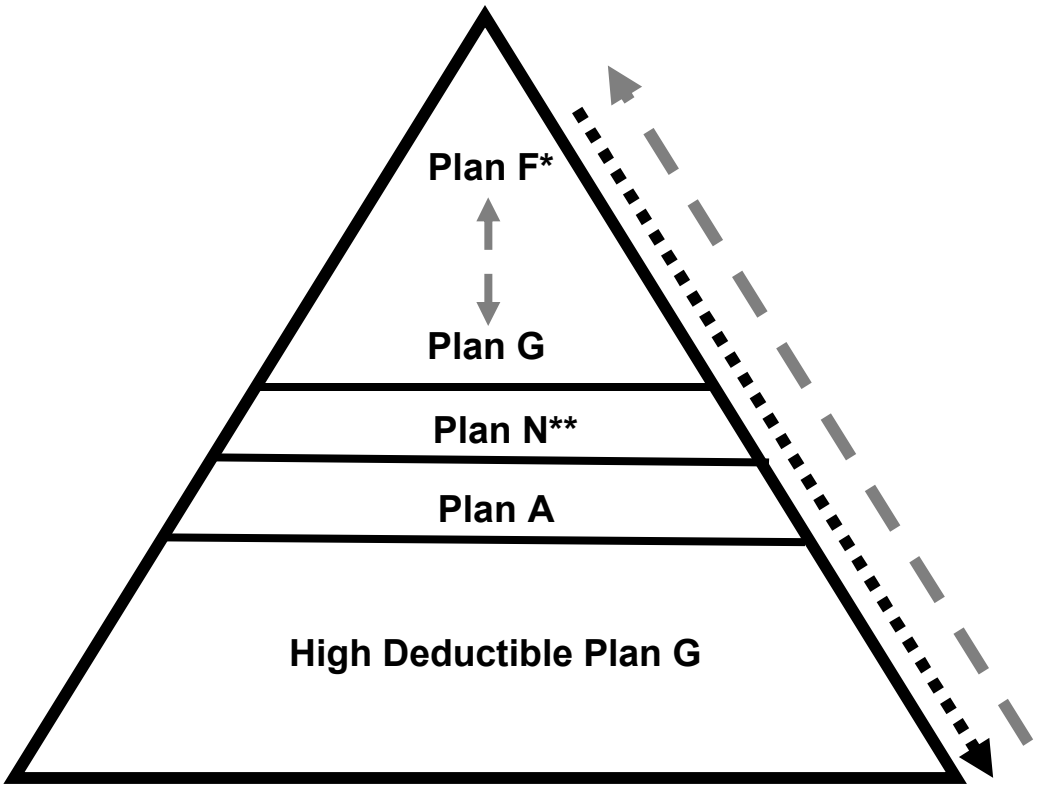
Physicians Select Internal Replacement Rules

INTERNAL REPLACEMENT PLAN RULES FOR PHYSICIANS SELECT A new application is always needed; regardless of whether underwriting is required.

Requires underwriting to change plans: 

Does not require underwriting to change plans:

For Innovative G, these rules work the same as for any Plan G. Plan G can be replaced with the Innovative G without underwriting. Either plan will be issued at the current age. Note: the Innovative Rider cannot be added to Plan G after issue.
*Starting in 2020, Congress will no longer allow Medicare Supplement (Medigap) Plan F to be sold to those first eligible for Medicare on or after January 1, 2020.
**Plan N not available in all states



PHYSICIANS LIFE MEDICARE SUPPLEMENT DISCOUNT RULES

Non-tobacco (10%): A 12-month nicotine free period is required to obtain this discount

Payment by Automatic Bank Withdrawal (ABW) $5.00: $5.00 less than the monthly direct payment method.

Medicare Supplement Household Discount (10%): Applies to Physicians Life policies only. If the applicant has continuously resided in the last 12 months with at least one but no more than three other individuals, that are 60 or older or reside with their spouse.

Note: A household resident will need to be identified at the time of application to obtain any available household discounts.

IL and OK (12%): Applicant must reside with at least one but no more than three other Medicare-eligible Individuals, and at least one of them must own a Medicare Supplement policy (any sold by the Company) from either Physicians Mutual, Physicians Life or Physicians Select.

OH (9%): Applicant must reside with at least one but no more than three other Medicare-eligible Individuals, and at least one of them must own a Medicare Supplement policy (any sold by the Company) from either Physicians Mutual, Physicians Life or Physicians Select.

Note: for IL, OK, OH: A household resident with an existing Medicare Supplement policy, either Physicians Mutual, Physicians Life or Physicians Select, will need to be identified at the time of application to obtain any available household discounts.

CLOSED BLOCK HANDLING

DISCOUNT AND INTERNAL REPLACEMENT RULES FOR PREVIOUSLY-SOLD PLANS

For Medicare Supplement policies in closed blocks, both Physicians Life and Physicians Mutual, there cannot be any upgrades or downgrades within each respective block.

A new application is always needed; regardless of whether underwriting is required.

With Underwriting, any plan from any closed block may be internally replaced with any 2020 plans.

- Plan F
- Plan G
- Innovative G
- Plan N

Without underwriting, any plan from any closed block may be internally replaced with any of the following Physicians Life plans:

- Plan A
- High Deductible G

Internal replacement without underwriting in these rules refers to replacement from one policy to another policy with no break in coverage.