lumico
medigap solutions

MEDICARE SUPPLEMENT

AGENT UNDERWRITING GUIDE

LUMICO MEDIGAP SOLUTIONS

Underwritten by
Elips Life Insurance Company

For Agent Use Only

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WELCOME

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 how insurance needs have evolved over time.

More about us

We are rated “A” (Excellent) by A.M. Best[1], the leading insurance rating agency. As the second highest rating that is awarded, this means that we are financially stable and secure.

We are also rated A+ by the Better Business Bureau (BBB)[2]. This shows that we’re committed to providing excellent customer service, and we’re operating in a way that people can trust.

With millions of dollars of life insurance coverage in force, we protects thousands of satisfied customers every day. We have an impeccable 50+ years of experience insuring individuals just like you.

We are proud to be part of Swiss Re, a global financial services organization and Fortune 500 company that has been protecting families since 1865.

[1]The rating refers onlt to the overall financial status of the company and is not a recommendation of the specific policy provisions, rates or practices of the insurance company. Rating as of March 2022.
[2]BBB accredited since 7/20/20; rating is not a guarantee of a business’ reliability or performance.

IMPORTANT CONTACT INFORMATION

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

New Business Mailing Address:	For Overnight Mail:
Elips 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:	
Elips 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
Policy Owner Services	1-816-701-2549

POLICY ISSUE GUIDELINES

All applicants must be covered under Medicare Part A and Part B to be eligible for Medicare Supplement insurance underwritten by Elips Life Insurance Company. 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 who do not meet the Guaranteed Issue or Open Enrollment qualifications will be underwritten, including applicants who are 65 with an effective coverage date beyond six (6) months of their 65th birthday and whose Medicare Part B date is beyond six (6) months of the effective coverage date. In addition, disabled applicants that are not applying during open enrollment, or who do not qualify for guaranteed issue, will be underwritten. 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.

Some states allow Medicare-eligible individuals under the age of 65 to apply for Medicare Supplement coverage. Please see Appendix.

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 are 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 right to guaranteed issue if...	Applicant has the right to buy...	Applicant can/must apply for a Medicare Supplement 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.	Medicare Supplement Plan A, B, C, F, K, or L (if eligible for Medicare prior to 1/1/2020), or A, B, D, G, K or L (if newly eligible for Medicare on or after 1/1/2020) 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. Medicare Supplement 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.	Medicare Supplement Plan A, B, C, F, K, or L (if eligible for Medicare prior to 1/1/2020), or A, B, D, G, K or L (if newly eligible for Medicare on or after 1/1/2020) that's sold in their state by any insurance company. If they have COBRA coverage, they can either buy a Medicare Supplement policy right away or wait until the COBRA coverage ends.	No later than 63 calendar days after the latest of these three dates: Date the coverage ends Date on the notice they get telling them that coverage is ending (if they get one) 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.	Medicare Supplement Plan A, B, C, F, K, or L (if eligible for Medicare prior to 1/1/2020), or A, B, D, G, K or L (if newly eligible for Medicare on or after 1/1/2020) 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 at 65, and within the first year of joining, they decide they want to switch to Original Medicare.	Any Medicare Supplement 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. **Note:** Rights may last for an extra 12 months under certain circumstances.
(Trial right) They dropped a Medicare Supplement 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 Medicare Supplement 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 Medicare Supplement policy **isn't** available, they can buy Medicare Supplement Plan A, B, C, F, K, or L (if eligible for Medicare prior to 1/1/2020), or A, B, D, G, K or L (if newly eligible for Medicare on or after 1/1/2020) 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.

Applicant has a right to guaranteed issue if...	Applicant has the right to buy...	Applicant can/must apply for a Medicare Supplement policy...
Their Medicare Supplement insurance company goes bankrupt and they lose their coverage, or their Medicare Supplement policy coverage otherwise ends through no fault of their own.	Medicare Supplement Plan A, B, C, F, K, or L (if eligible for Medicare prior to 1/1/2020), or A, B, D, G, K or L (if newly eligible for Medicare on or after 1/1/2020) 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 Medicare Supplement policy because the company hasn't followed the rules, or it misled them.	Medicare Supplement Plan A, B, C, F, K, or L (if eligible for Medicare prior to 1/1/2020), or A, B, D, G, K or L (if newly eligible for Medicare on or after 1/1/2020) 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 Guaranteed 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 +

	Decline	Proceed	Decline
Height	**Weight**	**Weight**	**Weight**
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 the Health questions section will be automatically declined.
For California, any "Not Sure" answers to the Health questions section, provided the applicant answers "No" to all other Health questions, will be automatically referred.

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

AIDS / HIV / ARC (AIDS related complex)	Diabetes with >50 units insulin per day or requiring >two medications (oral or injection)
ALS (Amyotrophic Lateral Sclerosis) / Lou Gehrig's Disease	Diabetes with vascular disease (coronary, carotid, peripheral) or kidney disease (stages 3-5)
Alzheimer's disease or Dementia	More than three blood pressure medications[1] with Diabetes
Chronic Kidney Disease (stages 3-5) or Renal Failure Requiring Dialysis	Schizophrenia
Other chronic pulmonary disorders, including: Bronchiectasis Chronic asthma Chronic bronchitis Chronic interstitial lung disease	Lupus – systemic
	Multiple Sclerosis (MS)
	Muscular Dystrophy
	Myasthenia Gravis

Chronic pulmonary fibrosis Cystic fibrosis Emphysema Sarcoidosis	Organ transplant (stem cells included; corneal transplants excluded) Organic brain disorder
Chronic obstructive pulmonary disease (COPD)	Osteoporosis with fracture
Cirrhosis	Parkinson's disease
Other cognitive disorders, including: Mild cognitive impairment (MCI) Delirium Senile Dementia	Pulmonary Arterial Hypertension/Pulmonary Hypertension Scleroderma Diabetes diagnosed prior to age 25
Crippling / disabling arthritis	Chronic Hepatitis

[1]Please note that single pill combination medications will be treated as two medications, common in the treatment of High Blood Pressure. Some examples of single pill combination medications are Lotrel, Amlodipine and HCTZ.

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.
- Any Applicant prescribed more than five opioid medications in the last 24 months.

Applicants with Arthritis

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

- If the applicant can perform their activities of daily living such as, dressing, eating, bathing, housework and shopping without limitations, that would not be considered crippling/disabling arthritis.
- If the applicant requires any assistance in walking, such as, use of a cane, walker, wheelchair, or another person to provide assistance, that would be considered crippling/disabling arthritis and the applicant would not be eligible for coverage.
- If the applicant is currently receiving, considering, or has been advised by a physician to have physical therapy or surgery, then that would be considered crippling/disabling arthritis, and the applicant would not be eligible for coverage.

Applicants with Injectables

- Bi-annual cortisone injections for the treatment of Osteoarthritis are allowed, and the applicant can be considered for coverage.
- If the applicant is currently receiving, considering or has been advised by a physician to have injections in a physician's office within the last two years, they will not be eligible for coverage.
- If the applicant has received any injections or infusions within the past 12 months for arthritis or degenerative bone disease, they will not be eligible for coverage.

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 three medications for hypertension. We consider hypertension stable if recent average high blood pressure readings are 150/90 or lower, treated or untreated.

If applicant answers "Yes" to the top level diabetes question "Do you have diabetes or take medication to control your blood sugar?", they will be approved as long as the applicant answers "NO" to all other subquestions (a through d) under the top level diabetes question.

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, or applicants diagnosed with diabetes prior to age 25 are not eligible for coverage.

Below are some complications that are viewed as unfavorable criteria and could deem the client's diabetes as not well-controlled:

- Pain or swelling in the feet
- Loss of feeling or tingling in the extremities
- Has been advised to see a Nephrologist

Consideration Health Questions

In general, if an applicant answers “Yes”, or "Not Sure" in California, to the second question under the Consideration health questions section, 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
- Applicants taking an anti-coagulant use may be referred for phone interview
- 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

Additional Questions to ask an Applicant

Below are some additional questions you can ask the applicant to better determine if the application should be submitted. If the applicant answers 'No' to the questions below, it is recommended that the application not be submitted:

- If you have received any occupational, speech, or physical therapy, or used the services of a home healthcare agency, are you considered to be fully recovered?
- If you are currently taking Tamoxifen (or similar medications), has it been at least two years since the completion of any primary cancer treatment such as chemotherapy, radiation therapy or surgery?
- If you have previously had a heart attack or other cardiac condition, are you taking three or less medications to control your high blood pressure?
- Have you had any changes to your medication within the last year? If so, was this due to a change in your prescription plan, or side effects from the medication?

Pharmaceutical Information

Elips Life Insurance Company has implemented a process to support the collection of pharmaceutical information for underwritten Medicare Supplement applications. To obtain pharmaceutical information, the Release of Personal and Medical Information form must be signed by the applicant.

Medication Guidelines

Use of the following drugs will most likely result in a decline. (Note, this list is not all-inclusive. Applications with collected Pharmaceutical Information indicating applicants with Uninsurable Health Conditions will be subject to Telephone Interviews or declined.) The same drugs may have other names (generic or brand names) or they may be included with other drugs with a combination name.

3TC	EmtrivaA	Nitrostat
Abatacept	Enbrel	Nivolumab
Abilify	Entacapone	Norvir
Abiraterone	Entecavir	Octreotide
Abstral	Entresto	Olanzapine
Acamprosate	Enulose	Oncovin
Aclasta	Enzalutamide	Onsolis
Actemra	Epclusa	Opana
Actimmune	Epogen	Opdivo
Actiq	Ergoloid	Orap
Adalimumab	Erlotinib	Orencia
Adcetris	Eskalith	Oxaliplatin
Adriamycin	Estramustine	Oxaydo
Afinitor	Etanercept	Palbociclib
Afrezza	Etoposide	Paraplatin
Agrylin	Eulexin	Parlodel
Aldesleukin	Everolimus	Pegasys
Alefacept	Exalgo	Pegfilgrastim
Alemtuzumab	Exelon	Peginterferon
Alferon	Exemestane	Pegintron
Alkeran	Extavia	Permax
Amantadine	Fareston	Permitil
Amaryl	Farxiga	Pethidine
Ambenonium	Faslodex	PhosLo
Amevive	Femara	Pimozide
Amiodarone	Fentanyl	Plaquenil
Amjevita	Fentora	Platinol
Ampyra	Filgrastim	Plavix
Anagrelide	Floxuridine	Pletal
Anastrozole[3]	Fluoroplex	Plicamycin
Antabuse	Fluorouracil	Pradaxa
Apixaban	Fluoxetine HCI	Prandin
Apokyn	Fluphenazine	Prednisone
Apomorphine	Flutamide	Primasol
Aralast	Fortovase	Procarbazine
Arava	FUDR	Procrit
Aricept	Fulvestrant	Procyclidine
Arimidex	Furosemide	Prograf
Aripiprazole	Gablofen	Proleukin
Aristada	Galantamine	Prolia
Aromasin	Gefitinib	Prolixin
Artane	Gengraf	Protopic
Astramorph	Geodon	Prozac
Atamet	Gleevec	Purixan
Atenolol	Gleostine	Pyridostigmine Bromide
Atrovent	Glipizide	Quetiapine Fumarate

Auroanofin	Glucotrol	Raltegravir
Avonex	Gold	Rasagiline
Avonexpen	Golimumab	Razadyne
Azathioprine	Goserelin	Rebif
Azidothymidine	Granix	Reclast
Azilect	Gravitor	Regonol
AZT	Haloperidol	Remeron
Baclofen	Harvoni	Remicade
Baraclude	Herceptin	Reminyl
Basaglar	hizentra	Requip[2]
Baycadron	Humalog	Retrovir
Benztropine	Humira	Revatio
Betapace	Hydergine	ReVia
Betaseron	Hydrea	Revlimid
Bexxar	Hydromorphone HCL	Rexulti
Bicalutamide	Hydroquin	Ribavirin
Biperiden	Hydroxychloroquine	Ridaura
Blenoxane	Hydroxyurea	Rifaximin
Bleomycin	HyQvia	Rilutek
Brentuximabvedotin	Ibrance	Riluzole
Brexpiprazole	Ibrutinib	Risperdal
Brilinta	Imatinib Mesylate	Risperidone
Bromocriptine	Imbruvica	Ritonavir
Bumetanide	Imuran	Rivaroxaban
Bumex	Indinavir	Rivastigmine
Bunavail	Infliximab	Rivastigmine Tartrate
Buprenorphine	Infumorph	Rocaltrol
Buprenorphine/Naloxone	Insulin Detemir	Roxanol
Burinex	Insulin Human	Roxicodone
Busulfan	Insulin Lispro	Ruxolitinib
Busulfex	Insulin Protamine	Sacubitril/valsartan
Calcijex	Interferon	Salmeterol
Calcitriol	Interferon Beta-1a	Sandimmune
Campath	Interferon gamma-1b	Sandostatin
Campral	Invirase	Sarafem
Capecitabine	Ipratropium	Selegiline
Capecitabine	Iressa	Sensipar
Carac	Isentress	Serevent
Carbidopa	Jakafi	Seroquel
Carboplatin	Januvia	Simponi Aria
Cariprazine	Kadian	Sinemet[2]
Carvedilol	Kemadrin	Sitagliptin
Casodex	Lactulose	Skelaxin
Cassipa	Lamivudine/zidovudine	Sofosbuvir
CDDP	Lanoxin	Sofosbuvir/Velpatasvir
Cell Cept	Lantus	SoluMedrol
Certolizumab	Lasix >60mg/day	Solurex
Cerubidine	Latuda	Sorine
Chlorambucil	L-Dopa	Sotylize
Chlormethine	Ledipasvir-Sofosbuvir	Sovaldi
Chlorpromazine	Leflunomide	Spiriva
Cilostazol	Lenalidomide	Stalevo
Cimzia	Letrozole[3]	Stelazine
Cinacalcet Hydrochloride	Leukeran	Sublimaze
Cisplatin	Levemir	Suboxone
Clopidogrel	Levodopa	Sustiva
Clopidogrel/Bisulfate	Lioresal	Sylatron
Clozapine	Lithium	Symmetrel

Clozaril	Lithium Carbonate	Tabloid
Cogentin	Lithobid	Tacrine
Cognex	Lodosyn	Tacrolimus
Comantan	Lomustine	Tarabine
Combivir	LurasidoneHCl	Tarceva
Copaxone	Matulane	Tasmar
Coreg	Mechlorethamine	Tenormin
Coreg CR	Medrol	Teslac
Cosmegen	Megace	Testolactone
Coumadin	Megestrol	Thioplex
Cozaar	Mellaril	Thioridazine
Crixivan	Melphalan	Thiotepa
CuuNu	Memantine HCl	Thiothixene
Cyclosporine	Memantine HCl-Donepezil HCl	Thorazine
Cytarabine	Mepergan	Ticagrelor
Cytosar	Meperidine	Tioguanine
D4T	Meprozine	Tocilizumab
Dabigatran	Mercaptopurine	Tolak
Dactinomycin	Mestinon	Tolcapone
Dalfampridine	Metaxalone	Toremifene
Dapagliflozin	Methadone	Torsemide
Daunorubicin	Methadose	Tositumomab
Dazidox	Methylprednisolone	Toujeo
DDC	Metolazone	Trastuzumab
Decadron	Metrifonate	Trihexyphenidyl
Demadex	Mimpara	Truvada
Demerol	Mirapex[2]	Tysabri
Depade	Mirtazapine	Valchlor
Depodur	Mithracin	Velban
DepoMedrol	Mitomycins	VePesid
DES	Mitosol	Vinblastine
Dexamethasone Intensol	Moban	Vincristine
Dexasone	Moderiba	Viracept
Digoxin	Molindone	ViraferonPeg
Dilaudid	Morphine Sulfate	Viramune
Diskets	MSContin	Virazole
Disulfiram	Mustargen	Vivitrol
Docefrez	Mutamycin	Vraylar
Docetaxel	Mycophenolatemofetil	Warfarin
Dolophine	Mykrox	Xarelto
Donepezil	Myleran	Xeloda
Dopar	Mylocel	Xifaxin
Doxorubicin	Mytelase	Xtandi
Droxia	Naltexone HCL	Zanosar
Duragesic	Namenda	Zarxio
Duramorph	Namzaric	Zelapar
Efavirenz	Navane	Zidovudine
Efudex	Neomycin	Ziprasidone
Eldepryl	Neoral	Zoladex
Eliquis	Neulasta	Zubsolv
Eloxatin	Neupogen	Zyprexa
Embeda	Neupro	Zytiga
Emcyt	Nevirapine	
Emsam	Nitroglycerin	

[2]Can be considered only if being used for the treatment of Restless Leg Syndrome (RLS).
[3]Can be considered if more than 24 months since completion of cancer treatment.

Prescribing Doctor information is taken into account when reviewing prescription drug history. If the medication is filled by a Specialist Doctor (e.g., Cardiologist, Oncologist, Rheumatologist, etc.), it could indicate the client is being treated for a medical condition that could be referred for Underwriter review or possible decline.

Replacements

A replacement takes place when an applicant wishes to exchange a new Medicare Supplement policy underwritten by Elips Life Insurance Company for:

1. An existing Medicare Supplement policy underwritten by Elips Life Insurance Company 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 the Replacement/Previous or existing coverage section of the application (Replacement Questions) for the state in which the application is signed. One copy should be provided to the applicant, and one copy should accompany the application.

Completing the replacement section of the application

- Applications may be submitted for applicants that have just enrolled in Medicare Part B, even if 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. Elips Life Insurance Company cannot issue a policy without confirmation of this information. If this question is answered "Yes", the replacement form must also be completed
- 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 (e.g., an employer, union, or individual plan). Note that maintaining a non-Medicare group plan and a Medicare Supplement plan is not considered double coverage.

Telephone Interviews

A telephone interview may be conducted at the discretion of the Underwriter. Please advise your clients that we may be contacting them to conduct an interview. Telephone interviews for health information are only conducted for underwritten policies; for Open Enrollment and Guaranteed Issue applications, applicants will not be asked any health questions. 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.
- Payer information – a third party payer 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 in 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

<u>Decline Process</u>

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

<u>Decline Appeals</u>

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 Elips Life Insurance Company 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 is 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 (marked to indicate they do not wish to keep the policy), a signed letter, or any other signed written statement. Elips Life Insurance Company requests that the original policy be returned to them 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

Elips Life Insurance Company offers five standard Medicare Supplement plans: A, F, G, High Deductible G and N. The plan selection must be indicated on the application in the space provided. 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 G
Step 3: Tobacco use	Non-Tobacco
Step 4: Age/Gender	Female, Age 65
Step 5: Annual Base Premium	$1,641
Step 6: Household Discount	$1,641 X (100% - 12%) = $1,444.08
Step 7: Apply premium mode	Monthly: $1,444.08 ÷ 12 = $120.34

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 the 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/she may be eligible for a household discount upon coverage approval.

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.

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.

States with state-specific household discount criteria**:**

- California is a 1-buy state. The 1st criteria requires that the applicant is residing with spouse (this includes validly recognized civil union and domestic partner) named on the form.
- Indiana, and North Dakota are 2-buy states. Applicants applying for the household discount must meet the following criteria:
  a) Married and residing with 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 Medicare Supplement policy underwritten by Elips Life Insurance Company.

The Household Discount will be removed if the other Medicare Supplement policyholder chooses to terminate his or her Medicare Supplement policy or he or she no longer resides with the applicant.

- Kentucky is a 1-buy state. The 2nd criteria requires that the applicant has been residing with the person named on the form for at least 12 months. The household discount will remain in effect for the life of the policy.
- Ohiois a 2-buy state. Applicants applying for household discount must meet the following criteria:
  a) Married and residing with legal spouse, or reside with the person named on the form for at least 12 months; AND

b) The legal spouse or additional resident named on the form has an existing Medicare supplement policy, or is applying for such a policy, with Elips Life Insurance Company or Lumico Life Insurance Company.

The Household Discount will be removed if the other Medicare Supplement policyholder chooses to terminate his or her Medicare Supplement policy or he or she no longer resides with the applicant.

- Pennsylvania is a 1-buy state. The 2nd criteria requires that the applicant has been residing with the person named in the household discount form for the last 12 months who has an existing Medicare Supplement policy, or is applying for such a policy with Elips Life Insurance Company or Lumico Life Insurance Company.
- Washington is a 2-buy state. Applicants applying for spousal discount must meet the following criteria:

a) Currently residing with the legal spouse, civil union partner, or domestic partner; and

b) The legal spouse, civil union partner or domestic partner named on the form has an existing Medicare Supplement policy, or is applying for such a policy, with Elips Life Insurance Company.

The spousal discount will be removed if the other Medicare Supplement policyholder chooses to terminate their Medicare Supplement policy or if the policyholder no longer resides with their legal spouse, civil union partner or domestic partner named on the form (other than in the case of death).

Tobacco Class

Unless otherwise determined by state law, the underwriting class is determined by the applicant’s use of any form of tobacco or nictoine products, including e-cigarettes, vape, nicotine patches/gum, 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. 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, Elips 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.

For California, only one month's premium may be accepted as the initial draft regardless of payment mode.

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	2nd 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 or about the next 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 California birthday rule open enrollment period, the effective date must fall on birthday or up to 60 days after birthday and must be within 60 days of the application signature date.

For applications submitted during the Kentucky annual open enrollment period, the effective date must fall on birthday or up to 60 days after birthday.

For applications submitted during the Louisiana special open enrollment period, the effective date must fall on birthday or up to 63 days after birthday.

POLICY SERVICES

Claims

Please call 1-855-774-4491 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

California
Birthday rule open enrollment period beginning 60 days prior to the individual's birthday and lasting 60 days thereafter, the individual may apply for a Medicare Supplement plan that offers benefits equal to or lesser than those provided by their current plan.

Current Plan (incl. 1990 Standardized Plan)	Equal to (2010 Standardized Plan)	Lesser Benefits (only plans offered by Elips Life)
A	A	None
B	B*	A
C	C*	A, N
D	D*	A, N
E	D*	A, N
F	F	A, G, High Deductible G, N
High Deductible F	High Deductible F*	High Deductible G
G	G	A, High Deductible G, N
High Deductible G	High Deductible G	None
H	D*	A, N
I	G	A, High Deductible G, N
J	F	A, G, High Deductible G, N
High Deductible J	High Deductible F*	High Deductible G
K	K*	A
L	L*	A
M	M*	A
N	N	A

*Plans not offered by Elips Life

Kentucky
Annual open enrollment beginning on the individual's birthday and lasting for a period of 60 days, the individual currently covered by a Medicare Supplement plan issued by a different insurer may apply for the same Medicare Supplement plan from Elips.

Louisiana
Open enrollment beginning on the individual’s birthday and lasting for a period of 63 calendar days, the individual with an existing Elips or Lumico Medicare Supplement policy may purchase any Elips Medicare Supplement that offers benefits equal to or lesser than those provided by the current Elips or Lumico coverage.

Lumico or Elips* Current Plan	Equal to or Lesser Benefits offered by Elips
A	A
F**	A, F**, G, High Deductible G, N
G	A, G, High Deductible G, N
High Deductible G	High Deductible G
N	N

* If the current Plan is an Elips Plan, applicants cannot switch to same letter Plan.
** No Plan F for applicants who are Newly Eligible to Medicare on or after January 1, 2020

Acceptable Proof

For California, provide a copy of the personalized policy/certificate schedule page or ID card for the Medicare Supplement plan that shows the policyholders name and plan. If the policy has been in force more than two years, we will also need documentation showing the paid to date of the existing coverage. Other documentation will be accepted if it provides the policyholder name, plan, and proof of paid to date.

Application Dates

California birthday rule open enrollment applications must be signed 60 days prior to individual's birthday and up to 60 days thereafter.

Wisconsin applications may be taken up to 90 days prior to the month the applicant turns age 65.

Guaranteed Issue

State	Qualifications	Plans Offered
CA	An individual enrolled in Medicare Part B who has been notified that because of an increase in income or assets, the individual meets one of the following requirements the individual: (a) Is no longer eligible for Medi-Cal (California Medicaid) benefits. (b) Is only eligible for Medi-Cal benefits with a share of cost and certifies at the time of application that the individual has not met the share of cost. An individual enrolled in Medicare Part B and enrolled in a Medicare Supplement plan but can no longer retain the coverage because the individual moved outside the plan's service area. The individual is entitled to a 6-month open enrollment period from the date the individual was notified that coverage will be or has been terminated. An individual enrolled in Military Health Coverage who lost access to coverage due to a military base closure, the base no longer offers health care services or the individual moved away from a military base. The individual is entitled to a 6-month open enrollment period from the date the individual was notified that coverage will be or has been terminated. An individual enrolled under an employee welfare benefit or retirement plan who has lost coverage or is no longer eligible due to divorce or death of a spouse or family member is entitled to a 6-month open enrollment from the date the individual is notified that the coverage will be or has been terminated. ***Voluntarily terminating employer group coverage is **not** a Guaranteed Issue trigger.* An individual under age 65 and is covered under Medicare Part B because of disability, but does not have end-stage renal disease (ESRD) is entitled to a 6-month open enrollment beginning with the first day of the month of the individual's Part B effective date.	Any Medicare Supplement plan offered by an insurer[1]
KS	An individual who loses eligibility for health benefits under Title XIX of the Social Security Act (Medicaid). Acceptable Proof: A copy of the personalized eligibility/determination letter from the Medicaid program that includes the benefits the client was receiving, the termination date and reason for the loss.	Any Medicare Supplement plan offered by an insurer[1]

State	Qualifications	Plans Offered
LA	An individual who does not have an existing Medicare supplement policy but has maintained health insurance coverage through employer at the time the individual became eligible for Medicare coverage, the individual shall have an open enrollment period for 63 days commencing on any of the following: (a) Termination date of the individual's employer-based plan; (b) The date the employer-based plan ceases to provide some or all health benefits to the individual; or (c) The date the individual leaves the employer-based plan.	Any Medicare Supplement plan offered by an insurer[1]
OH	An individual enrolled under a state Medicaid plan as described in Title XIX of the Social Security Act and the plan terminates or the plan ceases to provide all such supplemental health benefits to the individual. Acceptable Proof: A copy of the personalized eligibility/determination letter from the state Medicaid program that includes the benefits the client was receiving, the termination date and the reason for the loss of benefits.	A, F[1], G[2], High Deductible G[3]
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 disabled person who is involuntarily disenrolled from Medicaid or State Children's Health Insurance Program will have six (6) months from the date of disenrollment to purchase a policy. A disabled person who becomes retroactively enrolled in Medicare Part B due to a retroactive eligibility decision made by TennCare will have six (6) months from the date of the notice of retroactive enrollment to purchase a policy.	A, F[1], G[2], High Deductible G[3] Any Medicare Supplement plan offered by an insurer[1] Any Medicare Supplement plan offered by an insurer[1] Any Medicare Supplement plan offered by an insurer[1]
TX	The individual must no longer be eligible to receive Medicaid health benefits. The individual meets the following requirements: (A) the individual was enrolled in both the federal Medicare program and the Texas Health Insurance Pool on December 31, 2013; and (B) the individual's Pool coverage terminated on or after December 31, 2013.	A, F[1], G[2], High Deductible G[3]
UT	Medicaid health benefits must involuntarily terminate.	A, F[1], G[2], High Deductible G[3]
WA	An individual covered under Medicare Supplement Plan A can purchase from any other Medicare Supplement Plan A offered by any insurer at any time.	A Any Medicare Supplement plan

State	Qualifications	Plans Offered
	An individual covered under a Medicare Supplement plan (including high deductible Plan F or G) other than Plan A can purchase any other Medicare Supplement Plan B through N offered by any insurer.	except Plan A offered by an insurer[1]
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.	Base policy and the following riders: Part A Deductible Rider, Part B Deductible Rider[4], Part B Copayment or Coinsurance Rider, Part B Excess Charges Rider, Additional Home Health Care Rider and Foreign Travel Emergency Rider

[1]Plan F is not available for newly eligblie applicants
[2]Plan G is not available for nonnewly eligible applicants
[3]Plan High Deductible G is not available for nonnewly eligible applicants
[4] Part B deductible rider is not available to newly eligible applicants. Part B Deductible rider can't be selected with Part B Copayment or Coinsurance rider.

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

An individual who is **enrolled in Medicare Part B while enrolled in the State Medicaid plan** as described in Title XIX of the Social Security Act (Medicaid) but due to a change in Medicaid eligibility is no longer eligible for coverage under Medicaid, guaranteed issue rights are available in the following states:

State(s)	Qualifications	Plans Offered
AR, DE and ND	Exhausted the initial open enrollment period as a result of continued enrollment in Medicaid. The guaranteed issue period is 63 days starting on the date of the Medicaid eligibility change.	A, F[1], G and High Deductible G
IN, KY and MI	Exhausted the initial open enrollment period as a result of continued enrollment in Medicaid. The guaranteed issue period is 63 days starting on the date of the Medicaid eligibility change.	A, F[1], G, High Deductible G and N
PA	Exhausted the initial open enrollment period as a result of continued enrollment in Medicaid. The individual has a guaranteed issue right during the 63 days following the later of the individual's notice of termination or disenrollment or the date of termination from Medicaid.	A, B, F[1], G, High Deductible G and N
WV, MS and VA	Exhausted or nearly exhausted the initial open enrollment period as a result of continued enrollment in Medicaid. The individual has guaranteed issue right to enroll in any available Medicare supplement policy for the longer period of: (i) 63 days starting on the date of	A, F[1], G, High Deductible G and N

	Medicaid eligibility change; or (ii) the end of initial open enrollment period.	

[1]Plan F is not available for newly eligible applicants

Acceptable proof: Letter or notice from the State agency that administers the State's Medicaid program that shows that individual's coverage is being terminated due to a change in eligibility and the date that the coverage will end.

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

State(s)	Qualifications	Plans Offered
IN, LA, OH, TX	If the employer sponsored plan is primary to Medicare.	A, F[1], G[2] and High Deductible G[2]
PA	If the employer sponsored plan is primary to Medicare.	A, B, F[1], G[2] and High Deductible G[2]
WI	If the employer sponsored plan is primary to Medicare.	Medicare Supplement Plan along with any riders available Part B Deductible Rider is NOT available for "Newly Eligible" applicants
VA and WV	If the Employer sponsored plan's benefits are reduced substantially.	A, F[1], G[2] and High Deductible G[2]
AR and KS	No conditions–always qualified for Guaranteed Issue rights.	A, F[1], G[2] and High Deductible G[2]

[1] Plan F is not available for newly eligible applicants
[2]Please note: Plan G and High Deductible G are only available for those eligible for Medicare on or after 1/1/2020

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 VA and WV requirements. Proof of coverage termination is required. For most states, plans A, F, G or High Deductible G are available for Guaranteed Issue applications.

State-Specific Forms

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.

South Carolina – Duplication of Insurance Form: this form must be completed, dated and signed by the applicant when replacement Question 5 of the application ("Have you had coverage under any other health insurance within the past sixty three (63) days? (For example, an employer, union, or individual non-Medicare supplement plan))" is answered "Yes".

State Availability by Product

The chart below shows current state availability by product:

State	Tobacco Rates during Open Erollment?
Alabama	Y
Arizona	Y
Arkansas	N
California	N
Delaware	Y
Georgia	Y
Indiana	Y
Kansas	Y
Kentucky	N
Louisiana	N
Michigan	N
Mississippi	Y
North Carolina	N
North Dakota	N
Ohio	N
Pennsylvania	N
South Carolina	N
Tennessee	N
Texas	Y
Utah	N
Virginia	N
Washington	N
West Virginia	Y
Wisconsin	N

States that require plans to be offered to individuals under 65:

AR – Plan A only
CA (without ESRD)
DE
GA
IN – Plan A only
KY
LA
MS
NC
PA
TN
TX – Plan A only
VA – Plan A only
WI