Lumico
medigap solutions

MEDICARE SUPPLEMENT

AGENT UNDERWRITING GUIDE

LUMICO MEDIGAP SOLUTIONS

Underwritten by
Lumico 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] These ratings reflect claims paying ability but are not a guarantee of future performance, as of May 2019.
[2] BBB rating is current as of July 2020 and is not a guarantee of a business's reliablity or performance.

IMPORTANT CONTACT INFORMATION

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

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

Telephone Numbers:	
Customer Service, New Business, Claims, Underwriting	1-855-774-4491
Commissions	1-855-774-4491
Fax Numbers:	
Underwriting	1-855-774-4492
New Business	1-833-522-4001
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 Lumico Medicare Supplement Insurance. The policy issued is specific to the state of residence. The applicant's state of residence controls the application, forms, premium, and policy issue. If an applicant has more than one residence, the state where the Federal Income Taxes are filed should be considered the state of residence. Please refer to your introductory materials for required forms specific to your state. Also refer to the Appendix for state-specific guidelines for application dates.

Underwritten Policies
Applicants 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. 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 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 Medigap policy...
He/she is in a Medicare Advantage Plan (like an HMO or PPO), and their plan is leaving Medicare or stops giving care in their area, or they move out of the plan's service area.	Medigap Plan A, B, C, F, K, or L (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	As early as 60 calendar days before the date their health care coverage will end, but no later than 63 calendar days after their health care coverage ends. Medigap coverage can't start until their Medicare Advantage Plan coverage ends.

Applicant has a right to guaranteed issue if...	Applicant has the right to buy...	Applicant can/must apply for a Medigap policy...
	than join another Medicare Advantage Plan.	
He/she has Original Medicare and an employer group health plan (including retiree or COBRA coverage) or union coverage that pays after Medicare pays and that plan is ending. **Note:** In this situation, they may have additional rights under state law.	Medigap Plan A, B, C, F, K, or L (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 Medigap policy right away or wait until the COBRA coverage ends.	No later than 63 calendar days after the latest of these three dates: 1. Date the coverage ends 2. Date on the notice they get telling them that coverage is ending (if they get one) 3. Date on a claim denial, if this is the only way they know that their coverage ended
He/she has Original Medicare and a Medicare SELECT policy. They move out of the Medicare SELECT policy's service area. Call the Medicare SELECT insurer for more information about options.	Medigap Plan A, B, C, F, K, or L (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 Medigap policy that's sold in your state by any insurance company.	As early as 60 calendar days before the date their coverage will end, but no later than 63 calendar days after their coverage ends. **Note:** Rights may last for an extra 12 months under certain circumstances.
(Trial right) They dropped a Medigap policy to join a Medicare Advantage Plan (or to switch to a Medicare SELECT policy) for the first time, they've been in the plan less than a year, and they want to switch back.	The Medigap policy they had before they joined the Medicare Advantage Plan or Medicare SELECT policy, if the same insurance company they had before still sells it. If their former Medigap policy **isn't** available, they can buy Medigap Plan A, B, C, F, K, or L (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.
Their Medigap insurance company goes bankrupt and they lose their coverage, or their Medigap policy coverage otherwise ends through no fault of their own.	Medigap Plan A, B, C, F, K, or L (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 Medigap policy because the company hasn't followed the rules, or it misled them.	Medigap 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 Guarantee Issue period, the applicant will be underwritten for coverage. This includes:

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

Build Chart

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

	Decline	Proceed	Decline
Height	**Weight**	**Weight**	**Weight**
4' 2"	< 54	54 – 145	146 +
4' 3"	< 56	56 – 151	152 +
4' 4"	< 58	58 – 157	158 +
4' 5"	< 60	60 – 163	164 +
4' 6"	< 63	63 – 170	171 +
4' 7"	< 65	65 – 176	177 +
4' 8"	< 67	67 – 182	183 +
4' 9"	< 70	70 – 189	190 +
4' 10"	< 72	72 – 196	197 +
4' 11"	< 75	75 – 202	203 +
5' 0"	< 77	77 – 209	210 +
5' 1"	< 80	80 – 216	217 +
5' 2"	< 83	83 – 224	225 +
5' 3"	< 85	85 – 231	232 +
5' 4"	< 88	88 – 238	239 +
5' 5"	< 91	91 – 246	247 +
5' 6"	< 93	93 – 254	255 +
5' 7"	< 96	96 – 261	262 +
5' 8"	< 99	99 – 269	270 +
5' 9"	< 102	102 – 277	278 +
5' 10"	< 105	105 – 285	286 +
5' 11"	< 108	108 – 293	294 +
6' 0"	< 111	111 – 302	303 +
6' 1"	< 114	114 – 310	311 +
6' 2"	< 117	117 – 319	320 +
6' 3"	< 121	121 – 328	329 +
6' 4"	< 124	124 – 336	337 +
6' 5"	< 127	127 – 345	346 +
6' 6"	< 130	130 – 354	355 +
6' 7"	< 134	134 – 363	364 +
6' 8"	< 137	137 – 373	374 +
6' 9"	< 140	140 – 382	383 +
6' 10"	< 144	144 – 392	393 +

	Decline	Proceed	Decline
Height	Weight	Weight	Weight
6' 11"	< 147	147 – 401	402 +
7' 0"	< 151	151 – 411	412 +
7' 1"	< 155	155 – 421	422 +
7' 2"	< 158	158 – 431	432 +
7' 3"	< 162	162 – 441	442 +
7' 4"	< 166	166 – 451	452 +

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

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

Uninsurable health 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 – Chronic pulmonary fibrosis – Cystic fibrosis – Emphysema – Sarcoidosis	Lupus – systemic
	Multiple Sclerosis (MS)
	Muscular Dystrophy
	Myasthenia Gravis
	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
	Chronic Hepatitis
Crippling / disabling arthritis	

[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.

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,” to Question 9, they may be eligible for coverage. The underwriter will conduct a phone interview to obtain further information regarding the condition(s) listed below:

- Coronary artery disease, angina, aortic or cardiac aneurysm, cardiomyopathy, congestive heart failure, heart valve disorder, atrial fibrillation, or other heart rhythm disorder
- 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
Lumico Medicare Supplement Insurance 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	Entacapone	Olanzapine
Abatacept	Entecavir	Oncovin
Abilify	Entresto	Onsolis
Abiraterone	Enulose	Opana
Abstral	Enzalutamide	Opdivo
Acamprosate	Epclusa	Orap
Aclasta	Epogen	Orencia
Actemra	Ergoloid	Oxaliplatin
Actimmune	Erlotinib	Oxaydo
Actiq	Eskalith	Palbociclib
Adalimumab	Estramustine	Paraplatin
Adcetris	Etanercept	Parlodel
Adriamycin	Etoposide	Pegasys
Afinitor	Eulexin	Pegfilgrastim
Afrezza	Everolimus	Peginterferon

Agrylin	Exalgo	Pegintron
Aldesleukin	Exelon	Permax
Alefacept	Exemestane	Permitil
Alemtuzumab	Extavia	Pethidine
Alferon	Fareston	PhosLo
Alkeran	Farxiga	Pimozide
Amantadine	Faslodex	Plaquenil
Amaryl	Femara	Platinol
Ambenonium	Fentanyl	Plavix
Amevive	Fentora	Pletal
Amiodarone	Filgrastim	Plicamycin
Amjevita	Floxuridine	Pradaxa
Ampyra	Fluoroplex	Prandin
Anagrelide	Fluorouracil	Prednisone
Anastrozole[3]	Fluoxetine HCl	Primasol
Antabuse	Fluphenazine	Procarbazine
Apixaban	Flutamide	Procrit
Apokyn	Fortovase	Procyclidine
Apomorphine	FUDR	Prograf
Aralast	Fulvestrant	Proleukin
Arava	Furosemide	Prolia
Aricept	Gablofen	Prolixin
Arimidex	Galantamine	Protopic
Aripiprazole	Gefitinib	Prozac
Aristada	Gengraf	Purixan
Aromasin	Geodon	Pyridostigmine Bromide
Artane	Gleevec	Quetiapine Fumarate
Astramorph	Gleostine	Raltegravir
Atamet	Glipizide	Rasagiline
Atenolol	Glucotrol	Razadyne
Atrovent	Gold	Rebif
Auroanofin	Golimumab	Reclast
Avonex	Goserelin	Regonol
Avonexpen	Granix	Remeron
Azathioprine	Gravitor	Remicade
Azidothymidine	Haloperidol	Reminyl
Azilect	Harvoni	Requip[2]
AZT	Herceptin	Retrovir
Baclofen	hizentra	Revatio
Baraclude	Humalog	ReVia
Basaglar	Humira	Revlimid
Baycadron	Hydergine	Rexulti
Benztropine	Hydrea	Ribavirin
Betapace	Hydromorphone HCL	Ridaura
Betaseron	Hydroquin	Rifaximin
Bexxar	Hydroxychloroquine	Rilutek
Bicalutamide	Hydroxyurea	Riluzole
Biperiden	HyQvia	Risperdal
Blenoxane	Ibrance	Risperidone
Bleomycin	Ibrutinib	Ritonavir
Brentuximabvedotin	Imatinib Mesylate	Rivaroxaban
Brexpiprazole	Imbruvica	Rivastigmine
Brilinta	Imuran	Rivastigmine Tartrate
Bromocriptine	Indinavir	Rocaltrol
Bumetanide	Infliximab	Roxanol
Bumex	Infumorph	Roxicodone

Bunavail	Insulin Detemir	Ruxolitinib
Buprenorphine	Insulin Human	Sacubitril/valsartan
Buprenorphine/Naloxone	Insulin Lispro	Salmeterol
Burinex	Insulin Protamine	Sandimmune
Busulfan	Interferon	Sandostatin
Busulfex	Interferon Beta-1a	Sarafem
Calcijex	Interferon gamma-1b	Selegiline
Calcitriol	Invirase	Sensipar
Campath	Ipratropium	Serevent
Campral	Iressa	Seroquel
Capecitabine	Isentress	Simponi Aria
Capecitabine	Jakafi	Sinemet[2]
Carac	Januvia	Sitagliptin
Carbidopa	Kadian	Skelaxin
Carboplatin	Kemadrin	Sofosbuvir
Cariprazine	Lactulose	Sofosbuvir/Velpatasvir
Carvedilol	Lamivudine/zidovudine	SoluMedrol
Casodex	Lanoxin	Solurex
Cassipa	Lantus	Sorine
CDDP	Lasix >60mg/day	Sotylize
Cell Cept	Latuda	Sovaldi
Certolizumab	L-Dopa	Spiriva
Cerubidine	Ledipasvir-Sofosbuvir	Stalevo
Chlorambucil	Leflunomide	Stelazine
Chlormethine	Lenalidomide	Sublimaze
Chlorpromazine	Letrozole[3]	Suboxone
Cilostazol	Leukeran	Sustiva
Cimzia	Levemir	Sylatron
Cinacalcet Hydrochloride	Levodopa	Symmetrel
Cisplatin	Lioresal	Tabloid
Clopidogrel	Lithium	Tacrine
Clopidogrel/Bisulfate	Lithium Carbonate	Tacrolimus
Clozapine	Lithobid	Tarabine
Clozaril	Lodosyn	Tarceva
Cogentin	Lomustine	Tasmar
Cognex	LurasidoneHCl	Tenormin
Comantan	Matulane	Teslac
Combivir	Mechlorethamine	Testolactone
Copaxone	Medrol	Thioplex
Coreg	Megace	Thioridazine
Coreg CR	Megestrol	Thiotepa
Cosmegen	Mellaril	Thiothixene
Coumadin	Melphalan	Thorazine
Cozaar	Memantine HCl	Ticagrelor
Crixivan	Memantine HCl-Donepezil HCl	Tioguanine
CuuNu	Mepergan	Tocilizumab
Cyclosporine	Meperidine	Tolak
Cytarabine	Meprozine	Tolcapone
Cytosar	Mercaptopurine	Toremifene
D4T	Mestinon	Torsemide
Dabigatran	Metaxalone	Tositumomab
Dactinomycin	Methadone	Toujeo
Dalfampridine	Methadose	Trastuzumab
Dapagliflozin	Methylprednisolone	Trihexyphenidyl
Daunorubicin	Metolazone	Truvada
Dazidox	Metrifonate	Tysabri

DDC	Mimpara	Valchlor
Decadron	Mirapex[2]	Velban
Demadex	Mirtazapine	VePesid
Demerol	Mithracin	Vinblastine
Depade	Mitomycins	Vincristine
Depodur	Mitosol	Viracept
DepoMedrol	Moban	ViraferonPeg
DES	Moderiba	Viramune
Dexamethasone Intensol	Molindone	Virazole
Dexasone	Morphine Sulfate	Vivitrol
Digoxin	MSContin	Vraylar
Dilaudid	Mustargen	Warfarin
Diskets	Mutamycin	Xarelto
Disulfiram	Mycophenolatemofetil	Xeloda
Docefrez	Mykrox	Xifaxin
Docetaxel	Myleran	Xtandi
Dolophine	Mylocel	Zanosar
Donepezil	Mytelase	Zarxio
Dopar	Naltexone HCL	Zelapar
Doxorubicin	Namenda	Zidovudine
Droxia	Namzaric	Ziprasidone
Duragesic	Navane	Zoladex
Duramorph	Neomycin	Zubsolv
Efavirenz	Neoral	Zyprexa
Efudex	Neulasta	Zytiga
Eldepryl	Neupogen	
Eliquis	Neupro	
Eloxatin	Nevirapine	
Embeda	Nitroglycerin	
Emcyt	Nitrostat	
Emsam	Nivolumab	
EmtrivaA	Norvir	
Enbrel	Octreotide	

[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 Lumico Medicare Supplement Insurance for:

1. An existing Medicare Supplement policy underwritten by Lumico Medicare Supplement Insurance of lesser or greater value; or
2. A policy with an external company.

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

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

Completing the replacement section of the application (Section VII)

- Applications may be submitted for applicants that have just enrolled in Medicare Part B, even 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. Lumico Medicare Supplement Insurance 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 Guarantee 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

Decline Process
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.

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

All appeals require medical records pertaining to the condition for which the applicant was declined. It is the responsibility of the applicant to obtain his/her medical records. Medical records must be submitted to the Underwriting Department directly from the physician's office and will not be accepted if submitted by the applicant or agent. Please note that Lumico Medicare Supplement Insurance 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.

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. Lumico Medicare Supplement Insurance 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

Lumico Medicare Supplement Insurance offers four standard Medicare Supplement plans: A, F, 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 F
Step 3: Tobacco use	Non-Tobacco
Step 4: Age/Gender	Female, Age 65
Step 5: Annual Base Premium	$1,406
Step 6: Household Discount	$1,406 X (100% - 7%) = $1,307.58
Step 7: Apply premium mode	Monthly: $1,307.58 ÷ 12 = $108.97

In addition, there is a one-time policy fee of $25 (or as determined by state variation), payable at the time of application. The policy fee is not included in any premium amount.

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:

- Florida is a 2-buy state. Applicants applying for the household discount must meet the following criteria:
  a) Married and residing with legal spouse name on the form, or have been residing with the person name on the form for at least 12 months; AND
  b) The legal spouse or additional resident has an existing Medicare supplement policy, or is applying for such policy, with 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.

- Montana is a 1-buy state. The applicant must meet the following criteria:
  a) Currently married and have been residing with spouse named on the form below for at least the last 12 months
  b) Residing with the person named on the form for at least the last 12 months.

- New Jersey is 2-buy state. The applicant must meet the following criteria:
  a) Currently married and residing with legal spouse (this includes Civil Union partners) named on the form or residing with the person named on the form for at least 12 months; AND
  b) The legal spouse or additional resident has an existing Medicare supplement policy, or is applying for such a policy, with 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 you.

No household discount is available to the applicants in the state of Minnesota.

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, Lumico will require proof of the routing number and account number from the financial institution.

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

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

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

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

*For beneficiaries who first started receiving Social Security May 1997 or later.
**If date falls on weekend or holiday, the draft will occur on 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 Oregon Annual Enrollment period, the earliest effective date is the applicant's date of birth, and the latest available effective date is 30 days after their birthday, to the day.

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

Oregon

OR Enrollment Window

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

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

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

Oregon Annual Enrollment

Guaranteed Issue Replacement Matrix

Applicant has a:	Replace with:
1990 or 2010 Medigap Plan A 2020 Medigap Plan A	2010 Medigap Plan A ** and +
1990 or 2010 Medigap Plan B 2020 Medigap Plan B	2010 Medigap Plan A, B ** and +
1990 or 2010 Medigap Plan C	2010 Medigap Plan A, B, C, D, K, L, M or N +
1990 or 2010 Medigap Plan D 2020 Medigap Plan D	2010 Medigap Plan A, B, D, K, L, M or N ** and +
1990 Medigap Plan E	Any 2010 Medigap Plan (**not innovative**) +
1990 or 2010 Medigap Plan F	Any 2010 Medigap Plan (**not innovative**) +
1990 or 2010 Medigap Plan F (HD)	2010 Medigap Plan F (HD) or 2020 Plan G (HD) +
1990 or 2010 Medigap Plan G 2020 Medigap Plan G	2010 Medigap Plan A, B, D, G, K, L, M, N, F (HD) or G (HD) ** and +
2020 Medigap Plan G (HD)	2020 Medigap Plan G (HD) ** and + 1990 and 2010 Medigap Plan F (HD) +
1990 Medigap Plan H	2010 Medigap Plan A, B, D, K, L, M or N ** and +
1990 Medigap Plan I	2010 Medigap Plan A, B, D, G, K, L, M or N ** and +
1990 Medigap Plan J	Any 2010 Medigap Plan ** and +
1990 Medigap High Plan J (HD)	2010 Medigap Plan F (HD) ** and +
1990 or 2010 Medigap Plan K 2020 Medigap Plan K	2010 Medigap Plan K ** and +
1990 or 2010 Medigap Plan L 2020 Medigap Plan L	2010 Medigap Plan K or L ** and +
2010 Medigap Plan M 2020 Medigap Plan M	2010 Medigap Plan M or N ** and +
2010 Medigap Plan N 2020 Medigap Plan N	2010 Medigap Plan N ** and +

** Newly eligible for Medicare (age 65, due to two years of disability, end stage renal disease (ESRD) or amyotrophic lateral sclerosis (ALS)) on or after Jan. 1, 2020.
+ Beneficiaries who were eligible for Medicare (age 65, due to two years of disability, end stage renal disease (ESRD) or amyotrophic lateral sclerosis (ALS)) prior to Jan. 1, 2020.
(HD) – High Deductible
* Innovative benefits include benefits not contained in other standardized Medicare Supplement plans including, but not limited to, nurse advice lines, annual physical exam, preventive dental care, preventive vision care, routine hearing and drug discount card.
^ Note: SELECT plans are considered equal to the same plan type it is modifying.

Open Enrollment For Move-Ins Under 65

OR allows 63 days guaranteed issue period for an applicant under age 65 who qualifies for Medicare by reason of disability and has moved to Oregon from a state that does not require Medicare Supplement policies to be issued to persons under age 65. The guaranteed issue period begins on the date that the applicant establishes residency in Oregon and ends 63 days thereafter. The following 17 states do not require insurers to offer Med Supp Plan to applicants under 65: AL, AK, AZ, DC, IA, MI, NE, NV, NM, ND, OH, RI, SC, UT, WA, WV and WY.

Proof of Residency

Proof of new primary residence in Oregon within the last 63 days. Document submitted as proof must include the applicant's name and the date of the move. The applicant can submit:

- An internet, cable, phone, or other public utility (like gas or water) bill or service communication. This should show the date that your new utilities or services started.
- U.S. Postal Service change of address confirmation letter that includes the mail forwarding date and the address the mail will be forwarded to.

OR Application Dates

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

Guaranteed Issue

State	Qualifications	Plans Offered
CO	Enrolled in both Medicare and Medicaid and lose 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 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
OR	Enrolled in a Tricare plan as described in Title XVIII 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 letter from the Tricare program that includes the benefits the client was receiving, the termination date and the reason for the loss of benefits. 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, N

State	Qualifications	Plans Offered
MN	Enrolled in a state public program and is losing coverage due to the unwinding of the Medicaid continous enrollment conditions. **Acceptable Proof:** A copy of the letter from the state Medicaid Program that reflects that the applicant is losing coverage.	Any Medicare Supplement Plan or riders offered by the insurer[2]
MT	Medicaid health benefits must involuntarily terminate.	A, F[1], G, N

[1]Indicates Plan F is not available for newly eligible applicants.
[2]Any plan with a benefit or rider paying the Part B Deductible is not available for newly eligible applicants.

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
MT	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 N
NM	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] and G

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	Qualifications	Plans Offered
NM	If the Employer sponsored plan's benefits are reduced substantially.	A, F, *G
FL	No conditions–always qualified for Guaranteed Issue rights.	A, F, *G

* Plan G 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 NM requirements. Proof of coverage termination is required. For most states, plans A, B, C or F are available for Guaranteed Issue applications.

State-Specific Forms
Florida – Agent Certification: this form is required to be completed and copy must be furnished to the applicant upon the taking of the application.

State Availability by Product
The chart below shows current state availability by product:

State	Tobacco Rates during Open Enrollment?
Colorado	N
Florida	Y
Minnesota	Y
Montana	Y
New Jersey	N
New Mexico	N
Oregon	Y

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

CO
FL
MT
NJ
OR