Medicare Supplement Policy

Individual Assurance Company, Life, Health & Accident
Administrative Office: PO Box 3270, Salt Lake City, UT 84110-3270
Application- Medicare Supplement Insurance

☐ New Business ☐ Reinstatement
☐ Coverage Change

Part I – Personal Information

Title: ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Other _____

Last Name _____ First Name _____ MI _____

Birthdate (mm/dd/yyyy) _____ Social Security Number _____ Age _____ Height __ ft __ in Weight _____ lbs Gender ☐ Male ☐ Female

Medicare ID Number _____

Street Address _____

City _____ State _____ Zip _____

Best Time to Call (3 hour interval)_____ to _____ Weekend Calls Yes ☐ No ☐

Daytime Phone _____ Evening Phone _____

Cell Phone _____ E-Mail Address _____

Part II – Plan Selection

Plan Applied For:

☐ Basic ☐ Extended Basic ☐ Co-Pay Plan

Optional Riders (Basic Plan Only):

☐ Medicare Part A Deductible Rider ☐ Medicare Part B Excess Charges Rider ☐ Preventive Benefits Rider
☐ Medicare Part B Deductible Rider

Tobacco Use:
Have you used any tobacco products, including cigarettes, cigars, chewing tobacco or a pipe, in the past 12 months?
☐ Yes ☐ No

Part III – Eligibility

State law allows a 6 month open enrollment period beginning with the first day of the first month in which the applicant becomes enrolled in Medicare Part B. *If you are a qualified open enrollee, you may apply for and receive any Medicare Supplement Plan available from us.*

Yes **No**

☐ ☐ 1) Did you turn 65 in the last 6 months?

☐ ☐ 2) Are you covered under Medicare Part A?
a) If YES, what is your Part A effective date? _____/_____/_____
b) If NO, what is your eligibility date? _____/_____/_____

☐ ☐ 3) Are you covered under Medicare Part B?
a) If YES, what is your Part B effective date? _____/_____/_____
b) If NO, what is your eligibility date? _____/_____/_____

Part IV – Medicare & Insurance Information

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you are eligible for guaranteed issue of a Medicare Supplement insurance policy or certificate, or that you had certain rights to buy such a policy or certificate, you may be guaranteed acceptance in one or more of our Medicare Supplement plans. Please include a copy of the notice from your prior insurer with this Application. *Please mark "Yes" or "No" below with an "X", to the best of your knowledge.*

PLEASE ANSWER ALL QUESTIONS

Yes No

☐ ☐ 1) Are you applying during a guaranteed issue period? (If YES please attach proof of eligibility).

☐ ☐ 2) Are you covered for Medical Assistance through the state Medicaid program?

NOTE TO APPLICANT: If you are participating in a "Spend Down Program" and have not met your "Share of the Cost", please answer "NO" to this question.

If "Yes", answer:

☐ ☐ a) Will Medicaid pay your premiums for this Medicare Supplement policy?

☐ ☐ b) Do you receive any benefits from Medicaid, OTHER THAN payments toward your Part B premium? If so, which of the following programs provides coverage for you?

☐ ☐ i) Specified Low-Income Medicare Beneficiary (SLMB),

☐ ☐ ii) Qualified Medicare Beneficiary (QMB), or

☐ ☐ iii) full Medicaid Beneficiary?

3) a) If you had coverage from any Medicare Plan other than Original Medicare within the past 63 days, for example, a Medicare Advantage plan, or a Medicare HMO or PPO, fill in your *"Effective"* and *"Paid-to"* dates below.
If you are still covered under this plan, leave *"Paid to"* blank.

Effective _____/_____/_____ Paid to _____/_____/_____ (mm/dd/yyyy)

☐ ☐ b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy? (If "Yes" complete Replacement Notice.)
If so, with what company? _____

Company Address: _____

☐ ☐ c) Was this your first time in this type of Medicare Plan?

☐ ☐ d) Did you drop a Medicare Supplement policy or certificate to enroll in the Medicare Plan?

☐ ☐ 4) a) Do you have another Medicare Supplement policy or certificate in force?

b) If so, with what company? _____

Company Address: _____

What plan do you have? _____

☐ ☐ c) If so, do you intend to replace your current Medicare Supplement policy or certificate with this policy?
(If "Yes" complete Replacement Notice.)

☐ ☐ 5) Have you had coverage under any other health insurance within the past 63 days?
(for example, an employer, union, or individual plan)

a) If so, with what company? _____

What kind of policy? _____

b) What are your dates of coverage under the other policy?

Effective _____/_____/_____ Paid to _____/_____/_____ (mm/dd/yyyy)

Part V – General Information

1) You do not need more than one Medicare Supplement policy or certificate.
2) If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
3) You may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy or certificate.
4) If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. Upon receipt of your request, we will return to you that portion of the premium attributable to the period of your Medicaid eligibility, subject to an adjustment for paid claims. If you are no longer entitled to Medicaid, your suspended Medicare Supplement policy or, if that is no longer available, a substantially equivalent policy will be reinstituted, effective as of the date of termination of Medicaid, if requested within 90 days of losing your Medicaid eligibility. If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.
5) If you are eligible for, and have enrolled in a Medicare Supplement policy or certificate by reason of disability and you later become covered by an employer or union based group health plan, the benefits and premiums under your Medicare Supplement policy or certificate can be suspended, if requested, while you are covered under the employer or union based group health plan. If you suspend your Medicare Supplement policy or certificate under these circumstances, and later lose your employer or union based group health plan, your suspended Medicare Supplement policy or certificate or, if that is no longer available, a substantially equivalent policy or certificate, will be reinstituted if requested within 90 days of losing your employer or union based group health plan. If the Medicare Supplement policy or certificate provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy or certificate was suspended, the reinstituted policy or certificate will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.
6) Counseling services may be available in Minnesota to provide advice concerning your purchase of Medicare Supplement insurance and concerning medical assistance through the state Medicaid Program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low Income Medicare Beneficiary (SLMB).

Part VI – Guarantee Issue Eligibility

Guaranteed Issue For Eligible Persons Under the Balanced Budget Act of 1997: The following are definitions of the categories of individuals who are eligible for Guaranteed Issue under the Balanced Budget Act of 1997:

☐ Enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare; and the plan terminates, or the plan ceases to provide all such supplemental health benefits to the individual *(eligible for the Basic Policy, and any combination of the Medicare Part A deductible, Medicare Part B deductible, or Medicare Part B Excess Charges Riders)*; or

☐ Enrolled in a Medicare Advantage plan under Medicare Part C, or the individual is 65 years of age or older and is enrolled with a Program of All-Inclusive Care for the Elderly (PACE) and the organization's certification or plan under Medicare Part C is terminated or specific circumstances permit discontinuance including, but not limited to, a change in residence of the individual, the plan is terminated within a residence area, the organization substantially violated a material policy provision, or a material misrepresentation was made to the individual meets such other exceptional conditions as the secretary may provide *(eligible for the Basic Policy, and any combination of the Medicare Part A deductible, Medicare Part B deductible, or Medicare Part B Excess Charges Riders)*; or

☐ Enrolled in a Medicare risk contract, health care prepayment plan, cost contract or Medicare Select plan, or similar organization, and the organization's certification or plan is terminated or specific circumstances permit discontinuance including, but not limited to, a change in residence of the individual, the plan is terminated within a residence area, the organization substantially violated a material policy provision, or a material misrepresentation was made to the individual *(eligible for the Basic Policy, and any combination of the Medicare Part A deductible, Medicare Part B deductible, or Medicare Part B Excess Charges Riders)*; or

☐ Enrolled in a Medicare Supplement policy and coverage discontinues due to insolvency, or other involuntary termination of coverage or enrollment under the policy, substantial violation of a material policy provision, or material misrepresentation *(eligible for the Basic Policy, and any combination of the Medicare Part A deductible, Medicare Part B deductible, or Medicare Part B Excess Charges Riders)*; or

Part VI – Guarantee Issue Eligibility *(continued)*

☐ Enrolled under a Medicare Supplement policy, terminates and enrolls for the first time in a Medicare Advantage, a risk or cost contract, or a Medicare Select plan, a PACE provider, and then terminates coverage within 12 months of the subsequent enrollment *(eligible for the same Plan you terminated with us, or, if that Plan is no longer available, the Basic Policy and any combination of the Medicare Part A deductible, Medicare Part B deductible, or Medicare Part B Excess Charges Riders);* or

☐ Upon *first* becoming eligible for benefits under Medicare Part B, enrolls in a Medicare Advantage plan under Medicare Part C or PACE provider and then disenrolls within 12 months *(eligible for all plans available from us)*.

Documentation of these events must be submitted with this Application. You must apply within 63 days of the date of termination of previous coverage in order to qualify as an eligible person.

Part VII – Premium Payment & Administration

Initial Premium _____

For _____ Months

Application fee: (+) $25

Total Amount Submitted: **(=)** _____

Requested Effective Date (*if other than Application Date)*

_____ (mm-dd-yyyy)

Select Bank Draft Day _____ (1st -28th)

(must be on or prior to the application effective date)

☐ I authorize Bank Draft Payments

☐ Draft Initial Amount ☐ Draft Immediately ☐ Draft Initial Premium On (Date) _____

RENEWAL: ☐ Direct Bill ☐ Bank Draft (Account Type: ☐ Checking ☐ Savings)

PREMIUM Mode**:** ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly Bank Draft

Bank Routing # (9 digits) Bank Account # (do not include check #)

|¦ _____ |¦ _____

Bank Name: _____

Name(s) of Depositor(s): _____

If paying premium by Bank Draft, please include a voided check. The first draft will occur on the date your application is approved by Individual Assurance Company (unless specified otherwise).

Part VIII – Medical Questions

Do not answer health questions 1-16 if you are in an open enrollment or guaranteed issue period. Please see pages 3-4 for an explanation of open enrollment/guaranteed issue period information.

NOTICE TO APPLICANT: Please answer all of the following questions. Please verify the accuracy and completeness of the medical information on this application. Incomplete or false information on this application could jeopardize future claims. If you answer YES to any of the following questions 1-15, you are not eligible for coverage.

1. Are you currently hospitalized, in a nursing home or assisted living facility, or are you bedridden or confined to a wheelchair? Yes ❒ No ❒

2. Have you been diagnosed with emphysema, chronic obstructive pulmonary disease (COPD) or other chronic pulmonary disorders? Yes ❒ No ❒

3. Have you been diagnosed with Parkinson's disease, systemic lupus, myasthenia gravis, multiple or lateral sclerosis, osteoporosis with fractures, cirrhosis or chronic hepatitis? Yes ❒ No ❒

4. Have you been diagnosed with Alzheimer's disease, senile dementia, or any other cognitive disorder? Yes ❒ No ❒

5. Have you been diagnosed with or treated by a physician or licensed medical professional for acquired immune deficiency syndrome (AIDS) or AIDS related complex (ARC)? Yes ❒ No ❒

6. Do you have diabetes? Yes ❒ No ❒

7. Within the past two years have you been treated for or been advised by a physician to have treatment for internal cancer, alcoholism, drug abuse, mental or nervous disorder requiring psychiatric care or have you had any amputation caused by disease? Yes ❒ No ❒

8. Within the past two years have you been treated for or been advised by a physician to have treatment for heart attack, heart, coronary or carotid artery disease (not including high blood pressure), peripheral vascular disease, congestive heart failure or enlarged heart, stroke, transient ischemic attacks (TIA) or heart rhythm disorders? Yes ❒ No ❒

9. Within the past two years have you been treated for degenerative bone disease, crippling / disabling or rheumatoid arthritis or have you been advised to have a joint replacement? Yes ❒ No ❒

10. Have you been advised by a physician that surgery may be required within twelve (12) months for cataracts? Yes ❒ No ❒

11. In the last two years, have you been advised by a physician to have surgery, medical tests, treatment or therapy that has not been performed? Yes ❒ No ❒

12. Have you been hospital confined three or more times in the last two years? Yes ❒ No ❒

13. Have you had an organ transplant or been advised by a physician to have an organ transplant? Yes ❒ No ❒

14. Have you been diagnosed with or treated for chronic kidney disease, kidney failure, or kidney disease requiring dialysis? Yes ❒ No ❒

15. Do you have an implanted cardiac defibrillator? Yes ❒ No ❒

16. Are you taking or have you taken any prescription or over-the-counter medications within the past 24 months? If YES, please list the drug(s) below along with the date prescribed, dosage / frequency and diagnosis/medical condition for **each** medication. Attach a separate sheet if needed. Yes ❒ No ❒

Part IX – Medical Questions *(continued)*

Medication Name (copy off pharmacy label)	
Date **Originally** Prescribed	
Dosage and Frequency	
Diagnosis / Medical Condition	

Medication Name (copy off pharmacy label)	
Date **Originally** Prescribed	
Dosage and Frequency	
Diagnosis / Medical Condition	

Medication Name (copy off pharmacy label)	
Date **Originally** Prescribed	
Dosage and Frequency	
Diagnosis / Medical Condition	

Medication Name (copy off pharmacy label)	
Date **Originally** Prescribed	
Dosage and Frequency	
Diagnosis / Medical Condition	

Medication Name (copy off pharmacy label)	
Date **Originally** Prescribed	
Dosage and Frequency	
Diagnosis / Medical Condition	

Medication Name (copy off pharmacy label)	
Date **Originally** Prescribed	
Dosage and Frequency	
Diagnosis / Medical Condition	

Medication Name (copy off pharmacy label)	
Date **Originally** Prescribed	
Dosage and Frequency	
Diagnosis / Medical Condition	

PRIMARY CARE PHYSICIAN INFORMATION

Physician's Name: ____

Telephone Number: ____

Part X – Agreement & Acknowledgement

I wish to apply for Medicare supplement insurance coverage. I acknowledge that I have received or been given access to review: (a) an Outline of Coverage for the coverage applied for, and (b) a "Guide to Health Insurance for People with Medicare."

I HAVE READ AND FULLY UNDERSTAND the questions and my answers on this Application. To the best of my knowledge and belief they are true and complete. I understand the Company may conduct a telephone interview with me regarding the answers. I understand and agree the coverage applied for will not take effect until issued by the Company, and that the agent is not authorized to extend, waive or change any terms, conditions or provisions of the coverage.

Caution: If your answers on this Application are incorrect or untrue, the Company has the right to deny benefits or rescind your coverage.

A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

Signed at (City and State): ____________________ Date: ☐☐-☐☐-☐☐☐☐

Applicant's Signature: ____________________ Send Policy to: ☐ Applicant ☐ Producer

Producer's Signature: ____________________ Producer Number: ____________________

Producer Phone: ____________________

Part XI – Producer Supplement

All questions must be completed.

Yes	No	
☐	☐	1. Did you meet with the Applicant in person?
☐	☐	2. Did you complete this Application over the phone?
		3. State the name and relationship of any other person present when this Application was taken. Name ____________________ Relationship to Applicant ____________________
☐	☐	4. Did you review the Application for correctness and any omissions?
☐	☐	5. Did the Applicant review the Application for correctness and any omissions?
☐	☐	6. Are you related to the Proposed Insured? If Yes, provide relationship: ____________________

Listed below are all other health insurance policies or certificates I have (a) sold to the Applicant which are still in force; and (b) sold to the Applicant in the last 5 years which are no longer in force.

Company	Type of Policy	Effective Date	In Force
			❐ Yes ❐ No
			❐ Yes ❐ No
			❐ Yes ❐ No

Producer #1 Name (please print) ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Producer # ☐☐☐☐☐☐☐ Split % ☐☐

Producer #2 Name (please print) ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Producer # ☐☐☐☐☐☐☐ Split % ☐☐

Part XII – Anticipated Loss Ratio Disclosure

The overall anticipated lifetime loss ratio for this form and its riders exceeds the minimum standard set forth by the regulations of Minnesota, as they apply to guaranteed renewable policy forms providing these types of benefits.

This minimum loss ratio of 65% has been calculated based upon the incurred claims experience and earned premiums for the period and according to accepted actuarial principles and practices.

Health Information Authorization

This Authorization complies with the HIPAA Privacy Rule

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, medical facility, or other health care provider that has provided services, treatment or payment to me, or on my behalf, within the past 10 years ("My Providers"), or consumer reporting agency, or the Medical Information Bureau, to disclose my entire medical record and any other protected health information concerning me to Individual Assurance Company, Life, Health & Accident ("IAC") and its agents, employees and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes and excludes information related to genetic tests or genetic services (except to pay a claim related to such tests or services).

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this Authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

My protected health information is to be disclosed under this Authorization so that IAC may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; **2)** obtain reinsurance; **3)** administer claims and determine or fulfill their responsibility for coverage and provision of benefits; **4)** administer coverage; and **5)** conduct other legally permissible activities that relate to any coverage I have or have applied for with IAC.

For a period of 120 days from the date of this Authorization I authorize my IAC Producer to receive certain protected health information about me that is related to an adverse underwriting decision or counteroffer for alternative coverage made during the underwriting of my application.

This Authorization shall remain in force for as long as my insurance with IAC continues following the date of my signature below, and a copy of this Authorization is as valid as the original. I understand that I have the right to revoke this Authorization in writing, at any time, by sending a written request for revocation to: **IAC at PO Box 3270, Salt Lake City, Utah 84110-3270, Attention: Privacy Officer.** I understand that a revocation is not effective to the extent that any of My Providers has relied on this Authorization or to the extent that IAC has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this Authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this Authorization. I further understand that if I refuse to sign this Authorization to release my complete medical record, IAC may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments.

_____ _____

Name of Applicant (please print) Signature of Applicant or Personal Representative

_____ _____

Date of Birth Date

_____

Description of Personal Representative's Authority or Relationship to Applicant (if applicable)

I-HHA (14-MS) MN (Return to Company)

NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE OR MEDICARE ADVANTAGE

INDIVIDUAL ASSURANCE COMPANY, LIFE, HEALTH & ACCIDENT
Medicare Supplement Administrative Office: P. O. Box 3270, Salt Lake City, UT 84110-3270

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE!

According to your application, you intend to terminate existing Medicare supplement or Medicare Advantage insurance and replace it with a policy to be issued by Individual Assurance Company, Life, Health & Accident. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision, you should terminate your present Medicare supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY AGENT: I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason (check one):

❒ Additional benefits.
❒ No change in benefits, but lower premiums
❒ Fewer benefits and lower premiums.
❒ Change in benefits (Gaining additional benefit(s), but losing some existing benefit(s)).
❒ My plan has outpatient drug coverage and I am enrolling in Part D.
❒ Disenrollment from a Medicare Advantage Plan. Please explain reason for disenrollment.
_____
❒ Other (please specify) _____

If, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

_____ _____
Signature of Agent, Broker or Other Representative Agent's Printed Name and Address

The above "Notice to Applicant" was delivered to me on:

_____ _____
Applicant's Signature Date

IRN-2015

Return to Company

NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE OR MEDICARE ADVANTAGE

INDIVIDUAL ASSURANCE COMPANY, LIFE, HEALTH & ACCIDENT
Medicare Supplement Administrative Office: P. O. Box 3270, Salt Lake City, UT 84110-3270

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❒ Additional benefits.
❒ No change in benefits, but lower premiums
❒ Fewer benefits and lower premiums.
❒ Change in benefits (Gaining additional benefit(s), but losing some existing benefit(s)).
❒ My plan has outpatient drug coverage and I am enrolling in Part D.
❒ Disenrollment from a Medicare Advantage Plan. Please explain reason for disenrollment.

_____

❒ Other (please specify) _____

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Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

_____ _____
Signature of Agent, Broker or Other Representative Agent's Printed Name and Address

The above "Notice to Applicant" was delivered to me on:

_____ _____
Applicant's Signature Date

IRN-2015

Leave with Applicant

INDIVIDUAL ASSURANCE COMPANY, LIFE, HEALTH & ACCIDENT
("INDIVIDUAL ASSURANCE COMPANY")
Home Office: Edmond, Oklahoma 73003
OUTLINE OF MEDICARE SUPPLEMENT COVERAGE

THE COMMISSIONER OF COMMERCE OF THE STATE OF MINNESOTA HAS ESTABLISHED TWO CATEGORIES FOR MEDICARE SUPPLEMENTS. THE CATEGORIES ARE BASIC MEDICARE SUPPLEMENT AND EXTENDED BASIC MEDICARE SUPPLEMENTS WITH EXTENDED MEDICARE SUPPLEMENTS BEING THE MOST COMPREHENSIVE AND BASIC MEDICARE SUPPLEMENTS BEING THE LEAST COMPREHENSIVE. THESE CHARTS SHOW THE BENEFITS IN EACH PLAN. ADDITIONAL BENEFITS ARE SHOWN ON PAGE 14-17.

Basic Plan— **Policy Form 94050 MN**	**Extended Basic Plan—** **Policy Form 94050 EB MN**	**$20 and $50 Co-Pay Plan—** **Policy Form 94050 N MN**
Hospitalization: Part A Coinsurance	Hospitalization: Part A Coinsurance	Hospitalization: Part A Coinsurance
Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance for the 21st through 100th day
Blood: First 3 pints of blood each year	Blood: First 3 pints of blood each year	Blood: First 3 pints of blood each year
Medical Expenses: Part B Coinsurance	Medical Expenses: Part B Coinsurance	Medical Expenses: Part B Coinsurance except up to $20 copayment for office visit, and up to $50 copayment for ER
Part A Deductible *	Part A Deductible	Part A Deductible
Part B Deductible *	Part B Deductible	
Part B Excess *	Part B Excess (100%)	
Foreign Travel	Foreign Travel	Foreign Travel
Hospice Care	Hospice Care	Hospice Care
Preventive Care *	Preventive Care	

* Optional Riders available for Part A Deductible, Part B Excess, Medicare Part B Deductible and Preventive Health Services.

Ultimate Premiums - Monthly Bank Draft
Non-Tobacco
Zip Codes 551, 554
A one-time $25 policy fee applies to each application

	MONTHLY RATES
Basic - Policy Form 94050 MN	**Non-Tobacco**
ALL AGES	$ 150.80
Optional Riders	
Medicare Part A Deductible	$ 28.76
Medicare Part B Deductible	$13.83
Medicare Part B Excess Charges Rider	$ 1.65
Preventive Medical Care Benefits Rider	$ 5.39
Extended Basic - Policy Form 94050 EB MN	
ALL AGES	$ 229.93
$20 and $50 Copayment Plan - Policy Form 94050 N MN	
ALL AGES	$ 161.89

Ultimate Premiums - Monthly Bank Draft
Tobacco
Zip Codes 551, 554
A one-time $25 policy fee applies to each application

	MONTHLY RATES
Basic - Policy Form 94050 MN	**Tobacco**
ALL AGES	$ 173.42
Optional Riders	
Medicare Part A Deductible	$ 33.07
Medicare Part B Deductible	$13.83
Medicare Part B Excess Charges Rider	$ 1.89
Preventive Medical Care Benefits Rider	$ 6.19
Extended Basic - Policy Form 94050 EB MN	
ALL AGES	$ 264.42
$20 and $50 Copayment Plan - Policy Form 94050 N MN	
ALL AGES	$ 186.17

Modal Factors: Annual = MBD x 12; SA = MBD x 6; Q = MBD x 3

Notice: This disclosure is required by Minnesota law. This policy provides an anticipated loss ratio of 65% percent. This means that, on the average, policyholders may expect that $65 of every $100.00 in premium will be returned as benefits to policyholders over the life of the contract. The lowest percentage permitted by state law for this policy is 65 percent.

Ultimate Premiums - Monthly Bank Draft
Non-Tobacco
Zip Codes 550, 552-553, 555-567
A one-time $25 policy fee applies to each application

	MONTHLY RATES
Basic - Policy Form 94050 MN	**Non-Tobacco**
ALL AGES	$ 133.27
Optional Riders	
Medicare Part A Deductible	$ 25.42
Medicare Part B Deductible	$13.83
Medicare Part B Excess Charges Rider	$ 1.46
Preventive Medical Care Benefits Rider	$ 4.76
Extended Basic - Policy Form 94050 EB MN	
ALL AGES	$ 203.19
$20 and $50 Copayment Plan - Policy Form 94050 N MN	
ALL AGES	$ 143.06

Ultimate Premiums - Monthly Bank Draft
Tobacco
Zip Codes 550, 552-553, 555-567
A one-time $25 policy fee applies to each application

	MONTHLY RATES
Basic - Policy Form 94050 MN	**Tobacco**
ALL AGES	$ 153.26
Optional Riders	
Medicare Part A Deductible	$ 29.23
Medicare Part B Deductible	$13.83
Medicare Part B Excess Charges Rider	$ 1.67
Preventive Medical Care Benefits Rider	$ 5.47
Extended Basic - Policy Form 94050 EB MN	
ALL AGES	$ 233.67
$20 and $50 Copayment Plan - Policy Form 94050 N MN	
ALL AGES	$ 164.52

Modal Factors: Annual = MBD x 12; SA = MBD x 6; Q = MBD x 3

Notice: This disclosure is required by Minnesota law. This policy provides an anticipated loss ratio of 65% percent. This means that, on the average, policyholders may expect that $65 of every $100.00 in premium will be returned as benefits to policyholders over the life of the contract.The lowest percentage permitted by state law for this policy is 65 percent.

PREMIUM INFORMATION

We, Individual Assurance Company, Life, Health & Accident, can only raise your premium if we raise the premium for all policies like yours in this State. We will not change the premiums for this policy during your first year of coverage. Thereafter your premium will increase each year based on your age at that time. No rate adjustment may be made on an individual basis. Also, your renewal premiums may change on a renewal date following the Effective Date of any change in the deductible and/or coinsurance amounts which you are required to pay under Medicare. Any such premium change will be based on the actuarial computations that we then use to determine the renewal premium.

DISCLOSURES

Use this outline to compare benefits and premiums among policies, certificates and contracts.
THIS POLICY DOES NOT COVER ALL MEDICAL EXPENSES BEYOND THOSE COVERED BY MEDICARE. THIS POLICY DOES NOT COVER ALL SKILLED NURSING HOME CARE EXPENSES AND DOES NOT COVER CUSTODIAL OR RESIDENTIAL NURSING CARE. READ YOUR POLICY CAREFULLY TO DETERMINE WHICH NURSING HOME FACILITIES AND EXPENSES ARE COVERED BY YOUR POLICY.

READ YOUR POLICY VERY CAREFULLY

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company. This does not give all the details of Medicare coverage. Contact your local Social Security office or consult the Medicare handbook for more details.

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to us at: PO Box 3270, Salt Lake City, Utah 84110-3270. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued, and return all of your payments within 10 days.

POLICY REPLACEMENT

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE

This policy may not fully cover all of your medical costs. Neither Individual Assurance Company, Life, Health & Accident nor its agents are connected with Medicare. This Outline of Coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult "The Medicare Handbook" for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information. Review the application carefully before you sign it. Be certain that all information has been properly recorded.

LOSS RATIO

This policy provides an anticipated loss ratio of 65%. This means that, on the average, policyholders may expect that $65 of every $100.00 in premium will be returned as benefits to policyholders over the life of the contract.

BASIC PLAN
MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* *A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.*

SERVICES	MEDICARE PAYS	BASIC PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1288	$0 $1288 with Optional Benefit Rider E-A	$1288 (Part A deductible)
61st thru 90th day	All but $322 a day	$322 a day	$0
91st day and after:			
-While using 60 lifetime reserve days	All but $644 a day	$644 a day	$0
-Beyond the additional 150 days	$0	100% of Medicare eligible expenses	$0***
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $161 a day	Up to $161 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care.	Medicare copayment/coinsurance	$0

BASIC PLAN (continued)
MEDICARE (Part B) - MEDICAL SERVICES -PER CALENDAR YEAR

*** Once you have been billed $166 of Medicare-Approved amounts for covered services (which are noted with a double asterisk), your Part B Deductible will have been met for the calendar year.*

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES-IN OR OUT OF THE HOSPITAL AND OUTPATIENT TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $166 of Medicare Approved Amounts**	$0	$0 $166 with Optional Benefit Rider E-B	$166 (Part B Deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0 $166 with Optional Benefit Rider E-BEX	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $166 of Medicare Approved Amounts**	$0	$0 $166 with Optional Benefit Rider E-B	$166 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

* Once You have been billed $166 of Medicare Approved amounts for covered services, Your Part B Deductible will have been met for the calendar year.

** Part B coinsurance (generally 20% of Medicare approved expenses), or in the case of hospital outpatient department services under a prospective payment system, applicable copayments.

BASIC PLAN (continued)
MEDICARE (Part B) - MEDICAL SERVICES -PER CALENDAR YEAR

***Once you have been billed $166 of Medicare-Approved amounts for covered services (which are noted with a double asterisk), your Part B Deductible will have been met for the calendar year.*

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment First $166 of Medicare Approved Amounts**	$0	$0 $166 with Optional Benefit Rider E-B	$166 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS - NOT COVERED BY MEDICARE

FOREIGN TRAVEL- NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during travel outside the USA (hospital, medical expense and supplies)	$0	80% of covered expenses	expenses not paid by Medicare or the policy
PREVENTIVE MEDICAL CARE BENEFIT- NOT COVERED BY MEDICARE Annual physical and preventive tests and services administered or ordered by Your doctor when not covered by Medicare. First $120 each calendar year	$0	$0 $120 with Optional Benefit E-PREV	$120 $0
Additional Charges	$0	$0 $0 with Optional Benefit E-PREV	All costs All Costs

EXTENDED BASIC PLAN
MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* *A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.*

SERVICES	MEDICARE PAYS	BASIC PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1288	$1288 (Part A deductible)	$0
61st thru 90th day	All but $322 a day	$322 a day	$0
91st day and after:			
-While using 60 lifetime reserve days	All but $644 a day	$644 a day	$0
-Beyond the additional 150 days	$0	100% of Medicare eligible expenses	$0***
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $161 a day	Up to $161 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care.	Medicare copayment/coinsurance	$0

EXTENDED BASIC PLAN (continued)
MEDICARE (Part B) - MEDICAL SERVICES -PER CALENDAR YEAR

*** Once you have been billed $166 of Medicare-Approved amounts for covered services (which are noted with a double asterisk), your Part B Deductible will have been met for the calendar year.*

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES-IN OR OUT OF THE HOSPITAL AND OUTPATIENT TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $166 of Medicare Approved Amounts**	$0	$166 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $166 of Medicare Approved Amounts**	$0	$166 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

* Once You have been billed $166 of Medicare Approved amounts for covered services, Your Part B Deductible will have been met for the calendar year.

** Part B coinsurance (generally 20% of Medicare approved expenses), or in the case of hospital outpatient department services under a prospective payment system, applicable copayments.

EXTENDED BASIC PLAN (continued)
MEDICARE (Part B) - MEDICAL SERVICES -PER CALENDAR YEAR

***Once you have been billed $166 of Medicare-Approved amounts for covered services (which are noted with a double asterisk), your Part B Deductible will have been met for the calendar year.*

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment First $166 of Medicare Approved Amounts**	$0	$166 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS - NOT COVERED BY MEDICARE

FOREIGN TRAVEL- NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during travel outside the USA (hospital, medical expense and supplies)	$0	80% of covered expenses	Expenses not paid by Medicare or the policy
PREVENTIVE MEDICAL CARE BENEFIT- NOT COVERED BY MEDICARE Annual physical and preventive tests and services administered or ordered by Your doctor when not covered by Medicare. First $120 each calendar year	$0	$120	$0
Additional Charges	$0	$0	All Costs

$20 AND $50 COPAYMENT PLAN
MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD

* *A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.*

SERVICES	MEDICARE PAYS	BASIC PLAN PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1288	$1288 (Part A deductible)	$0
61st thru 90th day	All but $322 a day	$322 a day	$0
91st day and after:			
-While using 60 lifetime reserve days	All but $644 a day	$644 a day	$0
-Beyond the additional 150 days	$0	100% of Medicare eligible expenses	$0***
SKILLED NURSING FACILITY CARE*			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $161 a day	Up to $161 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care.	Medicare copayment/coinsurance	$0

$20 AND $50 COPAYMENT PLAN (continued)
MEDICARE (Part B) - MEDICAL SERVICES -PER CALENDAR YEAR

***Once you have been billed $166 of Medicare-Approved amounts for covered services (which are noted with a double asterisk), your Part B Deductible will have been met for the calendar year.*

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES-IN OR OUT OF THE HOSPITAL AND OUTPATIENT TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First $166 of Medicare Approved Amounts**	$0	$0	$166 (Part B Deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Balance, other than up to $20 per office visit and up to $50 per emergency room visit. The copyament of up to $50 is waived if the insured is admitted to any hospital and the emergency room visit is covered as a Medicare Part A expense	Up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency room visit is covered as a Medicare Part A expense
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD First 3 pints	$0	All costs	$0
Next $166 of Medicare Approved Amounts**	$0	$0	$166 Part B Deductible
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES - TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

* Once You have been billed $166 of Medicare Approved amounts for covered services, Your Part B Deductible will have been met for the calendar year.

$20 AND $50 COPAYMENT PLAN (continued)
MEDICARE (Part B) - MEDICAL SERVICES -PER CALENDAR YEAR

***Once you have been billed $166 of Medicare-Approved amounts for covered services (which are noted with a double asterisk), your Part B Deductible will have been met for the calendar year.*

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment First $166 of Medicare Approved Amounts**	$0	$0	$0
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS - NOT COVERED BY MEDICARE

FOREIGN TRAVEL- NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during travel outside the USA (hospital, medical expense and supplies)	$0	80% of covered expenses	Expenses not paid by Medicare or the policy

The charts above summarizing the Medicare benefits only briefly describe the benefits. The Health Care Financing Administration or its Medicare publication should be consulted for further details and limitations.

ADDITIONAL BENEFITS

Scalp Hair Prosthesis. Coverage for the Usual and Customary charge incurred for a scalp hair prosthesis that is needed because of hair loss suffered as a result of alopecia areata. Benefits will be paid on the same basis as any other sickness or injury and as if Medicare paid benefits. This benefit is limited to one prosthesis per calendar year. Benefits are not payable for that portion of expense that is paid by Medicare or under any other part of this policy.

Immunization. Coverage for 100% of the cost of immunizations unless covered under Part D of Medicare for an immunization received by You. Benefits are not payable for that portion of expense that is paid by Medicare or under any other part of this policy.

Routine Cancer Screening. Coverage for the Usual and Customary charge incurred for routine screening procedures for cancer, including colorectal screening, mammograms and Pap smears. We will also pay the expenses for surveillance tests for ovarian cancer for women at risk for ovarian cancer when ordered or provided by a physician. Benefits are not payable for that portion of expense that is paid by Medicare or under any other part of this policy.

Routine Screening Procedures for Prostate Cancer. Coverage for the usual and customary charge for prostate cancer screening for:

a) men who are 50 years of age or older; and
b) men who are 40 years of age or older if it is determined by Your Physician that You are symptomatic or at a high risk of developing prostate cancer.

A Prostate cancer screening must consist of:

a) a prostate-specific antigen blood test; and
b) a digital rectal examination.

Diabetes Care. Coverage for 80% of the Usual and Customary Charge not covered by Medicare or Medicare Part D for all Physician-prescribed medically appropriate and necessary equipment and supplies used in the management and treatment of diabetes. We will also pay diabetes outpatient self-management training and education, including medical nutrition therapy, that is provided by certified, registered, or licensed health care professionals working in a program consistent with the national standards of diabetes self-management education as established by the American Diabetes Association. This benefit is limited to equipment and supplies not covered by Medicare Part D, whether or not You are enrolled in Medicare Part D. Benefits are not payable for that portion of expense that is paid by Medicare or under any other part of this policy.

Alcoholism and Chemical Dependency Treatment. We will pay the Usual and Customary Charge for the treatment of alcoholism and chemical dependency on the same basis as any other Sickness or Injury and as if Medicare paid benefits when treatment is provided in:

a) a licensed hospital;
b) a residential treatment program licensed by the state of Minnesota pursuant to diagnosis or recommendation by a doctor of medicine; or
c) a nonresidential treatment program approved or licensed by the state of Minnesota.

Benefits are not payable for that portion of expense that is paid by Medicare or under any other part of this policy.

Lyme Disease. Coverage for benefits for diagnosed Lyme disease as any other medical service. Benefits are not payable for that portion of expense that is paid by Medicare or under any other part of this policy.

Temporomandibular Joint Disorder and Craniomandibular Disorder. Coverage for the usual and customary charge for the surgical and nonsurgical treatment of temporomandibular joint disorder and craniomandibular disorder on the same basis as that for treatment to any other joint in the body. Such treatment must be administered or prescribed by a physician or dentist. Benefits under this provision are not payable for any portion of expense that is paid under any other part of your policy.

Reconstructive Surgery. Coverage for the usual and customary charge for reconstructive surgery on the same basis as any other surgery if the reconstructive surgery is incidental to or follows surgery resulting from sickness or injury, including all stages of reconstruction of the breast on which the mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prosthesis and physical complications at all stages of a mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and patient. Benefits under this provision are not payable for any portion of expense that is paid under any other part of your policy.

Outpatient Services. Coverage for the usual and customary charge for a health care treatment or surgery on an outpatient basis at a facility equipped to perform these services, whether or not the facility is part of a hospital. We will pay benefits on the same basis as if you had received the health care treatment or surgery at a hospital. Benefits under this provision are not payable for any portion of expense that is paid under any other part of your policy.

Phenylketonuria. Coverage for the usual and customary charge for the dietary treatment of phenylketonuria you receive when recommended by a physician. Benefits under this provision are not payable for any portion of expense that is paid under any other part of your policy.

ADDITIONAL BENEFITS FOR THE EXPANDED BASIC PLAN FOR 94050 EB MN

Preventative Care. We will provide coverage for:

a) an annual clinical preventive medical history and physical examination that may include preventive screening tests and preventive services, and patient education to address preventive health care measures; and
b) preventive screening tests or preventive services that Your attending physician determines to be medically appropriate in selection and frequency.

We will pay the actual charges up to 100% of the Medicare-approved amount for each service as if Medicare were to cover the service as identified in the American Medical Association Current Procedural Terminology (AMA CPT) codes, to a maximum of $120 per calendar year. Benefits under this provision are not payable for any portion of expense that is paid under any other part of your policy.

ADDITIONAL BENEFITS

We will pay 80% of the Usual and Customary Charge You incur for the following articles and services that are prescribed by a Physician which are not paid by Medicare or under any other part of this policy.

When Your out-of-pocket expenses for these Additional Benefits equals $1,000.00 in a calendar year, we will pay 100% of the covered expenses you incur under these Additional Benefits during the remainder of such calendar year.

a) Hospital services.
b) Professional services for the diagnosis or treatment of an injury or sickness, other than dental. Such services must be given by a Physician or be under a Physician's direction.
c) Services of a nursing home for not more than 120 days each year if such services must qualify

as reimbursable under Medicare.

d) Services of a home health agency if such services must qualify as reimbursable under Medicare.
e) Use of radium or other radioactive materials.
f) Oxygen.
g) Anesthetics.
h) Non-Dental Prosthetic devices.
i) Rental or purchase, as appropriate, of durable medical equipment other than eyeglasses and hearing aids.
j) Diagnostic X-rays and lab tests.
k) Oral surgery for: partially or completely unerupted impacted teeth; a tooth root without the extraction of the entire tooth; or the gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth.
l) Services of a physical therapist.
m) Professional ambulance service to the nearest facility that is qualified to treat Your condition, or a reasonable mileage rate for transportation to a kidney dialysis treatment center for treatment.
n) A second opinion from a Physician on all surgical procedures expected to cost at least $500.00 which includes the Physician, laboratory and Hospital fees. The repetition of any diagnostic test is not included in that amount.
o) Services of an occupational therapist.

Benefits will be considered under this part of Your policy for charges incurred within or outside of the United States.

Exceptions.

Benefits that are not payable under this Additional Benefits provision:

a) Injuries or Sickness for which any benefits are provided for by workers' compensation or employers' liability laws;
b) cosmetic surgery, except for repair of an Injury or a birth defect;
c) care which is primarily for custodial or for domiciliary purposes which would not qualify as eligible services under Medicare;
d) any charge for confinement in a private room to the extent it is in excess of the institution's charge for its most common semiprivate room, unless a private room is prescribed as medically necessary by a Physician;
e) any charge for services or articles the provision of which is not within the scope of authorized practice of the institution or individual rendering the services or articles;
f) that part of any charge given or prescribed by a physician, dentist, or other health care personnel which exceeds the prevailing charge in the locality where the service is provided.

OPTIONAL COVERAGE AVAILABLE FOR BASIC PLAN 94050 MN

(check if applied for)

❒ **E-A – Medicare Part A Deductible Rider**

If you are confined in a hospital, we will pay 100% of the Medicare Part A inpatient hospital deductible amount due for each benefit period.

❒ **E-B – Medicare Part B Excess Charges Rider**

We will pay 100% of the Medicare Part B deductible amount due each calendar year for Part B Medicare-eligible expenses you incur.

❒ **E-BEX – Medicare Part B Deductible Rider**

We will pay 100% of the difference between the actual charge billed to Medicare Part B for your medical expenses and the amount approved by Medicare Part B. If a medical service providers accepts assignment, no excess charges will be payable by us. If a medical service provider does not accept assignment, the excess charges we will pay may not exceed any charge limitation established by Medicare or state law.

❒ **E-PRV – Preventive Medical Care Benefits Rider**

Coverage for 100% the Medicare approved amount of the actual charges for each of the following services, as if Medicare were to cover the service as identified in the American Medical Association Current Procedural Terminology (AMA CPT) codes, to a maximum, of $120.00 per calendar year:

(a) An annual clinical preventive medical history and physical examination that may include preventative screening tests and services from the following subsection (b) and patient education to address preventive health care measures.

(b) Any one or combination of the following preventive screening tests or preventive services, as often as medically necessary: fecal occult blood test and/or digital rectal exam; dipstick urinalysis for hematuria, bacteriuria and proteinuria; pure tone (air only) hearing screening test, ordered or administered by a physician; serum cholesterol screening at a frequency determined to be medically appropriate by the attending physician; thyroid function test; diabetes screening; and any other tests or preventive measures determined appropriate by the attending Physician.

Benefits for Preventive Health Services will not duplicate any payment for a procedure that is already covered by Medicare.

Receipt

Please Note: All premium checks must be made payable to Individual Assurance Company. ***Do not make checks payable to the insurance agent or leave the payee line blank.***

Received from _____

the sum of $_____ for _____ months premium, with this application. If for any reason the application is not approved and the policy is not issued, this premium is to be refunded. No liability is created or assumed by the Company, except for refund of this premium, until the policy applied for has been issued.

Date Receipt and Outline of Coverage was prepared _____, 20 _____

by _____

Agent's Signature

Individual Assurance Company, PO Box 3270, Salt Lake City, UT 84110-3270