Mutual of Omaha Insurance Company
United World Life Insurance Company
United of Omaha Life Insurance Company
Omaha Insurance Company
Omaha Supplemental Insurance Company

# Underwriting Guidelines

## MEDICARE SUPPLEMENT

For producer use only. Not for use with the general public.

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## Addresses for Mailing New Business and Delivery Receipts

When mailing or shipping your new business applications, be sure to use the preaddressed envelopes.

## Agency Mailing Information

Please forward all completed applications to your appropriate Division Office, which will forward them onto Mutual of Omaha's Blair facility.

## Brokerage Mailing Information

**Mailing Address**
Mutual of Omaha,
United World,
United of Omaha
Omaha Insurance Company, or
Omaha Supplemental Insurance Company
3300 Mutual of Omaha Plaza
Omaha, NE 68175

**Overnight/Express Address**
Mutual of Omaha,
United World,
United of Omaha
Omaha Insurance Company, or
Omaha Supplemental Insurance Company
Records/Mailing Processing Center
9330 State Highway 133
Blair, NE 68008-6179

## Fax Number for New Business (Brokerage ONLY)

Automated Bank Account Withdrawal Applications 1-866-799-9076

## Sales Professional Access (SPA)

**Agents:** mutualofomaha.com/sales_professionals
**Brokers:** mutualofomaha.com/broker

## Important Phone Numbers/Email

| Area | Purpose | Phone Number/Email |
|---|---|---|
| Compensation Support Center, Agency | • Agent support for compensation distribution | 1-866-512-3729 |
| Compensation Support Center, Brokerage | • Broker support for compensation distribution | 1-800-475-4465 |
| Customer Service | • Broker and agent support for policyholder information and assistance | 1-800-354-3289<br>mycustomerservicehealth @mutualofomaha.com |
| Licensing, Brokerage/Agency | • Producer licensing questions | 1-800-867-6873 |
| Sales Support, Agency | • Pre-sale questions<br>• Materials ordering (apps, brochures, rate guides) | 1-877-617-5589 |
| Sales Support/ Supplies, Brokerage | • Pre-sale questions<br>• Materials ordering (apps, brochures, rate guides) | 1-800-693-6083 |
| Supplies, Agency | • Pre-sale questions<br>• Materials ordering (apps, brochures, rate guides) | Contact Local Division Office |
| Underwriting | • Application reviews and processing<br>• Applicant interviews | 1-800-995-9324 |

***Quick Tip:*** When calling these phone numbers, be sure to listen to the prompts in the event they have changed since your last call.

# Policy Issue Guidelines



## The following policy issue guidelines apply:

- All applicants must be covered under Medicare Part A & B in Michigan, Texas and Washington; in all other states, only Part A is required
- Policy issue is state specific
- 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 taxes are filed should be considered as the state of residence
- Please refer to Sales Professional Access for required forms specific to your state

## Newly Eligible Clients and MACRA

As part of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), new rules apply to individuals who are newly eligible for Medicare on and after Jan. 1, 2020.

"Newly eligible" is defined as individuals who have attained age 65 on or after Jan. 1, 2020 or first become eligible for Medicare due to age, disability or end-stage renal disease, on or after Jan. 1, 2020.

For more information on MACRA, please see pages 32 and 33.

## 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 months of his/her enrollment in Medicare Part B. Applicants covered under Medicare Part B prior to age 65 are eligible for a six-month Open Enrollment period upon reaching age 65.

## Additional Open Enrollment Periods

Residents in the following states have additional Open Enrollment periods:

### California

Annual Open Enrollment lasting 90 days, beginning 30 days before and ending 60 days after the individual's birthday, during which time 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 or beyond 60 days from the application date. Please include documentation verifying the plan information. If replacing a pre-standardized plan, a copy of the current policy or policy schedule is required.

### Connecticut

Year-round Open Enrollment.

### Maine

One month Open Enrollment period every year in June for Plan A. Individuals who have had a Medicare supplement plan or another health plan that supplements benefits provided by Medicare within 90 days are eligible for a plan that provides equal or lesser benefits. Please include documentation verifying the plan information or the benefits of the coverage being replaced. Also, be sure to include documentation showing the current coverage is in force or was in force within the last 90 days.

Applicants replacing a current 1990 Standardized plan with a 2010 Modernized plan may apply for a 2010 Modernized Medicare supplement plan of equal or lesser benefits and would not be subject to underwriting guidelines.

**Missouri**
Individuals who terminate a Medicare supplement policy within 30 days of the annual policy anniversary date may obtain the same plan with no health questions asked for a period of 63 days after the termination of their existing policy, from any issuer that offers that plan. This would include Medicare supplement and SELECT plans. Please include documentation verifying the plan information and the policy anniversary of the current coverage. For policies with an effective date of 6/1/2010 or after, individuals with existing Plans E, H, I and J can convert to one of the following Plans: A, B, C, F, K or L.

**New York**
Year-round open enrollment.

**Oregon**
Annual Open Enrollment lasting 60 days, beginning 30 days before and ending 30 days after the individual's birthday, during which time a person may replace any standardized Medicare supplement policy with a policy of equal or lesser benefits. Coverage will not be made effective prior to the individual's birthday or beyond 60 days from the application date. Please include documentation verifying the plan information.

**Vermont**
Year-round open enrollment.

**Washington**
Individuals who currently have a 1990 standardized Medicare supplement plan may replace the plan as indicated below on an Open Enrollment basis:

- Persons with a Plan A may only move to another Plan A.
- Persons with a Plan B, C, D, E, F, G, M or N may move to any other Plan B, C, D, F (including high deductible), G or M. (Whether higher or lower in benefits compared to current plan.)
- Persons with a 1990 standardized Plan H, I or J may move to another less comprehensive Plan B, C, D, F, G or M.
- Persons with a Plan J will qualify for our Plan J Guaranteed Issue Conversion rule. See Page 8 for details.
- Please include documentation verifying the Plan information.

**Note:** Plans E, H, I and J are no longer available for new business as of June 1, 2010.

Please note some states may have additional Open Enrollment rights under state law.

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## States with Under Age 65 Requirements

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) defines "newly eligible" as anyone who: (a) attains age 65 on or after Jan. 1, 2020, or (b) who first becomes eligible for Medicare benefits due to age, disability or end-stage renal disease on or after Jan. 1, 2020.

Plans C and F (including High Deductible F) are not available to "newly eligible" Medicare beneficiaries. As states enact or update their specific under age 65 requirements in relation to MACRA, this section will be updated accordingly.

| State | Plans Available | Open Enrollment Requirements |
|---|---|---|
| **AR, IN, MD, OK, TX** | A | Open Enrollment if applied for within six months of Part B enrollment |
| **CA** | A, F*, G**, N | Open Enrollment if applied for within six months of Part B enrollment |
| **CO, DE, FL, GA, HI, ID, IL, KS, LA, ME, MO, MS, MT, NH, OR, PA, SD** | All plans*** | Open Enrollment if applied for within six months of Part B enrollment |
| **CT** | A | Open Enrollment year round |
| **KY** | All plans*** | No Open Enrollment. Guaranteed Issue available (not all plans) only if a person has an employer sponsored group plan or a Medicare Advantage plan that is being terminated or no longer available. |
| **MN** | All plans and riders*** | Open Enrollment if applied for within six months of Part B enrollment |
| **NC** | A, F*, G** | Open Enrollment if applied for within six months of Part B enrollment |
| **NJ** | C*, D** available to people ages 50-64 | Open Enrollment if applied for within six months of Part B enrollment. Newly eligible beneficiaries receive Open Enrollment if applied for within twelve months of Part B enrollment. Individuals who are entitled to Medicare benefits due to disability prior to 1/1/20 that are still within 6 months of enrolling in part B and not currently covered by any other Medicare Supplement plan will have the option of purchasing plans C and D. |
| **NY** | All plans*** | Open Enrollment year round |
| **TN** | All plans*** | Open Enrollment if applied for within six months of Part B enrollment for persons no longer having access to alternative forms of health insurance coverage due to termination or action unrelated to the individuals status, conduct or failure to pay premium or persons being involuntarily disenrolled from Title XIX (Medicaid) or Title XXI (State Children's Health Insurance Program) of Social Security Act. Alternative forms of health insurance in the statement above include accident and sickness policies, employer sponsored group health coverage or Medicare Advantage plans. |
| **VT** | All plans*** | Not available for persons with end stage renal disease |
| **WI** | Base policy and riders | Open Enrollment if applied for within six months of Part B enrollment |

**Note:**

*Plans C and F are **not** available to newly eligible Medicare beneficiaries.
**Plans D and G are **only** available to newly eligible Medicare beneficiaries.
***Plans C and F (including High Deductible F) are not available to "newly eligible" Medicare beneficiaries. As states enact or update their specific under age 65 requirements in relation to MACRA, this section will be updated accordingly.

## Selective Issue

Applicants over the age of 65, or under age 65 in the states previously listed, and at least six months beyond enrollment in Medicare Part B will be selectively underwritten, except in CT, NY and VT, which are year-round open enrollment states. All health questions must be answered. The answers to the health questions on the application will determine the eligibility for coverage. If any health questions are answered "Yes," including "Not Sure" in CA, the applicant is not eligible for coverage. Applicants will be accepted or declined. Elimination endorsements will not be used.

In addition to the health questions, the applicant's height and weight will be taken into consideration when determining eligibility for coverage. Applicants who fall outside the established guidelines for standard rating could receive a premium rate increase of 10 percent, 20 percent or be declined (a chart detailing the height and weight class ratings can be found on page 17).

In the states of CA, CT, FL, TX and WA, premium rate-ups do not apply. Coverage will be declined for those applicants who are outside the established height and weight guidelines, except for applicants in CT.

Health information, including answers to health questions on applications and claims information, is confidential and is protected by state and federal privacy laws. Accordingly, Mutual of Omaha and its affiliated companies do not disclose health information to any non-affiliated insurance company. Affiliated companies include Omaha Insurance Company, Omaha Supplemental Insurance Company, United of Omaha Life Insurance Company and United World Life Insurance Company.

## Application Dates

**Open Enrollment**
Up to six months prior to the month the applicant turns age 65.

**Underwritten Cases**
Up to 60 days prior to the requested coverage effective date.

**Connecticut**
Year-round open enrollment. Applications may be taken up to 60 days prior to the requested coverage effective date.

**Maine, Missouri, Washington (State Open Enrollment)**
Applications may be taken up to 60 days prior to the requested coverage effective date.

**New York**
Applications may be taken up to 90 days prior to the month the applicant turns 65.

Medicare beneficiaries are eligible for Guaranteed Issue all year long.

**Wisconsin**
Applications may be taken up to three months prior to the Medicare eligibility date.

Individuals whose employer group health plan coverage is ending can apply up to three months prior to the requested effective date of coverage.

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## Coverage Effective Dates

Coverage will be made effective as indicated below:

- Between age 64½ and 65 – The first of the month the individual turns age 65
- All Others – Application date or date of termination of other coverage, whichever is later

## Replacements

A "replacement" takes place when an applicant terminates an existing Medicare supplement/SELECT policy and replaces it with a new Medicare supplement policy. Mutual of Omaha and its affiliates require a fully completed application when applying for a replacement policy (both internal and external replacements).

A policyholder wanting to apply for a nontobacco plan must complete a new application and qualify for coverage.

Policyholders wishing to change their Risk Class rating because of weight loss must maintain that weight loss for at least 12 months. A new application is required and will be underwritten.

If an applicant has had a Medicare supplement/SELECT policy issued by Mutual of Omaha or one of its affiliates within the last 60 days, any new applications will be considered to be a replacement application. If more than 60 days has elapsed since prior coverage was in force, then applications will follow normal underwriting rules.

All replacements involving a Medicare supplement, Medicare SELECT or Medicare Advantage plan must include a completed Replacement Notice. One copy is to be left with the applicant; one copy should accompany the application. The replacement cannot be applied for on the exact same coverage and exact same company.

The replacement Medicare supplement policy cannot be issued in addition to any other existing Medicare supplement, SELECT or Medicare Advantage plan.

## Reinstatements

When a Medicare supplement policy has lapsed and it is within 90 days of the last paid to date, coverage may be reinstated, based upon meeting the underwriting requirements. Renewal commission rates will continue based on the policy's duration.

When a Medicare supplement 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.

## Medicare SELECT to Medicare Supplement Conversion Privilege

Policyowners covered under a Medicare SELECT plan with Mutual of Omaha or its affiliates may decide they no longer wish to participate in our hospital network. Coverage may be converted to one of our Medicare supplement plans not containing network restrictions. We will make available any Medicare supplement policy offered in their state that provides equal or lesser benefits. A new application must be completed; however, evidence of insurability will not be required if the Medicare SELECT policy has been in force for at least six months at the time of conversion.

## Telephone Interviews

Random telephone interviews with applicants will be conducted on underwritten cases. Please be sure to advise your clients that we may be calling to verify the information on their application.
In WI, telephone interviews will be conducted with applicants age 75 and over on underwritten cases.

If there is a Power of Attorney signing the application, a health interview with the applicant will be required. If we are unable to perform an interview with the applicant, we will require two years of current medical records at the applicant's expense.

## Pharmaceutical Information

Mutual of Omaha and its affiliates have implemented a process to support the collection of pharmaceutical information for underwritten Medicare supplement applications. The "Authorization to Disclose Personal Information (HIPAA)" is included in the Agreement and Authorization section of the application. Prescription information noted on the application will be compared to the additional pharmaceutical information received.

## Policy Delivery Receipt

Delivery receipts are required on all policies issued in LA, SD and WV.

Two copies of the delivery receipt will be included in the policy package. One copy is to be left with the client. The second copy must be returned to Mutual of Omaha in the postage paid envelope included in the policy package.

In KY, the policy is allowed to be mailed directly to the insured. If this option is elected, the delivery receipt does not need to be included in the policy package. If the policy is not mailed directly to the insured a delivery receipt will need to be included in the policy package.

# Plan J Guaranteed Issue Conversion



Anyone who was issued a standardized "1990" Plan J before June 1, 2010 can keep that plan with all of the existing benefits as long as they choose and continue to pay the premiums. However, in ME, MO, NE and WA where Plan J was available for new business until June 1, 2010 the following guaranteed issue rules apply.

Policyholders who have a Mutual of Omaha or affiliate company Plan J may convert to another available plan offered by Mutual of Omaha or affiliate company in their state of residence, at any time, without having to pass underwriting.

Applicants who have a Plan J with another company, and want to convert to one of our available plans, would be subject to both the normal application process AND underwriting rules, unless they're in a guaranteed issue situation.

## Plan J Guaranteed Issue Conversion Options

**California**
United World Plan J may convert to one of our available Mutual of Omaha Plans A, F or G.

**Maine**
Mutual of Omaha Plan J may convert to one of our available United of Omaha Plans A, F, G or M.

**Missouri**
United of Omaha Plan J may convert to one of our available Omaha Insurance Company Plans A, F or G.

**Nebraska**
Mutual of Omaha Plan J may convert to one of our available United World Plans A, F or G.

**Washington**
Mutual of Omaha Plan J may convert to one of our available United of Omaha Plans A, F or G.

# Guaranteed Issue Right

Some states may have additional Guaranteed Issue rights under state law. The situations listed below are based upon scenarios found in the Guide to Health Insurance.

**Note:** All plans are not Guaranteed Issue. Plans C and F (including High Deductible F) are not available to newly eligible Medicare beneficiaries.

"Newly eligible" is defined as individuals who have attained age 65 on or after Jan. 1, 2020 or first become eligible for Medicare due to age, disability or end-stage renal disease, on or after Jan. 1, 2020.

While Plans C and F are not available to these Medicare beneficiaries, Plans D, G and High Deductible G are available, where offered.

| Guaranteed Issue Situation | Client has the right to buy... | Client can/must apply for a Medigap policy... |
|---|---|---|
| Client is in Original Medicare and has an employer group health plan (including retiree or COBRA coverage) or union coverage that pays after Medicare pays. That coverage is ending.<br>Note: In this situation, state laws may vary. | Medigap Plan A, B, C*, D**, F*, High Deductible F*, G**, High Deductible G**, K or L that is sold in client's state by any insurance company.<br>If client has COBRA coverage, client can either buy a Medigap policy right away or wait until the COBRA coverage ends. | No later than 63 calendar days after the latest of these 3 dates:<br>1. Date the coverage ends.<br>2. Date on the notice the client gets, telling him/her that coverage is ending (the client receives one).<br>3. Date on a claim denial, if this is the only way the client knows that his/her coverage ended. |
| Client is in Original Medicare and has a Medicare SELECT policy. Client moves out of the Medicare SELECT plan's service area.<br>Client can keep your Medigap policy or he/she may want to switch to another Medigap policy. | Medigap Plan A, B, C*, D**, F*, High Deductible F*, G**, High Deductible G**, K or L that is sold by any insurance company in client's state or the state he/she is moving to. | As early as 60 calendar days before the date the client's Medicare SELECT coverage will end, but no later than 63 calendar days after the client's Medicare SELECT coverage ends. |
| Client's Medigap insurance company goes bankrupt and the client loses coverage, or client's Medigap policy coverage otherwise ends through no fault of client. | Medigap Plan A, B, C*, D**, F*, High Deductible F*, G**, High Deductible G**, K or L that is sold in client's state by any insurance company. | No later than 63 calendar days from the date the client's coverage ends. |

**Note:**

*Plans C and F are **not** available to newly eligible Medicare beneficiaries.
**Plans D and G are **only** available to newly eligible Medicare beneficiaries.

# Group Health Plan Proof of Termination



**Proof of Involuntary Termination**: If applying for Medicare supplement, Underwriting cannot issue coverage as Guaranteed Issue without proof that an individual's employer coverage is no longer offered. The following is required:

- Complete the Other Health Insurance section on the Medicare supplement application; and
- Provide a copy of the termination letter, showing date of and reason for termination, from the employer or group carrier

**Proof of Voluntary Termination**: Under the state specific voluntary terminations scenarios, the following proof of termination is required along with completing the Other Health Insurance section on the Medicare supplement application:

- Certificate of Group Health Plan Coverage
- In CA, provide proof of employer plan benefits being reduced, with Part B coinsurance no longer being covered
- In IA, NM, OK, VA and WV, provide proof of change in benefits from employer or group carrier

## Guaranteed Issue Rights for Voluntary Termination of Group Health Plan

**Note:** Plans C and F are not available to newly eligible Medicare beneficiaries (please see page 2 for the definition of "newly eligible").

While Plans C and F are not available to these Medicare beneficiaries, Plans D, G and High Deductible G are available, where offered.

| State | Qualifies for Guaranteed Issue... |
|---|---|
| AK, CO, ID, IL, IN, ME, MT, NJ, NV, OH, PA, TX, VT | If the employer sponsored plan is primary to Medicare. |
| CA | If the employer sponsored plan's benefits are reduced, with Part B coinsurance no longer being covered. |
| AR, FL, KS, LA, MO, SD | No conditions – always qualifies. |
| IA | If the employer sponsored plan's benefits are reduced, but does not include a defined threshold. |
| NM, OK, VA, WV | If the employer sponsored plan's benefits are reduced substantially. |
| WI | If the annualized premium for the employer-sponsored plan would be greater than 125% of the Basic Annual Premium for the applicant's age, gender and tobacco, then the applicant would qualify for GI eligibility. |

For purposes of determining Guaranteed Issue 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 copays or coinsurance percentage). A premium increase without an increase in the deductible or coinsurance requirement will not qualify for Guaranteed Issue eligibility. This definition will be used to satisfy IA, NM, OK, VA and WV requirements along with CA benefits being reduced. Proof of coverage termination is required.

## Additional States with Guaranteed Issue Rights

**CT, ME, OR, VT** All plans available for all Guaranteed Issue situations.

**MN** Basic Plan and any combination of these riders: Part A Deductible and Part B Excess for all Guaranteed Issue situations. **Note:** The Part B deductible rider and Extended Plan are not available for newly eligible beneficiaries.

**NY** All plans and riders available for all Guaranteed Issue situations.

**MT** All plans available when a person is losing employer-sponsored group coverage or individual insurance.

**WI** All plans, except the Part B deductible rider for newly eligible beneficiaries, are available for all GI situations.

## Guaranteed Issue Right for Loss of Medicaid Qualification

| State | Open Enrollment Situation | Client has the right to buy |
|---|---|---|
| **CA** | Client is enrolled in Medicare Part B, and as a result of an increase in income or assets, is no longer eligible for Medi-Cal benefits, or is only eligible for Medi-Cal benefits with a share cost and certify at the time of application that they have not met the share of cost.<br><br>Open enrollment beginning with notice of termination and ending six months after the termination date. | **65 years or older**<br>any Medigap plan offered by any issuer.<br>**Under Age 65**<br>Plans A, F and N not available for individuals with end stage renal disease. |
| **CO** | Client loses eligibility for health benefits under Medicaid. Guaranteed Issue beginning with notice of termination and ending six months after the termination date. | Medigap Plan A, B, C*, D**, F* (including High Deductible F*), G** (including High Deductible G**) offered by any issuer. |
| **KS** | Client loses eligibility for health benefits under Medicaid. Guaranteed Issue beginning with notice of termination and ending 63 days after the termination date. | any Medigap plan offered by any issuer. |
| **ME** | Client is eligible for Medicare and is enrolled in MaineCare, and they lose eligibility for medical benefits under MaineCare, including benefits for Medicare cost sharing such as coinsurance, copayments and deductibles (e.g., QMB). However, persons who lose eligibility only for premium assistance or limited benefits are not entitled to Medicare supplement Guaranteed Issue rights. Guaranteed Issue beginning with notice of termination and ending 90 days after the termination date. | any Medigap plan offered by any issuer. |
| **MT** | Client is enrolled in Medicaid and is involuntarily terminated. Guaranteed Issue beginning with notice of termination and ending 63 days after the termination date. | any Medigap plan offered by any issuer. |
| **OR** | Client is enrolled in an employee welfare benefit plan or a state Medicaid 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. Guaranteed Issue beginning with notice of termination and ending 63 days after the termination date. | any Medigap plan offered by any issuer. |
| **TN** | Client, age 65 and older covered under Medicare Part B, enrolled in Medicaid (TennCare) and the enrollment involuntarily ceases, is in a Guaranteed Issue beginning with notice of termination and ending 63 days after the termination date.<br>Client, under age 65, losing Medicaid (TennCare) coverage have a six-month Open Enrollment period beginning on the date of involuntary loss of coverage. | Medigap Plan A, B, C*, D**, F* (including High Deductible F*), G** (including High Deductible G**), K or L offered by any issuer.<br>any Medigap plan offered by any issuer. |
| **TX** | Client loses eligibility for health benefits under Medicaid. Guaranteed Issue beginning with notice of termination and ending 63 days after the termination date. | Medigap Plan A, B, C*, D**, F* (including High Deductible F*), G** (including High Deductible G**) K or L offered by any issuer; except that for persons under 65 years of age, it is a policy which has a benefit package classified as Plan A. |
| **UT** | Client is enrolled in Medicaid and is involuntarily terminated. Guaranteed Issue beginning with notice of termination and ending 63 days after the termination date. | Medigap Plan A, B, C*, D**, F* (including High Deductible F*), G** (including High Deductible G**), K or L offered by any issuer. |
| **WI** | Client is eligible for benefits under Medicare Parts A and B and is covered under the medical assistance program and subsequently loses eligibility in the medical assistance program. Guaranteed Issue beginning with notice of termination and ending 63 days after the termination date. | Wisconsin's Basic Medicare supplement policy or certificate, along with any offered rider. |

**Note:** *Plans C and F are **not** available to newly eligible Medicare beneficiaries.
**Plans D and G are **only** available to newly eligible Medicare beneficiaries.

## Medicare Advantage Open Enrollment Period

| General Election Periods for Medicare Advantage | Time Frame | Allows for... |
|---|---|---|
| Annual Enrollment Period (AEP) | Oct. 15th – Dec. 7th of every year | • Enrollment selection for a MA plan<br>• Disenrollment from a current MA plan<br>• Enrollment selection for Medicare Part D |
| Medicare Advantage Open Enrollment Period (MA OEP) | Jan. 1st – March 31st of every year | • MA enrollees to disenroll from any MA plan and return to Original Medicare<br>• Switch from one Medicare Advantage plan to another<br><br>The MA OEP does not provide an opportunity to:<br>• Switch from original Medicare to a Medicare Advantage plan<br>• Switch from one Medicare Prescription Drug plan to another<br>• Join, switch or drop a Medicare Medical Savings Account plan |

There are many types of election periods other than the ones listed above. If there is a question as to whether or not the MA client can disenroll, please refer the client to the local State Health Insurance Assistance Program (SHIP) office for direction.

## Medicare Advantage Proof of Disenrollment

If applying for Medicare supplement, Underwriting cannot issue coverage without proof of disenrollment. If a member disenrolls from Medicare, the MA plan must notify the member of his/her Medicare supplement Guaranteed Issue rights.

**Disenroll during the Annual Election Period and Medicare Advantage Open Enrollment Period (MA OEP)**
Complete the MA section on the Medicare supplement application; and

1. Send **ONE** of the following with the application
    - **a.** A copy of the applicant's MA plan's termination notice
    - **b.** Image of insurance ID card (only allowed if MA plan is being terminated)

**If an individual is disenrolling outside AEP/MA OEP**

1. Complete the MA section on the Medicare supplement application; and
2. Send a copy of the applicant's MA plan's disenrollment notice with the application.

For any questions regarding MA disenrollment eligibility, contact your State Health Insurance Assistance Program office or call 1-800-MEDICARE, as each situation presents its own unique set of circumstances. The SHIP office will help the client disenroll and return to Medicare.

## Guaranteed Issue Rights

The situations listed below are based upon scenarios found in the Guide to Health Insurance.

**Note:** All plans are not Guaranteed Issue. Plans C and F (including High Deductible F) are not available to newly eligible Medicare beneficiaries. "Newly eligible" is defined as individuals who have attained age 65 on or after Jan. 1, 2020 or first become eligible for Medicare due to age, disability or end-stage renal disease, on or after Jan. 1, 2020. While Plans C and F are not available to these Medicare beneficiaries, Plans D, G and High Deductible G are available, only for newly eligible beneficiaries where offered.

| Guaranteed Issue Situation | Client has the right to... | Client can/must apply for a Medigap policy... |
|---|---|---|
| Client's MA plan is leaving the Medicare program, stops giving care in his/her area, or client moves out of the plan's service area. | buy a Medigap Plan A, B, C*, D**, G**, F*, K or L that is sold in the client's state by any insurance carrier. Client must switch to Original Medicare Plan. | As early as 60 calendar days before the date your health care coverage will end, but no later than 63 calendar days after your health care coverage ends. Medigap coverage can't start until your Medicare Advantage Plan coverage ends. |
| (Trial right) Client joined an MA plan when first eligible for Medicare Part A at age 65 and within the first year of joining, decided to switch back to Original Medicare. | buy any Medigap plan that is sold in your state by any insurance company. | As early as 60 calendar days before the date the client's coverage will end, but no later than 63 calendar days after his/her coverage ends. **Note:** The client's rights may last for an extra 12 months under certain circumstances. |
| (Trial right) Client dropped his/her Medigap policy to join an MA plan for the first time, has been in the plan less than one year and wants to switch back. | obtain client's Medigap policy back if that carrier still sells it. If his/her former Medigap policy is not available, the client can buy a Medigap Plan A, B, C*, D**, G**, F*, K or L that is sold in his/her state by any insurance company. | As early as 60 calendar days before the date the client's coverage will end, but no later than 63 calendar days after his/her coverage ends. **Note:** The client's rights may last for an extra 12 months under certain circumstances. |
| Client leaves an MA plan because the company has not followed the rules, or has misled the client. | buy Medigap plan A, B, C*, D**, G**, F*, K or L that is sold in the client's state by any insurance company. | No later than 63 calendar days from the date the client's coverage ends. |
| **In Wisconsin Only**. Client's group health plan ended and the client joined an MA plan for the first time, has been in the plan less than a year, and wants to switch back to Original Medicare. | buy any Medigap plan and riders.<br><br>Note: The Part B deductible rider and extended plan are not available for newly eligible clients. | |

**Note:** *Plans C and F are **not** available to newly eligible Medicare beneficiaries.
**Plans D and G are **only** available to newly eligible Medicare beneficiaries.

# Premium Payment and Calculation Guidelines



## Calculating Premium

### Utilizing the Outline of Coverage

- Determine ZIP code where the client resides and find the correct rate page for that ZIP code
- Determine plan
- Determine if nontobacco or tobacco
- Find Age/Gender – Verify that the age and date of birth are the exact age as of the application date
- This will be your base monthly premium

**Tobacco rates do not apply during Open Enrollment or Guaranteed Issue situations in the following states:**
AR, CA, CO, CT*, IA, IL, KY, LA, MD, MI, MO, NC, ND, NH, NJ, NY*, OH, PA, TN, UT, VA, VT*, WA*, WI

*Tobacco rates never apply in CT, NY, VT, WA

### Utilizing the Calculate Your Premium Form (excluding CT)

- Enter the base premium on line #2 and proceed with the instructions that follow

### Types of Medicare Policy Ratings

**Community rated**
The same monthly premium is charged to everyone who has the Medicare policy, regardless of age. Premiums are the same no matter how old the applicant is. Premiums may go up because of inflation and other factors, but not based on age.

**Issue age rated**
The premium is based on the age the applicant is when the Medicare policy is bought. Premiums are lower for applicants who buy at a younger age, and won't change as they get older. Premiums may go up because of inflation and other factors, but not because of applicant's age.

**Attained age rated**
The premium is based on the applicant's current age so the premium goes up as the applicant gets older. Premiums are low for younger buyers, but go up as they get older. In addition to change in age, premiums may also go up because of inflation and other factors.

**Note:** If a premium is paid by a business account, refer to the "Business Checks" section of this guide to determine if acceptable, and if so, which rate type will be applied.

## Rate Type Available by State

| State | Company | Tobacco / Nontobacco Rates | Gender Rates | Attained, Issue, or Community Rated | Tobacco Rates During Open Enrollment | Household Discount | Class Rating |
|---|---|---|---|---|---|---|---|
| **AK** | M | Y | Y | A | Y | N/A | N |
| **AL** | O | Y | Y | A | Y | 12% | Y |
| **AR** | O | Y | N | C | N | 12% | Y |
| **AZ** | O | Y | Y | I | Y | 12% | Y |
| **CA** | M | Y | N | A | N | 12% | N |
| **CO** | U | Y | Y | A | N | 12% | Y |
| **CT** | O | N | N | C | N | N/A | N |
| **DC** | M | Y | Y | A | Y | N/A | N |
| **DE** | O | Y | Y | A | Y | 12% | Y |

| State | Company | Tobacco / Non-Tobacco Rates | Gender Rates | Attained, Issue, or Community Rated | Tobacco Rates During Open Enrollment | Household Discount | Class Rating |
|---|---|---|---|---|---|---|---|
| GA | M | Y | Y | I | Y | 12% | Y |
| FL | U | Y | Y | I | Y | N/A | N |
| HI | M | Y | Y | A | Y | N/A | N |
| IA | W | Y | Y | A | N | 12% | Y |
| ID | O | Y | N | I | Y | N/A | Y |
| IL | W | Y | Y | A | N | 7% | Y |
| IN | W | Y | Y | A | Y | 7% | Y |
| KS | O | Y | Y | A | Y | 12% | Y |
| KY | W | Y | Y | A | N | 12% | Y |
| LA | O | Y | Y | A | N | 12% | Y |
| MD | U | Y | Y | A | N | 12% | Y |
| ME | U | Y | N | C | Y | 7% | N |
| MI | W | Y | Y | A | N | 12% | Y |
| MO | O | Y | Y | I | N | 12% | Y |
| MN | O | Y | N | C | Y | N/A | N |
| MS | W | Y | Y | A | Y | 12% | Y |
| MT | M | Y | N | A | Y | 12% | Y |
| NC | W | Y | Y | A | N | 12% | Y |
| ND | O | Y | Y | A | N | 7% | N |
| NE | W | Y | Y | A | Y | 12% | Y |
| NH | M | Y | Y | I | N | 12% | Y |
| NJ | O | Y | Y | A | N | 7% | Y |
| NM | O | Y | Y | A | Y | 12% | Y |
| NV | W | Y | Y | A | Y | 12% | Y |
| NY | M | N | N | C | N | N/A | N |
| OH | M | Y | Y | A | N | 7% | Y |
| OK | M | Y | Y | A | Y | 7% | Y |
| OR | O | Y | Y | A | Y | 12% | Y |
| PA | M | Y | Y | A | N | 12% | Y |
| RI | M | Y | Y | A | Y | N/A | N |
| SC | W | Y | Y | A | Y | 12% | Y |
| SD | O | Y | Y | A | Y | 12% | Y |
| TN | W | Y | Y | A | N | 12% | Y |
| TX | S | Y | Y | A | Y | 12% | N |
| UT | O | Y | Y | A | N | 12% | Y |
| VA | M | Y | Y | A | N | 12% | Y |
| VT | M | N | N | C | N | N/A | N |
| WA | U | N | N | C | N | 7% | N |
| WI | W | Y | Y | A | N | 12% | Y |
| WV | W | Y | Y | A | Y | 12% | Y |
| WY | M | Y | Y | A | Y | 12% | Y |

Due to changes and timing, not all states may currently be available for new business sales. Please check the available products information on Sales Professional Access, Products link.

# Premium Payment and Calculation Guidelines (continued)



## Unisex Rates

The policies that are paid for under the List-Bill program will not be assigned different premium for males and females. Unisex rates will apply to all applicants in these situations.

## Anniversary Re-rating

Policyholders receive increases only on their policy anniversary in all states.

## Household Discount (not applicable in all states)

Based on the state, one of the following household discounts are available:

**12% Household Discount –** Applicant may be eligible for the household discount if he/she either:

- Resides with a spouse or civil union/domestic partner; or
- Has resided with as many as three adults age 60 or older for the last 12 months

**7% Household Discount –** Applicant may be eligible for the household discount if:

- He/She resides with a spouse or civil union partner or has continuously resided for the past 12 months with as many as three household members; and
- The spouse, civil union partner or household member either has an existing Medicare supplement plan with or is also applying for and is issued coverage with Mutual of Omaha or an affiliate

These requirements generally apply everywhere. There are state-specific variations, so please see a specific state application or policy for details.

How to determine eligibility for the household discount:

1. Refer to the Household Discount section on the application.
2. If question 1 is answered "Yes," the individual qualifies.

Household discounts are **not** available in AK, CT, DC, FL, HI, ID, MN, NY, RI or VT.

## Definition of Domestic Partner

Either partner of an unmarried couple (includes same sex) in a relationship considered as being equivalent to marriage for the purpose of extending certain legal rights and benefits.

## Definition of Civil Union Partner

Partners who are recognized by a state or government as conferring all or some of the rights conferred by marriage.

## Class Rating (not applicable in all states and only applies to fully underwritten applications)

How to determine class rating:

1. Follow the instructions on the Calculate Your Premium form.
2. Complete the form and return with the application.

## Height and Weight Chart for States WITH Class Rating

Check your state-specific Outline of Coverage to determine if the class rating is applicable in your state.

## Eligibility

Find the applicant's height in the left-hand column and look across the row to find the weight. If the weight is in the Decline column, the applicant is not eligible for coverage at this time.

## Rate Adjustment

The column heading above the weight indicates the appropriate rate adjustment, if any (risk class).

| Height | Decline Weight | Class I Weight | Standard Weight | Class I Weight | Class II Weight | Decline Weight |
|---|---|---|---|---|---|---|
| 4' 2" | ‹ 54 | 54 – 60 | 61 – 110 | 111 – 128 | 129 – 145 | 146 + |
| 4' 3" | ‹ 56 | 56 – 62 | 63 – 114 | 115 – 133 | 134 – 151 | 152 + |
| 4' 4" | ‹ 58 | 58 – 65 | 66 – 119 | 120 –138 | 139 – 157 | 158 + |
| 4' 5" | ‹ 60 | 60 – 67 | 68 – 123 | 124 – 143 | 144 –163 | 164 + |
| 4' 6" | ‹ 63 | 63 – 70 | 71 – 128 | 129 – 149 | 150 – 170 | 171 + |
| 4' 7" | ‹ 65 | 65 – 73 | 74 – 133 | 134 –154 | 155 – 176 | 177 + |
| 4' 8" | ‹ 67 | 67 – 75 | 76 – 138 | 139 –160 | 161 – 182 | 183 + |
| 4' 9" | ‹ 70 | 70 – 78 | 79 – 143 | 144 –166 | 167 –189 | 190 + |
| 4' 10" | ‹ 72 | 72 – 81 | 82 – 148 | 149 –172 | 173 –196 | 197 + |
| 4' 11" | ‹ 75 | 75 – 84 | 85 – 153 | 154 –178 | 179 – 202 | 203 + |
| 5' 0" | ‹ 77 | 77 – 87 | 88 – 158 | 159 – 184 | 185 – 209 | 210 + |
| 5' 1" | ‹ 80 | 80 – 89 | 90 – 164 | 165 – 190 | 191 – 216 | 217 + |
| 5' 2" | ‹ 83 | 83 – 92 | 93 – 169 | 170 – 196 | 197 – 224 | 225 + |
| 5' 3" | ‹ 85 | 85 – 95 | 96 – 175 | 176 – 203 | 204 – 231 | 232 + |
| 5' 4" | ‹ 88 | 88 – 99 | 100 – 180 | 181 – 209 | 210 – 238 | 239 + |
| 5' 5" | ‹ 91 | 91 – 102 | 103 – 186 | 187 – 216 | 217 – 246 | 247 + |
| 5' 6" | ‹ 93 | 93 – 105 | 106 – 192 | 193 – 223 | 224 – 254 | 255 + |
| 5' 7" | ‹ 96 | 96 – 108 | 109 – 197 | 198 – 229 | 230 – 261 | 262 + |
| 5' 8" | ‹ 99 | 99 – 111 | 112 – 203 | 204 – 236 | 237 – 269 | 270 + |
| 5' 9" | ‹ 102 | 102 – 115 | 116 – 209 | 210 – 243 | 244 – 277 | 278 + |
| 5' 10" | ‹ 105 | 105 – 118 | 119 – 216 | 217 – 250 | 251 – 285 | 286 + |
| 5' 11" | ‹ 108 | 108 – 121 | 122 – 222 | 223 – 258 | 259 – 293 | 294 + |
| 6' 0" | ‹ 111 | 111 – 125 | 126 – 228 | 229 – 265 | 266 – 302 | 303 + |
| 6' 1" | ‹ 114 | 114 – 128 | 129 – 234 | 235 – 272 | 273 – 310 | 311 + |
| 6' 2" | ‹ 117 | 117 – 132 | 133 – 241 | 242 – 280 | 281 – 319 | 320 + |
| 6' 3" | ‹ 121 | 121 – 136 | 137 – 248 | 249 – 288 | 289 – 328 | 329 + |
| 6' 4" | ‹ 124 | 124 – 139 | 140 – 254 | 255 – 295 | 296 – 336 | 337 + |
| 6' 5" | ‹ 127 | 127 – 143 | 144 – 261 | 262 – 303 | 304 – 345 | 346 + |
| 6' 6" | ‹ 130 | 130 – 147 | 148 – 268 | 269 – 311 | 312 – 354 | 355 + |
| 6' 7" | ‹ 134 | 134 – 150 | 151 – 275 | 276 – 319 | 320 – 363 | 364 + |
| 6' 8" | ‹ 137 | 137 – 154 | 155 – 282 | 283 – 327 | 328 – 373 | 374 + |
| 6' 9" | ‹ 140 | 140 – 158 | 159 – 289 | 290 – 335 | 336 – 382 | 383 + |
| 6' 10" | ‹ 144 | 144 – 162 | 163 – 296 | 297 – 344 | 345 – 392 | 393 + |
| 6' 11" | ‹ 147 | 147 – 166 | 167 – 303 | 304 – 352 | 353 – 401 | 402 + |
| 7' 0" | ‹ 151 | 151 – 170 | 171 – 311 | 312 – 361 | 362 – 411 | 412 + |
| 7' 1" | ‹ 155 | 155 – 174 | 175 – 318 | 319 – 369 | 370 – 421 | 422 + |
| 7' 2" | ‹ 158 | 158 – 178 | 179 – 326 | 327 – 378 | 379 – 431 | 432 + |
| 7' 3" | ‹ 162 | 162 – 183 | 184 – 333 | 334 – 387 | 388 – 441 | 442 + |
| 7' 4" | ‹ 166 | 166 – 187 | 188 – 341 | 342 – 396 | 397 – 451 | 452 + |

Contacts
Policy Issue Guidelines
Plan J Guaranteed Issue Conversion
Guaranteed Issue Right
Group Health Plan Proof of Termination
Medicare Advantage (MA)
Premium Payment and Calculation Guidelines
Application
Health Questions
Mailing Applications to Prospects
Required Forms
Mobile Quote App
Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)

## Height and Weight Chart for States WITHOUT Class Rating (excluding CT)

Check your state-specific Outline of Coverage to determine if the class rating is applicable in your state.

## Eligibility

Find the applicant's height in the left-hand column and look across the row to find the weight. If it is in the Decline column, the applicant is not eligible for coverage at this time.

| Height | **Decline** Weight | **Standard** Weight | **Decline** Weight |
|---|---|---|---|
| 4' 2" | ‹ 54 | 54 – 145 | 146 + |
| 4' 3" | ‹ 56 | 56 – 151 | 152 + |
| 4' 4" | ‹ 58 | 58 – 157 | 158 + |
| 4' 5" | ‹ 60 | 60 – 163 | 164 + |
| 4' 6" | ‹ 63 | 63 – 170 | 171 + |
| 4' 7" | ‹ 65 | 65 – 176 | 177 + |
| 4' 8" | ‹ 67 | 67 – 182 | 183 + |
| 4' 9" | ‹ 70 | 70 – 189 | 190 + |
| 4' 10" | ‹ 72 | 72 – 196 | 197 + |
| 4' 11" | ‹ 75 | 75 – 202 | 203 + |
| 5' 0" | ‹ 77 | 77 – 209 | 210 + |
| 5' 1" | ‹ 80 | 80 – 216 | 217 + |
| 5' 2" | ‹ 83 | 83 – 224 | 225 + |
| 5' 3" | ‹ 85 | 85 – 231 | 232 + |
| 5' 4" | ‹ 88 | 88 – 238 | 239 + |
| 5' 5" | ‹ 91 | 91 – 246 | 247 + |
| 5' 6" | ‹ 93 | 93 – 254 | 255 + |
| 5' 7" | ‹ 96 | 96 – 261 | 262 + |
| 5' 8" | ‹ 99 | 99 – 269 | 270 + |
| 5' 9" | ‹ 102 | 102 – 277 | 278 + |
| 5' 10" | ‹ 105 | 105 – 285 | 286 + |
| 5' 11" | ‹ 108 | 108 – 293 | 294 + |
| 6' 0" | ‹ 111 | 111 – 302 | 303 + |
| 6' 1" | ‹ 114 | 114 – 310 | 311 + |
| 6' 2" | ‹ 117 | 117 – 319 | 320 + |
| 6' 3" | ‹ 121 | 121 – 328 | 329 + |
| 6' 4" | ‹ 124 | 124 – 336 | 337 + |
| 6' 5" | ‹ 127 | 127 – 345 | 346 + |
| 6' 6" | ‹ 130 | 130 – 354 | 355 + |
| 6' 7" | ‹ 134 | 134 – 363 | 364 + |
| 6' 8" | ‹ 137 | 137 – 373 | 374 + |
| 6' 9" | ‹ 140 | 140 – 382 | 383 + |
| 6' 10" | ‹ 144 | 144 – 392 | 393 + |
| 6' 11" | ‹ 147 | 147 – 401 | 402 + |
| 7' 0" | ‹ 151 | 151 – 411 | 412 + |
| 7' 1" | ‹ 155 | 155 – 421 | 422 + |
| 7' 2" | ‹ 158 | 158 – 431 | 432 + |
| 7' 3" | ‹ 162 | 162 – 441 | 442 + |
| 7' 4" | ‹ 166 | 166 – 451 | 452 + |

## Completing the Premium on the Method of Payment Form

***Premiums are calculated based upon the applicant's exact age at the time of application, not the age as of the requested coverage effective date.***

## Collection of Premium

At least one month's premium must be submitted with the application.

1. Money orders, cashier's checks and counter checks are only acceptable if obtained by the applicant. Third party payors cannot obtain a money order or cashier's check on behalf of the applicant.
2. **Note:** The company does not accept post-dated checks or payments from third parties except for approved List-Bill and other situations. Immediate family and domestic partners are acceptable payors. We do not accept checks or payments from foundations as premium for Medicare supplement for either individuals or List-Bill situations.

## Initial Premium Payment Options

1. **Automatic Bank Withdrawal upon policy issue**
   - The applicant must use a bank account that contains their name on the account
   - If ACH, we need both the account number and the routing number to process payment
   - The account number can be from a checking or savings account
2. **Credit Card payment upon policy submission**
   - Available on e-App only
3. **Check**
   - Available only if the applicant is going to wet sign their application
   - Check is cashed upon policy issue

## Ongoing Premium Payment Options

1. **Monthly Automatic Bank Withdrawal**
   - 1st through the 28th or the last day of every month
   - Week (1st, 2nd, 3rd, 4th, last)
   - Weekday (Mon, Tue, Wed, Thu, Fri)
   - Every _____ months (insert 3, 6 or 12)
2. **Check**
   - Insured may mail a premium check to Mutual of Omaha
     - Quarterly
     - Semiannually
     - Annually

## List-Bill Collection of Premium

Use List-Bill for Mutual of Omaha and its affiliates' Medicare supplement plans paid through an employer or a third-party List-Bill administrator. In order to use the List-Bill program, you must establish and maintain a List-Bill account for three or more individuals.

Program participants must be retirees (and/or their spouses) of the employer indicated on the enrollment form, active employees are not eligible. Follow the steps in the List-Bill Administration Guide (M27005) and submit a completed List-Bill Enrollment Form (M27024).

Both documents can be found on Sales Professional Access under "Forms and Materials," product name and "List-Bill Medicare Supplement." For more information, contact a customer service representative at 1-800-877-1050. In Kentucky, employers may not directly contribute to any portion of the premium. Premiums must be paid entirely with policyholder funds.

## Business Checks

If premium is paid by a business account, complete the information located on the Payer Information section (Part II) of the Method of Payment Form. Business checks are acceptable if they are submitted for the business owner, the owner's spouse, or retirees of the business. ERISA (unisex) rates apply to retirees of the business.

# Premium Payment and Calculation Guidelines (continued)



### Premium Receipt

The Premium Receipt must be completed and provided to applicant if premium is collected.
**Note:** **Do not** mail a copy of the receipt with the application.

### Shortages

The company will communicate with the producer by telephone, email or FAX in the event of a premium shortage. The application will be held in pending until the balance of the premium is received. Producers may communicate with Underwriting by calling 1-800-995-9324 or by FAX at 1-402-997-1920.

### Our General Administrative Rule – 12-Month Rate

Our current administrative practice is not to adjust rates for 12 months from the effective date of coverage.

### Refunds

In the event of rejection, incomplete submission, overpayment, cancellations, etc., the company will not cash checks. The company will destroy all checks and refund credit cards. Refunds on List-Bill groups are made to the List-Bill administrator/payor.

**Initial Premium Payment Processing and Refunding**
**Medicare Supplement Applications Only**

| Initial Premium Payment Method | Payment is Processed | Handling the Refund when Policy is Not Issued |
|---|---|---|
| ACH | At policy issue | N/A; premium wasn't withdrawn |
| Credit card (e-App only) | At policy issue | N/A; premium wasn't withdrawn |
| Personal check with individual application | At policy issue | Check is destroyed; not returned |
| Personal check with dual application | When the first person's policy is issued | Refund mailed within 30 business days if second person's policy isn't issued* |
| Bank draft, cashier's check, money order | When underwriting decision is made (issue, reject, withdraw, incomplete) | Refund mailed within 30 business days* |

*Refunds are sent to the applicants under separate cover from the letter indicating the reject, withdrawn or incomplete status of their application.

# Application

Properly completed applications should be finalized within 5-7 days of receipt at the company. The ideal turnaround time provided to the producer is 11-14 days, including mail time.

### Application Sections

The application must be completed in its entirety. Please be sure to review your applications for the following information before submitting.

### Administrative Information

1. **Agent Writing Number**
   - **a.** Enter your agent writing number or Social Security number.
2. **Group Number**
   - **a.** If filling out application booklets for List-Bill situations, please be sure to include the assigned group number in the field provided at the top right hand portion of the application. We assign the List-Bill number when a List-Bill Enrollment Form is processed. Applications should not be submitted without the group number.
   - **b.** This information is not needed for standard Medicare supplement application packets.

   **Note:** You do NOT need to complete the FAV Key, Auth #, and Keyline fields.

### Plan Information Section

1. Complete the entire section.
2. Indicate the plan or policy form selected, requested effective date and the policy delivery option.

### Applicant Information

1. Please complete the applicant's residence address in full. If premium notices are to be mailed to an address other than the applicant's residence address, please complete the mailing address in full.
2. Age and Date of Birth are the **exact age** as of the **application date**.
3. Height/Weight – These are required on underwritten cases.
4. Answer the tobacco question, this includes any nicotine or electronic cigarette (e-cigarette) use. (Refer to the Calculating Premium section of this Guide for a list of states where tobacco rates do not apply during Open Enrollment or Guaranteed Issue situations.)
5. Indicate if the applicant would like to receive the Explanation of Benefits (EOBs) online.

### Medicare Information

1. Medicare claim number, also referred to as the Medicare Beneficiary Identifier (MBI) number, is vital for electronic claims payment.
2. Please indicate if the applicant is covered under Parts A and B of Medicare.

### Household Discount (not available in all states)

1. If question 1 is answered "Yes," the individual qualifies.
2. This information is necessary for premium calculation.

### Previous or Existing Coverage Information

1. Verify if the applicant is covered through his/her state Medicaid program. If Medicaid is paying for benefits beyond the applicant's Part B premium or the Medicare supplement premium for this policy, then the applicant is not eligible for coverage.
2. If the applicant is replacing another Medicare supplement policy, complete question 4 and include the replacement notice.
3. If the applicant is leaving a Medicare Advantage plan, complete question 5 and include the replacement notice.
4. If the applicant has had any other health insurance coverage in the past 63 days, including coverage through a union plan, employer group health plan, or other non-Medicare supplement coverage, complete question 6.

### Please answer all of the following questions

1. If the applicant is applying during a Guaranteed Issue period, be sure to include proof of eligibility.
2. If either applicant A or B answered "YES" to question 7 OR BOTH questions 8 and 9 in Section F, skip to Section I – Agreement and Authorization.

**Note:** In Kentucky, if any applications contain an error or omission, it will either need to be corrected and initialed or a new application will be required. Voice amendments for Medicare supplement applications taken in the state of Kentucky are not permitted.

### Health Information

1. If the applicant is applying during an Open Enrollment or a Guaranteed Issue period, do not answer the health questions.
2. If applicant is not considered to be in Open Enrollment or a Guaranteed Issue situation, all health questions must be answered.

**Note:** To be considered eligible for coverage, all health questions must be answered "No."
For questions on how to answer a particular health question, see the **Health Questions** section of this Guide for clarification.

### Medication Information

1. If the applicant is applying during an Open Enrollment or a Guaranteed Issue period, do not answer the medication information section.
2. If applicant is not considered to be in Open Enrollment or a Guaranteed Issue situation, all medication information must be listed as indicated.

***For compliance purposes, sections G – Health Information and H – Medication Information (application pages 5 and 6, respectively) must be included with submitted applications.***

***While these pages are not required to be completed during Open Enrollment and Guaranteed Issue situations, they must be submitted for a complete contract.***

### Agreement and Authorization

1. Applicant acknowledges receiving the Guide to Health Insurance and Outline of Coverage. You are required to leave these two documents with the client at the time the application is completed.
2. Applicant agrees to the Authorization to Disclose Personal Information.
3. Signatures and dates: required by applicant(s).
4. If someone other than the applicant is signing the application (i.e., Power of Attorney), please include copies of the papers appointing that person as the legal representative.

### To be Completed by Producer

The producer(s) must certify that he/she:

1. Provided the applicant with a copy of the replacement notice if applicable.
2. Accurately recorded in the application the information supplied by the applicant.
3. Has interviewed the proposed applicant.
4. Signed and dated the application.

The licensed agent must be appointed with the underwriting company in the state the application was signed in. For example, if a United of Omaha application is being signed in state A, the producer must be appointed with United of Omaha in state A (even if the applicant lives in state B).

If an application is taken on a Kansas resident, the producer must be appointed in Kansas and in the state where the application is signed.

If an application is signed in New York, it must be for a resident of New York.

If an application is taken for Omaha Supplemental Insurance Company in Texas, it must be signed by the applicant in the state of Texas.

**Regardless of state, writing agents must always have an EFFECTIVE license date prior to an application being signed. This is state law.**

**Note:** Policy will not issue unless the writing agent also has an appointment with Mutual of Omaha.

Montana, Oklahoma and Pennsylvania are pre-appointment states for the writing agents only. (This means that the writing agent in these states MUST have their license submitted to Mutual of Omaha and their appointments effective at the state level prior to submitting a policy application, there are no exceptions.)

**Note:** Applicant's signature must match the name of the applicant on the application. In rare cases where the applicant cannot sign his/her name, a mark ("X") is acceptable. For their own protection, producers are advised against acting as sole witness.

# Health Questions



Unless an application is completed during Open Enrollment or a Guaranteed Issue period, all health questions, including the question regarding prescription medications, must be answered. Our general underwriting philosophy is to deny Medicare supplement coverage if any of the health questions are answered "Yes," including "Not Sure" in California. For a list of uninsurable conditions and the related medications associated with these conditions, please refer to the next pages in this guide.

There may be, however, situations where an applicant has been receiving medical treatment or taking prescription medication for a long-standing and controlled health condition. Those conditions are listed in the health questions.

A condition is considered to be controlled if there have been no changes in treatment or medications for at least two years. If this situation exists and you would like consideration to be given to the application, answer the appropriate question "Yes," and attach an explanation stating how long the condition has existed and how it is being controlled. Be sure to include the names and dosages of all prescription medications.

People with diabetes (insulin dependent or treated with oral medications) who also have one or more of the complicating conditions that are specified in the health question, are not eligible for coverage. For purposes of this question, hypertension (high blood pressure) is considered a heart condition.

Some additional questions to ask your client to determine if he/she does have a complication include:

1. Does he/she have eye/vision problems?
2. Does he/she have numbness or tingling in the toes or feet?
3. Does he/she have problems with circulation? Pain in the legs?

Consideration for coverage may be given to those persons with well-controlled cases of hypertension and diabetes.

A case is considered to be well controlled if the person is taking no more than:

- Two oral medications for diabetes and;
- Two medications for hypertension

A combination of insulin and one oral medication would be the same as two oral medications if the diabetes were well controlled.

In general, to verify stability, there should be no changes in the dosages or medications in the past **two** years. Individual consideration will be given where deemed appropriate. We consider hypertension to be stable if recent average blood pressure readings are 150/85 or lower.

### 2 x 2 Rule

| | |
|---|---|
| No More Than **TWO** Medications for Blood Pressure and No More than **TWO** Medications for Diabetes Management | With No Changes to the medication, dosage or frequency in the past **TWO** years. |

## Uninsurable Health Conditions

**Applications should not be submitted if the applicant has the following conditions:**

**AIDS**

**Alzheimer's Disease**

**ARC**

**Any cardiopulmonary disorder requiring oxygen**

**Cirrhosis**

**Chronic Hepatitis**

- Chronic Hepatitis B
- Chronic Hepatitis C
- Chronic Hepatitis D
- Autoimmune Hepatitis
- Chronic Active Hepatitis
- Chronic Steatohepatitus

**Chronic Kidney/Renal Disease**

- Chronic Nephritis
- Chronic Glomerulonephritis
- Chronic protein loss in the urine (proteinuria)
- Requiring 4 or more MD office visits per year in the follow up of renal disease
- Chronic Renal Insufficiency
- Hypertensive Chronic Renal Disease
- Nephrotic Syndrome
- Stage 3, Stage 4 or Stage 5 Chronic Kidney Disease

**Chronic Obstructive Pulmonary Disease (COPD)**

Other chronic pulmonary disorders to include:

- Asbestosis
- Chronic Bronchitis
- Chronic Cardiopulmonary Disease
- Chronic Obstructive Lung Disease (COLD)
- Chronic Asthma
- Chronic Interstitial Lung Disease
- Chronic Pulmonary Fibrosis
- Cystic Fibrosis
- Pulmonary Hypertension
- Sarcoidosis
- Bronchiectasis
- Scleroderma
- Emphysema

**End-Stage Renal Disease (ESRD)**

**Kidney Disease requiring dialysis**

**Kidney (Renal) Failure/End-Stage Renal Disease Any kidney disorder that has the applicant being evaluated for, or who is currently on dialysis**

**Amyotrophic Lateral Sclerosis**
(Lou Gehrig's Disease)

**Lupus – Systematic**

**Multiple Sclerosis**

**Myasthenia Gravis**

**Organ Transplant**

**Osteoporosis with Fracture**

**Parkinson's Disease**

**Pulmonary Hypertension**

**Senile Dementia**

**Other cognitive disorders to include:**

- Mild Cognitive Impairment (MCI)
- Delirium
- Organic Brain Disorder
- Cerebrovascular Disease with Cognitive Deficits
- Dissociative Amnesia
- Huntington's Chorea (Huntington's Disease)
- Post-Concussion Syndrome with residual problems

**In addition to the above conditions, the following will also lead to a decline:**

- Implantable cardiac defibrillator
- Use of supplemental oxygen
- Use of a nebulizer
- Asthma requiring continuous use of three or more medications including inhalers
- Taking any medication that must be administered in a physician's office
- Advised to have surgery, medical tests, further diagnostic evaluation, treatment or therapy

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**Partial List of Medications Associated with Uninsurable Health Conditions**

This list is not all-inclusive. An application should not be submitted if a client is taking any of the following medications:

| Medication | Condition | Medication | Condition |
|---|---|---|---|
| 3TC | AIDS | DDC | AIDS |
| Acetate | Prostate Cancer | Daliresp | COPD |
| Accuneb | COPD | DDI | AIDS |
| Alkeran | Cancer | DES | Cancer |
| Amantadine | Parkinson's Disease | Donepezil | Alzheimer's Disease |
| Anoro Ellipta | COPD | DuoNeb | COPD |
| Apokyn | Parkinson's Disease | Ebixa | Alzheimer's Disease |
| Aptivus | HIV | Eldepryl | Parkinson's Disease |
| Aricept | Dementia | Eligard | Prostate Cancer |
| Aricept ODT | Alzheimer's Disease | Embrel | Rheumatoid Arthritis |
| Artane | Parkinson's Disease | Emtriva | HIV |
| Atripla | HIV | Epivir | HIV |
| Aubagio | Multiple Sclerosis | Epogen | Kidney Failure, AIDS |
| Avonex | Multiple Sclerosis | Ergoloid | Dementia |
| Azilect | Parkinson's Disease | Esbriet | Chronic Pulmonary Disorder |
| AZT | AIDS | Exelon | Dementia |
| Baclofen | Multiple Sclerosis | Extavia | Multiple Sclerosis |
| BCG | Bladder Cancer | Fuzeon | HIV |
| Betaseron | Multiple Sclerosis | Galantamine | Dementia |
| Bicalutamide | Prostate Cancer | Geodon | Schizophrenia |
| Breo | COPD | Gilenya | Multiple Sclerosis |
| Brovana | COPD | Glatopa | Multiple Sclerosis |
| Carbidopa | Parkinson's Disease | Gold | Rheumatoid Arthritis |
| Casodex | Prostate Cancer | Haldol | Psychosis |
| Cerefolin | Dementia | Herceptin | Cancer |
| Cogentin | Parkinson's Disease | Hydergine | Dementia |
| Cognex | Dementia | Hydrea | Cancer |
| Combivir | HIV | Hydroxyurea | Melanoma, Leukemia, Cancer |
| Comtan | Parkinson's Disease | | |
| Copaxone | Multiple Sclerosis | Imuran | Immunosuppression, Severe Arthritis |
| Crixivan | HIV | | |
| Cytoxan | Cancer, Severe Arthritis, Immunosuppression | Incruse Ellipta | COPD |
| | | Indinavir | AIDS |
| D4T | AIDS | Insulin (MN Only) | Diabetes * |

| Medication | Condition |
|---|---|
| Interferon | AIDS, Cancer, Hepatitis |
| Invega | Schizophrenia |
| Invirase | AIDS |
| Kaletra | HIV |
| Kemadrin | Parkinson's Disease |
| Lasix/Furosemide (>60mg/day) | Heart Disease |
| L-Dopa | Parkinson's Disease |
| Lemtrada | Multiple Sclerosis |
| Letairis | Cancer, Pulmonary Hypertension |
| Leukeran | Cancer, Severe Arthritis, Immunosuppression |
| Leuprolide | Prostate Cancer |
| Leuprolide Acetate | Prostate Cancer |
| Levodopa | Parkinson's Disease |
| Lexiva | HIV |
| Lioresal | Multiple Sclerosis |
| Lomustine | Cancer |
| Lupron | Cancer |
| Lupron Depot | Prostate Cancer |
| Lupron Depot-Ped | Prostate Cancer |
| Megace | Cancer |
| Megestrol | Cancer |
| Mellaril | Psychosis |
| Melphalan | Cancer |
| Memantine | Alzheimer's Disease |
| Methotrexate (>25mg/wk) | Rheumatoid Arthritis |
| Metrifonate | Dementia |
| Mirapex | Parkinson's Disease |
| Myleran | Cancer |
| Namenda | Alzheimer's Disease |
| Namenda XR | Alzheimer's Disease |
| Namzaric | Alzheimer's Disease |
| Natrecor | CHF |
| Navane | Psychosis |

| Medication | Condition |
|---|---|
| Nelfinavir | AIDS |
| Neoral | Immunosuppression, Severe Arthritis |
| Neupro | Parkinson's Disease |
| Norvir | HIV |
| Novatrone | Multiple Sclerosis |
| Nucala | Chronic Pulmonary Disorder |
| OFEV | Chronic Pulmonary Disorder |
| Paraplatin | Cancer |
| Parlodel | Parkinson's Disease |
| Permax | Parkinson's Disease |
| Plegridy | Multiple Sclerosis |
| Prezista | HIV |
| Procrit | Kidney Failure, AIDS |
| Prolixin | Psychosis |
| Provenge | Prostate Cancer |
| Razadyne | Dementia |
| Razadyne ER | Alzheimer's Disease |
| Remicade | Rheumatoid Arthritis |
| Reminyl | Dementia |
| Remodulin | Pulmonary Hypertension |
| Requip | Parkinson's Disease |
| Rescriptor | HIV |
| Retrovir | AIDS |
| Rebif | Multiple Sclerosis |
| Reyataz | HIV |
| Rilutek | Amyotrophic Lateral Sclerosis |
| Riluzole | ALS |

* Coverage is not available for individuals in Minnesota with diabetes.



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# Health Questions (continued)



| Medication | Condition |
|---|---|
| Risperdal | Psychosis |
| Rivastigmine | Dementia |
| Sandimmune | Immunosupression Severe Arthritis |
| Selzentry | HIV |
| Sinemet | Parkinson's Disease |
| Stalevo | Parkinson's Disease |
| Stelazine | Psychosis |
| Stiolto Respimat | COPD |
| Sustiva | AIDS |
| Symmetrel | Parkinson's Disease |
| Tacrine | Dementia |
| Tasmar | Parkinson's Disease |
| Tecfidera | Multiple Sclerosis |
| Teslac | Cancer |
| Thiotepa | Cancer |
| Thorazine | Psychosis |
| Trelegy Ellipta | COPD |
| Trelstar-LA | Prostate Cancer |
| Triptorelin | Prostate Cancer |

| Medication | Condition |
|---|---|
| Trizivir | HIV |
| Tudorza | COPD |
| Tysabri | Multiple Sclerosis |
| Valycte | CMV, HIV |
| VePesid | Cancer |
| Viadur | Prostate Cancer |
| Videx | HIV |
| Vincristine | Cancer |
| Viracept | HIV |
| Viread | HIV |
| Zanosar | Cancer |
| Zelapar | Parkinson's Disease |
| Zerit | HIV |
| Ziagen | HIV |
| Zinbryta | Multiple Sclerosis |
| Ziprasidone | Schizophrenia |
| Zolandex | Cancer |
| Zometa | Hypercalcemia in Cancer |

# Mailing Applications to Prospects

Mailing a completed application adds a few steps to the normal sales process. Below is a brief description of the necessary steps. The form (M24769_0208) is available for download on Sales Professional Access in Forms and Materials, provides a complete description of the process.

When calling a prospect who responds to a lead, always attempt to schedule a face-to-face interview. However, if the prospect prefers, you may continue the sales process on the phone. You need to begin by explaining to the prospect the following steps you will take to complete the sale.

You will:

1. Ask the prospect the questions on the application and required forms; mail the completed application and required forms to the prospect for their review and signature.
2. Tell the prospect that they need to carefully review the application and forms for completeness and accuracy and then sign.
3. Have the prospect return the signed application, forms and premium payment to you in a postage paid envelope.
4. Upon return of the application and other forms, verify that all the required forms are completed and signed.
5. Submit the application through the usual channel; and
6. When issued, deliver the policy according to current policy delivery guidelines.

Always remember:

- You must be licensed to sell in the state where the prospect is at the time of solicitation
- The applicant's state of residence controls the application, forms and premium
- The client must return the signed applications, forms and premium payment to you and should not submit them directly to Mutual of Omaha
- Incomplete application submissions will be returned to you, so review thoroughly
- If you solicited the business, you must be the one to sign the corresponding application
- You cannot sign blank applications
- It is not acceptable to mail blank applications, brochures and outlines as prospecting materials

If you have questions, please call Sales Support at (800) 693-6083 for Brokerage and (877) 617-5589 for Agency.

# Required Forms



## Application

Only current Medicare supplement applications may be used in applying for coverage. We will attach a copy of the application to the policy to make it part of the contract.

The producer or designated office staff is responsible for submitting completed applications to Mutual of Omaha or the applicable affiliate.

## Producer Information Checklist (Brokerage ONLY)

Producers must include their name and Agent Writing Number or Social Security number. A maximum of two producers are allowed and they should indicate the commission percentage shares, which must total 100 percent.

Commission Code is required only if the producer is not appointed or licensed or is changing brokerage firms.

## Method of Payment Form

Complete this required form regarding payment options and submit with all applications.

## Premium Receipt and Notice of Information Practices

Receipt must be completed and provided to applicant as receipt for premium collected. Notice must be provided to applicant.

## Replacement Form

The replacement form must be signed and submitted with the application when replacing any Medicare supplement or Medicare Advantage application. A signed replacement notice must be left with the applicant; a second signed replacement notice must be submitted with the application. *__Note__: In New York and Wisconsin, the replacement form must be completed when replacing any other health insurance.

## Agent or Witness Certification for Non-English Speaking and/or Reading Applicants

If the applicant does not speak English, this form is to be completed by the agent if agent is translating or a witness if a witness is translating. A witness cannot be a relative or a family member. A copy must be submitted with the application and a copy left with the applicant.

## List-Bill Enrollment Form

This form must be completed and submitted if three or more Medicare supplement plans are to be paid for through pension deductions, employer contributions, and/or direct bill by a third-party List-Bill administrator. The form should be submitted and processed before any applications are submitted to us.

# Mobile Quote App

Quickly provide your Medicare supplement clients with the rate information they need. Get rates on the go that include household discounts (where applicable) and optional height/weight inputs.

### Features and Highlights

- Three ways to provide customized quotes:
    - Single quote
    - Single quote with household discount
    - Two quotes with household discount
- Optional height/weight inputs, where applicable, can be included for more accurate premiums
- Include a quote for dental coverage — with an optional vision benefit rider — in the states where dental is sold

### Requirements

- The app functions on smartphones and tablets
- Smartphones or Android (4.0 and higher) and iOS (6.0 and higher) platforms
- Continuous internet access required

### Download

*iOS in the Apple App Store*

*Android in Google Play*

From the Apple Store or Google Play, search "Quotes for Sales Professionals."

### State Availability

All states are on the app (except Massachusetts).

# Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)



The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) was passed March 26, 2015, as a means to help reduce the cost of Medicare by reducing first dollar coverage provided by supplemental insurance plans. ***The Act prohibits individuals who become eligible for Medicare on Jan. 1, 2020, or after, from purchasing a Medicare supplement policy that covers the Part B Deductible.*** This includes Medicare supplement Plans C, F, High Deductible F (and Minnesota and Wisconsin Part B deductible coverage).

**Important note:** As a number of states are in the process of enacting or updating their specific legislation/regulation requirements in relation to MACRA, this section will be updated accordingly.

## Medicare-eligibility through Dec. 31, 2019

For your clients who are already Medicare-eligible or will be through Dec. 31, 2019, their Medicare options are the same as they've always been. They can keep their existing plans or purchase any that cover the Part B deductible.

## Medicare-eligibility Jan. 1, 2020 and after

The MACRA rule will impact your clients who become Medicare-eligible after Dec. 31, 2019, as they're considered newly eligible and won't be able to purchase plans that cover the Part B deductible. "Newly eligible" is defined as individuals who have attained age 65 on or after Jan. 1, 2020 or first become eligible for Medicare due to age, disability or end-stage renal disease, on or after Jan. 1, 2020.

Additionally, MACRA makes Plans D and G the guaranteed issue plans for newly eligible Medicare beneficiaries (as of Jan. 1, 2020) for the specified period under current law that name Plans C or F for current beneficiaries.

**Mutual of Omaha Medicare Supplement Plan Choices as of Jan. 1, 2020**

| Medicare Supplement Plans Available | Medicare-eligibility through Dec. 31, 2019 | Medicare-eligibility on or after Jan. 1, 2020 |
|---|---|---|
| | A, C, D, F, High-Deductible F, G, High-Deductible Plan G, N | A, D, G, High-Deductible Plan G, N |

**Frequently Asked Questions about MACRA**

| Question | Answer |
|---|---|
| **Are clients currently on Plan C and Plan F "Grandfathered"?** | Clients who currently have Plan C or Plan F will be "Grandfathered" or excluded from the MACRA provision. In addition, individuals eligible for Medicare on or before Dec. 31, 2019, will be eligible to purchase a Plan C or Plan F, subject to carrier guidelines, and will be "Grandfathered." Mutual of Omaha will continue to offer Plan C and Plan F to those eligible. |
| **If a client is going on Medicare in 2019 and is considering purchasing Plan C or F, can they still purchase it?** | Yes. Starting in 2020, Medigap Plan C or F can no longer be sold to beneficiaries who become "newly eligible" for Medicare on or after Jan. 1, 2020. Newly eligible Medicare beneficiaries are those who attain age 65 on or after Jan. 1, 2020 or become entitled to Medicare Part A by reason of disability or ESRD on or after Jan. 1, 2020. Individuals who are enrolled in Medicare before 2020 can still purchase these plans and will be able to keep their plan as long as they pay their premiums. |
| **If an insured client is currently enrolled in Plan C or F, does the client need to do anything?** | No, the customer does not need to take any action. Plans C and F will be available for consumers eligible to purchase in 2020 and beyond if the customer is Medicare-eligible prior to Jan. 1, 2020. |
| **Can my client, whose birthday is Jan. 1, 1955, purchase either a High-Deductible Plan F (HDF) or High-Deductible Plan G (HDG)? Or just HDG?** | An individual (born January 1, 1955) with a birthday on January 1, 2020 is eligible for Medicare on December 1, 2019. This is consistent with the Medicare eligibility rules. This same individual is defined to be, and CMS recognized to be, a "newly eligible Medicare beneficiary" on January 1, 2020, and as such cannot purchase a Plan C or F. They can purchase a Medigap policy on December 1, 2019, but it cannot be Plan C or F. |
| **If clients want to leave Plan F, is there a guaranteed issue route to another plan?** | Mutual of Omaha will not make special guaranteed issue rules for individuals on Plan F. If a customer would like to move to another plan, the individual would have to meet the underwriting requirements for that particular state. |
| **If a client is currently on a Medicare Advantage plan, but wants to convert his or her coverage back to a Medicare supplement Plan C or F, can they do so without underwriting?** | If an eligible customer would like to move to another plan, the individual would have to meet the underwriting requirements for his or her particular state.<br><br>Please refer to our Medicare Advantage section on pages 12 and 13 of this guide for additional details. |

**Note:** As additional questions and clarifications regarding MACRA are received, this section will be updated.


Medicare Supplement Insurance underwritten by:
**Mutual of Omaha Insurance Company**
**United of Omaha Life Insurance Company**
**United World Life Insurance Company**
**Omaha Insurance Company**
**Omaha Supplemental Insurance Company**

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