"Serving you
-since '32"

OLD SURETY LIFE
INSURANCE COMPANY
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Revised: July 2021

MEDICARE SUPPLEMENT UNDERWRITING GUIDELINES

Please review this guide BEFORE presenting proposals and submitting applications. The purpose of this guide is to provide agents with the basic information needed to market **OLD SURETY LIFE INSURANCE COMPANY'S** Medicare Supplement coverage. While we have made every effort to make this information as accurate as possible, it should only be used as a guide to help agents to field underwrite potential applicants for **OLD SURETY LIFE INSURANCE COMPANY'S** Medicare Supplement plans. Please remember that no agent has the authority to change any benefits to bind coverage with OLD SURETY LIFE INSURANCE COMPANY or to promise a certain effective date.

OLD SURETY'S PHILOSOPHY

We seek to insure individuals in good health who want quality products and excellent service. By working together with the agent, we believe we can generate a good block of business that will maintain a favorable loss ratio and thereby keep the rates affordable.

It is the agent's responsibility and duty to obtain accurate and complete information on the application. It is the agent's obligation to the applicant to review all questions and related answers. Care on the part of the agent saves time, expense, misunderstanding and litigation. This guide provides information about the evaluation process used in underwriting and issuing of Medicare Supplement insurance policies.

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Business Phone:	800-272-5466

All inquiries in regards to policies, claims, underwriting, supplies or any other questions will use the business phone.

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Guidelines for Potential Applicants

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 or first become eligible for Medicare due to age, disability or end-stage renal disease, on or after Jan. 1, 2020. Plans C and F are not available to newly eligible Medicare beneficiaries.

Premium rates are based on applicant's state of residence (where their taxes are filed) and the age the applicant will be on the date of issue (effective date) of a policy.

Underwritten applications will only be accepted up to sixty (60) days prior to requested effective date. (Exception will be during the AEP period, we will accept applications in the month of October for a January 1st effective date of the following year.)

Applications submitted during Open Enrollment or a Guaranteed Issue scenario will be accepted up to ninety (90) days prior to the requested effective date.

All applications will be telephone "Verified". The verification process is used to make sure the information on the application and the answers to the health questions, medications, etc., have been recorded correctly. Any application submitted during *Open Enrollment with creditable coverage documentation,* or a *Guaranteed Issue application* will be included, but only to verify the information that was submitted on the application is correct in regards to the applicant disregarding any health information and/or medications. If an application is submitted during *Open Enrollment without creditable coverage documentation*, the applicant will be advised of the pre-existing condition clause as it relates to the Medicare Supplement policy that is being applied for. If during the telephone verification it is deemed that an applicant may be in a guaranteed issue scenario, and the application was not submitted as such, underwriting will contact the agent and request the correct documentation and corrected pages of the application to verify the status of the applicant as a guaranteed issue.

Home Office Underwriting Procedures

Step 1 Upon receipt of a Medicare Supplement application, home office personnel will verify the contents of the application by telephone. This "double check" is designed to protect the agent and the Company, as well as answer any questions the applicant may have had since the time of application.

Step 2 Most Medicare Supplement applications are underwritten based on the information from the application and the telephone verification process. The Company reserves the right to request additional medical data, such as an APS report from the applicant's physician or a pharmacy benefit manager report for any applicant that is not in their open enrollment period or a guaranteed issue scenario. A telephone interview will be made when information is not clear or complete on the application, or if the pharmacy report does not match the application information. An APS may be requested notwithstanding instances when an APS will always be required. When additional medical information is requested, there will be a delay in underwriting being able to make a final decision. Such cases normally remain in the home office for 10 to 15 more working days. We will do everything possible to hold these situations and delays to a minimum. Your help and cooperation will be appreciated. If additional medical information is needed, underwriting will advise the agent.

Step 3 Issued policies are mailed to the agent for delivery, unless the agent has requested on the application otherwise.

Applicants Requesting the Reason for Declination

Notification of declined applications and refunds are mailed directly to the applicant, with a copy sent to the agent. If the reason for decline was based on the information provided on the application or obtained through the phone verification with the applicant, underwriting can discuss verbally the reasoning for the decision with the applicant or the agent. This request can also be made in writing from the applicant.

If the reason for the decline came from medical records we obtained the applicant can send in a written request to underwriting to disclose our reasons to the physician from whom the records were obtained. The applicant can then contact the physician for this information. This information cannot be discussed verbally with the applicant or the agent.

Pharmaceutical Information

Old Surety has implemented a process to support the collection of pharmaceutical information for Medicare Supplement applications. Prescription information noted on the application will be compared to the additional pharmaceutical information received for underwriting purposes. This additional information will not be solely used to decline coverage.

Tips for Completing an Application

To avoid solicitation of applicants who cannot qualify for this insurance, always compare conditions, medications and the applicant's height and weight to the attached Uninsurable Impairments, Partial List of Uninsurable Medications and the Height and Weight Chart.

The application must be completed in its entirety.

Always verify that applicants are covered by, or will be covered by, Medicare Parts A and B at the time the policy goes into effect and that they are not fully covered by a State Medicaid program.

Ask each question exactly as it is written on the application and complete all the information on the application.

Record each answer exactly as it is given.

Furnish complete information on the application:

1. Any treatments that were received and the dates for treatments
2. Any medication(s) and dosage(s) and reason medication(s) was prescribed
3. Name, address and telephone number of each individual physician

***Always* complete the application legibly and in black ink.**

Always have each applicant initial and date any correction or mistake.

Always have the application signed by the applicant and yourself (do not print names for signatures).
Power of Attorney signatures and signatures of spouses are not permitted.

Never tell or suggest to the applicant how he or she should answer a question.

Never leave out any details of an applicant's answer; it may be helpful to issue the policy.

Never ask a general question such as "Are you in good health", and then answer all the health questions "No".

To expedite the underwriting process, the agent needs to provide:

- ***** Full names and addresses of the doctors seen
- ***** Diagnoses of all impairments
- *Results of any tests, if known
- *Dates of diagnosis and dates of treatment
- ***** If recurring symptoms, date of first and last episode and average number of occurrences per year

Careful questioning of the applicant is very important in developing medical history. **Only the Underwriting Department can make the final decision.** Therefore, ***never*** suggest or promise that a policy will be issued. **NEVER suggest an applicant should drop their current coverage until their policy with us is issued!**

Submission of New Business

All applications must be received in the home office within 14 days of the application date, or the application will not be processed and a new application will be required.

Applications cannot have a requested effective date before the date the application is signed by the applicant.

The requested billing date cannot be later than the 28th date of the month.

If an applicant will be using ACH payments for the initial and renewal premiums, an application can be faxed using our Sure-Apps program. The entire application along with the cover page is required.

If an applicant will be paying the initial premium with a written check, money order, etc… the original application and the initial premium will be required to be mailed into the home office for processing. All monies received must be made out to Old Surety Life, only.

The company does not accept C.O.D. payments under any circumstances.

Incomplete Applications or Supporting Documentation

If there is insufficient information on the application or if an applicant is applying during an open enrollment or a guaranteed issue scenario where supporting documentation is required, we will contact the agent during the application process to obtain information. If information is not received within sixty (60) days of the application date, the application may be terminated as "Incomplete" and a letter sent to the applicant and agent. Any refund of premium will be returned to the applicant.

Withdrawn Applications

If an applicant wishes to withdraw their application during the application process for any reason, it will require a signed letter from the applicant in order to process the application as "Withdrawn". If a written request to withdraw an Open Enrollment or Guaranteed Issue application is received by Old Surety Life, the company will contact the applicant to confirm their request to withdraw their application.

Pre-Existing Restrictions on Open Enrollment Applications

If an applicant is in their open enrollment period and does not provide proof of creditable coverage, their policy may contain a pre-existing conditions exclusion. Pre-existing restrictions apply ONLY during "Open Enrollment" if the applicant does NOT have creditable coverage. Therefore, be sure to include the applicant's prior coverage information on the application, as well as proof of this coverage with the application when submitted. Coverage for a pre-existing condition can only be excluded in a Medicare Supplement policy if the condition was treated or diagnosed within the six (6) months before the effective date of the Medicare Supplement policy. The pre-existing condition(s) may not be covered for the first six (6) months of the Medicare Supplement policy. Beneficiaries in their open enrollment period cannot be denied coverage even if they have pre-existing conditions and no creditable coverage. Original Medicare will still cover their condition(s) even if the Medicare Supplement policy won't cover the beneficiary's out of pocket expenses.

Household Discount

(not applicable in all states – check rate sheet in specific state for availability)

How to determine eligibility for household discount:

*****Refer to Household Discount Qualification section on the application
*****If question #1 or #2 is answered "Yes", the applicant qualifies

The household discount is available to:

*An applicant who has resided, for at least one (1) year, with a living person over the age of 18, or an individual who is married residing together regardless of length of time. The other individual does not have to be an Old Surety policyholder.

Premium Shortages

The Company will communicate with the agent by telephone, e-mail or fax in the event of a premium shortage. The application will be held in pending until the balance of the premium is received, unless the application was processed using the ACH payment process for the initial premium, in which case the shortage will be adjusted to be drafted on the initial premium and any renewals.

The company does not accept C.O.D. payments under any circumstances.

Policy Conversions

Policy conversions are considered to be a current policyholder submitting an application for a "New Policy". In order to be considered for a policy conversion, the following conditions must apply:

1. Applicant should have a current policy with Old Surety.
2. Rate will be based on age of applicant on the effective date of the "new" policy. Applicant will be required to submit a new application and will be underwritten based on the new application and underwriting information obtained during the application process.
3. Applicant can have no lapse in coverage for policy to be considered for a conversion.
4. If an applicant wishes to change rate class due to non-tobacco use in past two (2) years, proof of tobacco cessation must be provided in a statement from a physician. This statement is to be provided by the applicant at the time the application is submitted. They will be considered the same as a conversion and will be subject to those same guidelines.

Policy Reinstatements

When a Medicare Supplement policy has lapsed and it is within ninety (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 ninety (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 Advantage ("MA")

MEDICARE ADVANTAGE ("MA") ANNUAL MEDICARE PART C ELECTION PERIOD

General Election Periods for	Timeframe	Allows for
Annual Election Period ("AEP")	Oct. 15th – Dec. 7th of every year	• Enrollment selection for MA (Part C) • Disenroll from a current MA Plan • Enrollment selection for Medicare Part D Prescription Drug Coverage
Medicare Advantage Disenrollment Period ("MADP")	Jan. 1st – March 31st of every year	MA enrollees to disenroll from any MA plan and return to original Medicare The MADP does not provide an opportunity to: • Switch from original Medicare to a Medicare Advantage Plan • Switch from one Medicare Advantage Plan to another • Switch from one Medicare Prescription Drug Plan to another • 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 a Medicare Supplement policy, underwriting cannot issue coverage without proof of disenrollment. If a member disenrolls from Medicare Advantage, the MA Plan must notify the member of his/her Medicare Supplement guaranteed issue rights.

Voluntarily disenrolling during AEP or MADP and not eligible for Guaranteed Issue

The section of the application as well as the replacement form concerning the Medicare Advantage program should be answered completely:

- Stating when the Medicare Advantage program started;
- Leaving the "END" date blank, since the applicant is still covered;
- Confirming the applicant's intent to replace the current MA coverage with this new Medicare Supplement policy;
- Confirming the receipt of the replacement notice;
- Stating the reason for the termination/disenrollment;
- Completing the planned date of termination/disenrollment;
- Specifying whether this was the first time in this type of Medicare Advantage plan (MA);
- Specifying whether there had been previous Medicare Supplement coverage; and
- Answering whether that previous Medicare Supplement coverage is still available.

If the applicant is applying during the Medicare Advantage Annual Enrollment Period (AEP), and all of the above information is provided, we will NOT require proof of termination from the Medicare Advantage provider. ***It is the applicant's responsibility to disenroll from the Medicare Advantage coverage during either the AEP or MADP.*** Please note that the CMS guidelines, Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare, advises that if the client joins a Medicare Advantage plan, he/she cannot be sold a Medigap policy unless the coverage under the Medicare Advantage plan will end before the effective date of the Medigap policy.

IF AN INDIVIDUAL IS REQUESTING GUARANTEED ISSUE OR DISENROLLING OUTSIDE AEP/MADP

1. The section concerning the MA program should be answered completely, as stated above; AND
2. Send a copy of the applicant's MA Plan disenrollment/termination notice with the application. This is especially important if the applicant is claiming a Guaranteed Issue right based on any situation as outlined in the CMS guidelines, Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare.

Please note: All plans are not available as Guaranteed Issue in most situations.

For any questions regarding MA disenrollment eligibility, contact your SHIP 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

Some states may have additional Guaranteed Issue rights under state law.

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.

The situations listed in the following tables can also be found in the Guide to Health Insurance.

Guaranteed Issue situation	Client has the right to
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**,F*,G**, K, or L that is sold in the client's state by any insurance company. Client must switch to an original Medicare Plan.
Client joined a 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 client's state by any insurance company.
Client dropped his/her Medigap policy/certificate to join a MA Plan for the first time, has been in the plan less than one (1) year, and wants to switch back	Obtain client's Medigap policy/certificate back if that carrier still sells it. If his/her former Medigap policy/certificate is not available, the client can buy a Medigap Plan A, B, C*, D**, F*, G**, K, or L that is sold in his/her state by any insurance Company.
Client leaves a MA Plan because the company has not followed the rules or has misled the client	Buy a Medigap Plan A, B, C*, D**,F*,G**, K, or L that is sold in the client's state by any insurance company.

Note: A copy of the applicant's MA Plan termination notice is needed if applying for Guaranteed Issue.

Guaranteed Issue Rights and Scenarios

The Affordable Care Act has affected many group and employer sponsored health plans. Old Surety is seeing an increase in individuals on Medicare losing or having to change their group or employer sponsored health plans. We are also seeing some confusion with what does or does not trigger an individual's rights to guaranteed issue.

Old Surety wants to clarify its policy on how Federal and State laws determine an individual's guaranteed issue rights:

GUARANTEED ISSUE RULES

The rules listed below are the Federal requirements. These rules can also be found in the Centers for Medicare & Medicaid Services (CMS) annual publication, "Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare."

Guaranteed Issue situation	Client has the right to
Client is in the original Medicare plan and has an employer group health plan (including retiree or COBRA coverage) or union coverage that pays after Medicare pays. That coverage is ending. *Note: State laws may vary in this situation.*	Medigap Plan A, B, C*,D**, F*,G**, K, or L that is sold in the client's state by any insurance company (if plan is offered). If the client has COBRA coverage, the client must wait until the COBRA coverage ends.
Client is in the original Medicare plan and has a Medicare SELECT policy. The client moves out of the Medicare SELECT plan service area. Client can keep their Medigap policy or he/she may want to switch to another Medigap policy.	Medigap Plan A, B, C*,D**, F*,G**, K or L that is sold by any insurance company in the client's state or the state he/she is moving to (if plan is offered).
The client's Medigap insurance company goes bankrupt and the client loses coverage; or, the client's Medigap policy coverage otherwise ends through no fault of the client.	Medigap Plan A, B, C*,D**, F*,G**, K or L that is sold in the client's state by any insurance company (if plan is offered).

Note:
***Plans C and F are <u>NOT</u> available to newly eligible Medicare beneficiaries.**
****Plans D and G are <u>ONLY</u> available to "newly eligible" Medicare beneficiaries.**

*Please note that applicants may apply up to sixty (60) calendar days prior to the date the coverage will end and **MUST** apply no later than sixty-three (63) days after the coverage ends.*

Group Health Plan Proof of Termination

Proof of Involuntary Termination
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 termination scenarios, a copy of the I.D. card for the applicant's current coverage and a letter stating the date coverage will be ending will be required if not completed on the application.

GUARANTEED ISSUE RIGHTS FOR VOLUNTARY TERMINATION OF GROUP HEALTH PLAN

State Specific Rules	Guaranteed Issue situation	Client has the right to
CO, MT, TX	Client is voluntarily leaving their group health plan and the employer sponsored plan is primary to Medicare.	Medigap Plan A, B, C*,D**, F*, G**, K, or L that is sold in the client's state by any insurance company (if plan is offered).
NM, OK ***See Note	Client is voluntarily leaving their group health plan and the employer sponsored plan benefits are reduced substantially.	Medigap Plan A, B, C*,D**, F*, G**, K, or L that is sold in the client's state by any insurance company (if plan is offered).
AR, KS, MO	Client is voluntarily leaving their group health plan: No conditions – always qualifies.	Medigap Plan A, B, C*,D**, F*, G**, K, or L that is sold in the client's state by any insurance company (if plan is offered).

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.**

***NM and OK
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 co-pays or coinsurance %). A premium increase without an increase in the deductible or coinsurance requirement will not qualify for guaranteed issue eligibility.

If a beneficiary is planning to voluntarily drop or disenroll from their current group or employer sponsored health plan in the following states (CO, TX, AR, KS, MT and MO) and apply for a Medicare Supplement with Old Surety, Old Surety will process the application as a guaranteed issue.

If a beneficiary plans to keep their current group or employer sponsored health plan and apply for a Medicare Supplement with Old Surety, documentation of continuation of coverage must be submitted. If documentation is not provided, the application will be processed as a guaranteed issue.

Missouri Residents – Missouri Annual Option Guaranteed Issue Rights

Missouri – Individuals that terminate a Medicare Supplement policy within thirty (30) days of their annual policy anniversary date may obtain the same plan on a guaranteed issue basis from any issuer that offers that plan. This would include Medicare Supplement and select plans and individuals with existing plans E, H, I, and J can convert to one of the following plans: A, B, C, F, K, or L. Please include documentation verifying the plan information, paid-to-date and the policy anniversary of the current coverage.

Underwriting Guidelines for Underwritten Applications

These guidelines are intended to help the agent avoid solicitation of applicants who cannot qualify for this insurance. There are many conditions or circumstances for which we cannot provide a policy because of the increased risk to the Company. If the agent has questions regarding specific medical conditions which may deserve special consideration, he or she may call and discuss the matter with the Underwriting Department prior to submission of the application. Any representations made by individuals in the home office will be based upon the information provided in the call and are not to be taken as guarantees. If an application will then be submitted, the agent will need to provide the details on a separate sheet of paper along with the application.

The attached list of Uninsurable Impairments, Partial List of Uninsurable Medications, and Height and Weight Chart are subject to periodic revision by the Underwriting Department. ***REMEMBER:*** the fact that a specific impairment is not listed on the application or on the Uninsurable Impairments list does not mean it is insurable.

Guidelines for Answering Health Questions

(Currently in the Arkansas, and New Mexico application it does not reference Section #1 and Section #2 guidelines but the following guidelines still apply)

SECTION 1: All questions must be answered. If any question in Section 1 is answered "Yes," the applicant is not eligible for coverage.

*__Diabetes__ – condition must be stable. Treated with no more than two (2) non-insulin type medications. Consideration will be given if taking in conjunction with hypertension medication but cannot exceed a total of four (4) medications to treat the combination of diabetes and hypertension. (Examples: 1 Diab pill and 3 HBP pills or 2 Diab pills and 2 HBP pills) Diabetes in combination with a statin reducing (Cholesterol) medication will be considered on a case by case basis. Any applicant diagnosed with diabetes and taking medication for anticoagulant/platelet (Blood Thinner) will not be considered.

SECTION 2: Applicants who answer "Yes" to any question(s) in this section may be considered for coverage. The following is a guideline to help determine consideration for an applicant but is not an all-inclusive list. The underwriter will make the final determination based on the information provided on the application, the phone verification and any additional information the Underwriting Department receives relevant to the applicant. If you have any questions, you may call Underwriting at 800-272-5466.

A condition is considered "Stable" if treated with no more than three (3) medications and there have been no significant changes in treatment(s) or significant changes in medication(s) for that particular condition for a period of two (2) years.

Consideration will be given for the following:

#9. *__Any Heart and/or Vascular Surgeries__, etc. – after two (2) years.
*__Stroke__ – after two (2) years if there are no residual symptoms and no more than one during lifetime.
*__TIA__ – after two (2) years if there are no residual symptoms and no more than one during lifetime.
*__Heart Rhythm Disorders (Afib)__ - No treatments including hospital/ER visits in past two (2) years.
__Pacemaker__- will be considered after (2) years of having implanted.
*__Internal Cancer__ – after two (2) years and no more than one (1) occurrence or multiple types of internal cancer.
*__Melanoma__ (not including benign and other non-cancerous skin conditions) – after two (2) years and no reoccurrences.
__Blood Disorder__-case by case basis if not on declinable health conditions list
__Chronic Kidney Disease__- only considered if diagnosed as Stage 1 or Stage 2
__One Kidney__- considered only if born with one or donated one more than two(2) years ago. Will not be considered if a kidney was lost due to disease.

#10. *__Asthma__ or non-chronic pulmonary condition – condition must be stable and treated with no more than two (2) medications including any inhaler(s).

#11. *__Injections or Infusions__ – the following types of medications/injections will be considered based on diagnosis, frequency and dosage this includes normal treatments such as allergy shots, cortisone injections, B12 shots, testosterone and most non-chronic treatments.
Any injections or infusions within the past 60 months to treat osteoporosis will not be considered.
Any injections to treat any autoimmune disorders or to treat any eye disorder will not be considered.

#12. *__Surgery/physical therapy/joint replacement__ – must be fully released for a minimum of 60 days from doctor and no future treatment(s) are scheduled or anticipated for condition that was treated. No use of a device to help with activities of daily living. Consideration will be based on type of surgery and/or treatment(s) and release dates.

#13. *__Hospital or Emergency Room__ – more than two (2) hospitalizations (including being under observation care in a hospital/ER facility) and/or Emergency Room visits for uncontrolled and/or unstable condition(s) within the past two (2) years will not be considered. An accident is not considered to be uncontrolled or unstable.

#14. *__If an applicant is taking a medication that is listed in the uninsurable medications, the application will not be considered.__ Any prescribed medication the applicant has taken in the past twenty-four (24) months that is not listed on the uninsurable medications list should be included in this section. Please list the medication name, dosage and frequency, diagnosis or condition being treated, and date originally prescribed. This information will help determine consideration.

REMINDER- any condition not listed above that requires more than three (3) medications will not be considered.

Standard Rating

Tobacco use of any kind within the past 24 months should be quoted Standard rates. This includes chewing tobacco, e-cigarettes, and vapes. Standard rates are determined by adding an additional 10% to the applicant's base rate. (This information is also located on the rate sheet.) Use the chart below to determine if Standard rates should be applied during Open Enrollment or during a Guaranteed Issue scenario for tobacco use.

Height and Weight Chart. Determine if the applicant should be rated "Standard" by Using their Height and Weight.

If the applicant is rated "Standard" using the Ht/Wt chart and a tobacco user as defined above, they should only be rated the "Standard" rate. They should not be rated up twice due to both conditions qualifying for the "Standard" rate.

Rate Type Available by State

	Standard Rates Apply	Gender Rates	Tobacco Rates Apply During Open Enrollment/Guaranteed Issue	Height/Weight Chart Apply During Open Enrollment/Guaranteed Issue	Household Discount
AR	**Y**	N	N	N	N
CO	**Y**	**Y**	N	**Y**	N
KS	**Y**	**Y**	**Y**	N	N
MO	**Y**	**Y**	N	N	N
MT	**Y**	N	**Y**	**Y**	N
NC	**Y**	**Y**	N	N	N
NE	**Y**	**Y**	**Y**	**Y**	N
NM	**Y**	**Y**	**Y**	N	N
OK	**Y**	**Y**	**Y**	**Y**	N
TX	**Y**	**Y**	**Y**	**Y**	**Y**

Premium Changes

Old Surety policies issued in CO, KS, MO, MT, NC, NE, NM, OK and TX are "Issue Age" rated policies. Premium is based on the age the applicant is on the effective date of the Medicare Supplement policy. Arkansas is a "community rated" state where policies are priced the same for all ages in a specific area. Premiums cannot be changed due to increasing age for either type of these policies. They may only be changed if Old Surety changes the premiums for all like policies in that specific state.

Uninsurable Impairments

In addition to the table below, the following will also lead to a decline:

. Advised to have surgery, medical tests, further diagnostic evaluation, treatment or therapy that has not been performed
. Implantable cardiac defibrillator
. Use of Supplemental Oxygen or use of a nebulizer
. Asthma requiring continuous use of more than two (2) medications including inhalers
. Taking any medication that must be administered in a medical facility
. If applicant's height/weight is in the decline column on the chart
. Drug or alcohol abuse in past 5 years
. No verifiable health information in the past 24 months

This list is not all-inclusive.
An application should not be submitted if a client has any of the following uninsurable impairments.

Addison's Disease	**Chronic Kidney Disease Stage 3, Stage 4 or Stage 5**
AIDS, ARC or HIV infection	**Congestive Heart Failure (CHF)**
Alzheimer's Disease	**Crohn's Disease**
Other cognitive disorders to include:	**Cushing's Syndrome**
Cerebrovascular Disease with cognitive deficits	**Diabetes** requiring Insulin
Dissociative Amnesia	**Diabetes** with history of high blood pressure
Huntington's Chorea(Huntington's Disease)	No more than **4** total medications to treat combination of
Mild Cognitive Impairment (MCI)	**Diabetes** in conjunction with any anticoagulant medication
Delirium	**Diabetes** with complications, retinopathy, neuropathy,
Organic Brain Disorder	peripheral vascular disease, or history of
Post-Concussion Syndrome with residual problems	heart attack, stroke or any kidney disease
Senile Dementia	**Emphysema**
Amputation caused by Disease	**End Stage Renal Disease (ESRD)**
Amyotorphic Lateral Sclerosis(lou Gehrig's Disease)	Any Kidney Disease requiring Dialysis
Angina treated within past 12 months	**Experimental medication/treatment not FDA approved**
Autoimmune disorder diagnosis of any type	**Heart or Vascular Surgery in past 2 years**
Bone Marrow Transplant	**Heart disorder that is inoperable**
Cancer if currently present	**Hemochromatosis**
Treated with Chemo or Radiation in past 5 years	**Hemophilia**
Treated with surgery only in past 2 years	**Hodgkin's Disease**
Cardiomyopathy	Non-Hodgkin's Lymphoma
Catheter or Colostomy bag use	**Lymphoma**
Cerebral Palsy	**Leukemia**
Cirrhosis	**Lupus**
Chronic Hepatitis	**Melanoma with more than one occurrence**
Chronic Hepatitis B, C or D	**Multiple Myeloma**
Autoimmune Hepatitis	**Multiple Sclerosis or Muscular Dystrophy**
Chronic Active Hepatitis	**Myasthenia Gravis**
Chronic Steatohepatitis	**Organ Transplant**
Chronic Obstructive Pulmonary Disease (COPD)	**Osteoporosis with related fracture**
Other chronic pulmonary disorder to include:	Or treated with injection/infusion in past 60 months
Asbestosis	**Pain Management (currently being treated)**
Bronchiectasis	**Parkinson's Disease**
Chronic Obstructive Lung Disease (COLD)	**Paget's Disease**
Chronic Asthma	**Polycythemia Vera**
Chronic Bronchitis	**Psoriasis** of any form
Chronic Cardiopulmonary	**Raynaud's Syndrome**
Chronic Interstitial Lung Disease	**Retinopathy**
Chronic Pulmonary Fibrosis	**Rheumatoid Arthritis**
Cystic Fibrosis	Any Arthritis that is considered crippling or disabling
Pulmonary Hypertension	**Scleroderma**
Sarcoidosis	**Stem Cell Transplant**
Chronic Kidney/Renal Disease	**Sjogren's Disease**
Chronic Nephritis	**Ulcerative Colitis**
Chronic Glomerulonephritis	**Wet Macular Degeneration**
Chronic Protein Loss in urine (proteninuria)	
Chronic Renal Insufficiency	