Physicians Mutual Insurance Company, Inc.®
a member of the Physicians Mutual family

Physicians Mutual®
Insurance for all of us.®

Michigan

Medicare Supplement Application Booklet

Insurance Policy:
P070MI-Plan A
P075MI-Plan F Wellness Plus
P076MI-Plan G Wellness Plus
P078MI-High Deductible Plan G Wellness Plus
P079MI-Plan N Wellness Plus

For Agent Use Only

Physicians Mutual Insurance Company, Inc.
Underwriting Services
2600 Dodge Street
Omaha, NE 68131-2671
1.800.228.9100

Medicare Supplement Required Forms

Completed	Doesn't Apply			
☐		PM2472-0726	Medicare Supplement Checklist	Home Office Copy
☐		PA070-MI	Application for Medicare Supplement	Home Office Copy
☐		PM3588-0726	Electronic Welcome Package Consent	Home Office Copy
☐		PM2466-0726	Acknowledgment	Home Office Copy
☐		PM2470	Agent's Statement	Home Office Copy
☐	☐	PM1902A-1010	Business Owner Waiver	Home Office Copy
☐	☐	PM2469-0726	Additional Information Regarding Current or Pending Coverage	Home Office Copy
☐	☐	PM2471-0120	Telephone Interview for Underwritten Applications	Home Office Copy
☐		PM2467-0726	Third Party Designee	Home Office Copy
☐	☐	PM2448-1-0726	Authorization for Automatic Bank Withdrawal	Home Office Copy
☐		ALL645-0726E	HIPAA Authorization for Underwriting Purposes	Home Office Copy Applicant's Copy
☐		PM2112-0726	Receipt for Medicare Supplement Policy	Applicant's Copy
☐	☐	PM2441-0726	Telephone Interview	Applicant's Copy
☐	☐	PM-3607	Notice to Applicant Regarding Replacement of Medicare Supplement Insurance or Medicare Advantage	Home Office Copy Applicant's Copy
☐	☐	PM2434-0726	Proof of Medicare Eligibility	Home Office Copy
☐		C070-MI	Outline of Coverage Cover Page	Applicant's Copy
☐		OC070-UNI	Plan A Outline of Coverage **(to be used with Policy P070MI)**	Applicant's Copy
☐		OC075-UNI	Plan F Outline of Coverage **(to be used with Policy P075MI)**	Applicant's Copy

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Completed	Doesn't Apply			
☐		OC076-UNI	Plan G Outline of Coverage **(to be used with Policy P076MI)**	Applicant's Copy
☐		OC076-GDD	Plan G with Deductible Discount Rider Outline of Coverage	Applicant's Copy
☐		OC078-UNI	High Deductible Plan G Outline of Coverage **(to be used with Policy P078MI)**	Applicant's Copy
☐		OC079-UNI	Plan N Outline of Coverage **(to be used with Policy P079MI)**	Applicant's Copy
☐		Electronic Quote	Summary Page (Must be submitted with application)	Home Office Copy

Physicians Mutual Insurance Company, Inc.
Physicians Life Insurance Company
Physicians Select Insurance Company
2600 Dodge Street
Omaha, NE 68131-2671
1.800.228.9100

Medicare Supplement Checklist

Agents: Please use the following checklist and include with the application.

Application Information

Completed	Does Not Apply	
☐		Is the applicant's information complete (name, address, age, date of birth, gender, height/weight, phone number)?
☐	☐	Did you indicate the applicant's Medicare Number?
☐		Does the customer's check match the quote?
☐		Does the mode selected on the application match the quote?
☐	☐	If automatic bank withdrawal, is the Automatic Bank Withdrawal form completed and is a voided check included?
☐	☐	If paying with a business check, is the Business Owner Waiver form completed?

Coverage

☐		Is the appropriate Plan selected, based on when the applicant was first eligible for Medicare?

Health and Coverage Questions

☐		Are all questions answered?
☐	☐	Are questions 6, 7 or 8 completed for replacements of a MA, group or other Medicare Supplement insurance?
☐	☐	Did you include effective dates?
☐	☐	Did you include previous coverage details?
☐	☐	Did you complete the "End Date" for the other coverage?

Proof of Eligibility

☐	☐	Did you include proof of Medicare Part B Eligibility or proof of Medicare Eligibility form PM2434? Note: This is not a requirement on first time open enrollment between age 64½ and 65½.
☐	☐	Did you include proof that Medicare Advantage (MA) or group insurance is terminating for apps requesting guaranteed issue? Note: Underwriting will accept a copy of the letter they sent to the MA or group insurance carrier requesting cancellation. However, proof of cancellation from MA or other carrier will be required at policy delivery.

Miscellaneous

☐		Did you include a copy of the Electronic Quote Summary Page?
☐	☐	Did you include a copy of the Lead Detail sheet from Salesforce?

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Application for Medicare Supplement

Personal Information (please print)

Applicant's Name _____ **Date of Birth** _____
First Middle Initial Last Month Day Year

Legal Address _____ **Age** _____
Street Address

_____ ☐ **Male** ☐ **Female**
City State ZIP Code

Mailing Address _____
Street Address

_____ **Phone Number** (_____)_____
City State ZIP Code

Email Address _____ **Social Security Number** _____-_____-_____
(For service and product updates from us.)

Medicare Supplement Plan Information

Requested Effective Date _____ **Date of Application** _____
Month Day Year Month Day Year

Applicant's Medicare Number (Please write legibly) |_|_|_|_|_|_|_|_|_|_|_|

Enter exactly as shown on your red, white and blue Medicare Card. If you're not yet enrolled in Medicare, or have enrolled but not yet received your Medicare card, leave this line blank.

Plan Selection (check only one Plan)

☐ **Plan A** [P070]
☐ **Innovative Plan G Wellness Plus** [P076 + F034]
☐ **Plan N Wellness Plus** [P079]
☐ **Plan G Wellness Plus** [P076]
☐ **High Deductible Plan G Wellness Plus** [P078]
☐ **Plan F Wellness Plus** [P075] (only for those first eligible for Medicare prior to January 1, 2020)

Payment Options: ☐ Monthly Automatic Bank Withdrawal
Direct Bill: ☐ Monthly ☐ Quarterly ☐ Semiannual ☐ Annual

Premium Collected $_____ Modal Premium $_____

Household Premium Discount

You may qualify for a premium discount based on a YES answer to either of the following questions:

Do you have a household resident (at least one but no more than three) that is age 60 or older, with whom you have continuously resided for the last 12 months? ☐ **YES** ☐ **NO**

Do you reside in a household with your spouse*? ☐ **YES** ☐ **NO**

*Spouse includes Registered Domestic Partner, Civil Union Partner, or party to a domestic partnership between two adults, as recognized by state law.

If you answered "YES" to either of the questions above, please complete the information below:

Name of household resident/spouse* _____

Address _____

Date of Birth _____

Information About Your Existing Coverage

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for Guaranteed Issue of a Medicare Supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare Supplement plans. Please include a copy of the notice from your prior insurer with your application.

PLEASE ANSWER ALL QUESTIONS. (Some of the information can be found on your Medicare card.)

To the best of your knowledge:

1. **Are you covered under Medicare Part A?** ☐ YES ☐ NO

   If yes, what is your Part A effective date? (Month/Day/Year) _____

   If no, what date are you eligible for Part A? (Month/Day/Year) _____

2. **Are you covered under Medicare Part B?** ☐ YES ☐ NO

   If yes, what is your Part B effective date? (Month/Day/Year) _____

   If no, what is your planned Part B effective date? (Month/Day/Year) _____

3. **Did you turn age 65 in the last six months?** ☐ YES ☐ NO

4. **Did you enroll in Medicare Part B in the last six months?** ☐ YES ☐ NO

   If yes, what is your effective date? (Month/Day/Year) _____

5. **Are you covered for medical assistance through the state Medicaid program?** ☐ YES ☐ NO

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

   If yes:

   a. Will Medicaid pay your premiums for this Medicare Supplement policy? ☐ YES ☐ NO

   b. Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B or Part D premium? ☐ YES ☐ NO

6. **Have you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO)?** ☐ YES ☐ NO

   If yes,

   a. Fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.

      Start Date _____ (Month Day Year) End Date _____ (Month Day Year)

   b. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy? ☐ YES ☐ NO

      If yes, what is your requested date of termination/disenrollment? (Month/Day/Year) _____

   c. Was this your first time in this type of Medicare plan? ☐ YES ☐ NO

   d. Did you drop a Medicare Supplement policy to enroll in the Medicare plan? ☐ YES ☐ NO

7. **Do you have another Medicare Supplement policy in force?** ☐ YES ☐ NO

   If yes,

   a. Do you intend to replace your current Medicare Supplement policy with this policy? ☐ YES ☐ NO

      If yes, what is your planned date of termination/disenrollment? (Month/Day/Year) _____

   b. With what company and what plan do you have?

      Company _____

      Plan (e.g. Plan F, Plan G) _____

8. **Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union or individual plan)** ☐ YES ☐ NO

   a. **If so,** with what company and what kind of policy?

      Company _____

      ☐ **Employer Plan** ☐ **Union Plan** ☐ **Individual Plan** ☐ **Other** _____

   b. What are your dates of coverage under the other policy? (If you are still covered under this plan, leave "END" blank)

      Start Date _____ (Month Day Year) End Date _____ (Month Day Year)

   c. If you are still covered by the policy described above, do you intend to replace your current coverage with this new Medicare Supplement policy? ☐ YES ☐ NO

      If yes, what is your planned date of termination/disenrollment? (Month/Day/Year) _____

Information About Your Health

The answers you provide in this section help us determine if you qualify for coverage. If you qualify for Open Enrollment or provide a copy of a notice you received from your prior insurer indicating you are eligible for Guarantee Issue, you do not need to answer questions 9 – 24.

9. Please provide your height ___ /_____ (ft./in.) and weight _____ (lbs.)

10. Have you used any form of tobacco, an electronic cigarette or other nicotine products in the past 12 months? ☐ YES ☐ NO

Answer questions 11 – 17.

11. Within the past 24 months, have you had, been treated for, or been told by a medical professional that you have any of the following:

- Chronic kidney disease (stages 3, 4 or 5); kidney failure or kidney disease requiring dialysis ☐ YES ☐ NO
- Diabetes requiring the use of insulin or any diabetes when in combination with heart disease (excluding high blood pressure) ☐ YES ☐ NO
- Arthritis that restricts mobility or daily activities, requires physical therapy, requires major joint (hip, knee, shoulder) injection(s) or you have been advised to have a joint replacement; Rheumatoid Arthritis ☐ YES ☐ NO
- Liver Disease; chronic hepatitis; cirrhosis; pancreatitis; alcoholism or drug abuse ☐ YES ☐ NO
- Bipolar disease; schizophrenia or any other psychotic disorders ☐ YES ☐ NO
- Drugs administered by intravenous (IV) infusion, other than during an emergency room visit, hospitalization, or surgery ☐ YES ☐ NO

12. Within the past 36 months, have you had, been treated for, or been told by a medical professional that you have internal cancer; cancer in need of surveillance or cancer that has gone into remission within the past three years; blood cancer(s); leukemia; lymphoma; melanoma or a non-routine medical test to rule out or confirm the presence of cancer that has not been completed? ☐ YES ☐ NO

13. Within the past 5 years, have you had a recurrence of a previous cancer (excluding non-melanoma skin cancers)? ☐ YES ☐ NO

14. Have you ever been treated for or diagnosed with metastatic cancer (cancer that has spread to other parts of the body)? ☐ YES ☐ NO

15. Do you use oxygen as treatment for diagnosed medical condition? ☐ YES ☐ NO

16. Have you been admitted to the hospital within the past three months? ☐ YES ☐ NO

17. Has a medical professional advised or discussed as a treatment option that you may need surgery (includes cataract surgery) or drugs administered by intravenous (IV) infusion? ☐ YES ☐ NO

NOTE: If you answered "YES" to any item in question 11 – 17 you will not qualify for coverage.

Answer questions 18 – 24 only if you will be 69 years of age or older on the effective date of the coverage for which you are applying. Otherwise, skip questions 18 – 24.

18. Within the past 24 months, have you had, been treated for, or been told by a medical professional that you have any of the following:

- Coronary artery disease; atherosclerosis; heart attack; heart surgery (includes angioplasty, heart stent, or bypass); angina ☐ YES ☐ NO
- Congestive heart failure; cardiomyopathy; enlarged heart; heart valve disorder; atrial fibrillation or other heart rhythm disorder; implanted cardiac defibrillator; pulmonary hypertension; unoperated aneurysm; peripheral vascular disease; embolus or deep vein thrombosis (DVT) ☐ YES ☐ NO
- Stroke; transient ischemic attack (TIA); carotid artery disease; cerebrovascular disease ☐ YES ☐ NO
- Osteoporosis with fracture; degenerative bone disease; spinal stenosis; skin grafts; amputation or fracture caused by disease ☐ YES ☐ NO
- Chronic obstructive pulmonary disease (COPD); chronic bronchitis; emphysema or any chronic pulmonary disorder ☐ YES ☐ NO
- Myasthenia Gravis; Grave's Disease; wet macular degeneration; systemic lupus erythematosus (SLE) ☐ YES ☐ NO
- Multiple Sclerosis; Amyotrophic Lateral Sclerosis (ALS); Parkinson's Disease; Huntington's Disease ☐ YES ☐ NO
- Alzheimer's Disease; dementia, or any other cognitive disorder ☐ YES ☐ NO
- Acquired Immune Deficiency Syndrome (AIDS), and/or Positive HIV and/or AIDS Related Complex (ARC) ☐ YES ☐ NO

19. Have you been hospitalized or confined to a nursing home or residing in an assisted-living facility within the past 90 days, or have you been hospitalized two or more times in the past 12 months? ☐ YES ☐ NO

20. Are you confined to a bed, or do you require the use of a wheelchair or any motorized mobility device? ☐ YES ☐ NO

21. Have you had or been recommended to have an organ or stem cell transplant (excluding cornea transplants)? ☐ YES ☐ NO

22. Has a medical professional advised or discussed as a treatment option that you may need a non-routine medical procedure within the next 12 months? ☐ YES ☐ NO

23. Do you have **both** High Blood Pressure and Diabetes **and** any of the following is true: a) take three or more medications for either condition, b) increased dosage or addition of medication for either condition in the past two years, c) have diabetic complications (peripheral neuropathy; diabetic retinopathy)? ☐ YES ☐ NO

NOTE: If you answered "YES" to any item in question 18 – 23 you will not qualify for coverage.

24. In the past 12 months, have you taken or been advised to take any prescription medication(s)?..... ☐ YES ☐ NO

If "YES", indicate the specifics below:

Name of Medication	Disease-Disorder-Condition	How long have you been taking this medication?

Important Statements to be Read by Medicare Supplement Applicant

(1) You do not need more than one Medicare Supplement policy.

(2) If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

(3) You may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy.

(4) If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing Medicaid eligibility. If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

(5) If you are eligible for, and have enrolled in a Medicare Supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare Supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.

(6) Counseling services may be available in your state to provide advice concerning your purchase of Medicare Supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

The Undersigned applicant and agent certify that the applicant has read, or had read to him or her, the completed application and that the applicant realizes that any false statement or misrepresentation in the application may result in loss of coverage under the policy.

I represent and agree that all information stated in this application is complete and correct to the best of my knowledge. I understand no coverage is in force until the Company issues a policy showing a Policy Effective Date and the first full premium has been paid.

X_____
Applicant's Signature

Date Application Completed _____ Dated at _____
Month Day Year City State

I represent and agree that I have truly and accurately recorded in this application all information supplied by the applicant and personally witnessed (his-her) signature. I also certify that only Company approved sales material was used in connection with this sale.

This Medicare Supplement policy ☐ **does replace** ☐ **does not replace** any insurance presently in force.

X _____	_____	_____
Licensed Resident Agent's Signature	Licensed Resident Agent's Printed Name	Licensed Resident Agent's NPN
X _____	_____	_____
Licensed Resident Agent's Signature	Licensed Resident Agent's Printed Name	Licensed Resident Agent's NPN
X _____	_____	_____
Licensed Resident Agent's Signature	Licensed Resident Agent's Printed Name	Licensed Resident Agent's NPN
X _____	_____	_____
Licensed Resident Agent's Signature	Licensed Resident Agent's Printed Name	Licensed Resident Agent's NPN

To Be Filled Out By Agent

1. List any other health insurance policies you have sold the applicant which are still in force.

_____

2. List any other health insurance policies you have sold the applicant in the past five (5) years which are no longer in force

_____

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Physicians Life Insurance Company
Physicians Select Insurance Company
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Electronic Welcome Package Consent

We will email your welcome package via an Adobe Acrobat PDF. You may request a paper copy of your materials anytime at no cost by contacting us at 1-800-228-9100.

Do you consent to receive the welcome package electronically? ☐ Yes ☐ No

X _____ _____

Applicant's Signature Date

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2600 Dodge Street
Omaha, NE 68131-2671
1.800.228.9100

Physicians Mutual Insurance Company, Inc. Acknowledgment

The renewal provision of the policy for which I am applying this date has been explained to me. I understand the policy cannot be cancelled by the Company unless they do not receive my premium before the 31-day grace period ends, in which case my coverage stops at the end of the grace period. The Company may change the premium only if the same change is made for all policies of the same form and class held by residents of my state. The premium is based on attained age, I understand my Renewal Premium may change each year on or after my birthday. I further acknowledge receipt of the Outline of Coverage, the Guide to Health Insurance for People with Medicare, and the Notice to Applicant Regarding Replacement of Medicare Supplement Insurance or Medicare Advantage and all other forms unique to my state of residence. I understand I may be interviewed by telephone to verify the application information.

X _____ _____

Applicant's Signature Date

PM2466 Rev.0726

Agent's Statement

Are you related to any proposed insured by blood or marriage? ☐ Yes ☐ No

What is your relationship? _____

PM2470

Business Owner Waiver

As the owner of _____, I understand this individual health insurance policy(s) is not and will not be considered a group health plan according to the Employee Retirement Income Security Act (ERISA). Therefore, the premium being paid by the business account will not be used as a business expense. I understand I should contact my tax advisor about the deductions of health insurance premiums.

X _____ _____

Business Owner's Signature Date

PM1902A Rev. 1010

Additional Information Regarding Current or Pending Coverage

Does anyone proposed for coverage have other health or life insurance coverage with Physicians Mutual Insurance Company, Inc., Physicians Life Insurance Company, or Physicians Select Insurance Company currently pending or issued within the last 90 days? If yes, please provide the following information:

Policyowner's Name _____

Policy Type(s) (Life, Cancer, etc.) _____

Policy Number(s) _____

Date Issued (If applicable) _____

PM2469 Rev. 0726

Telephone Interview for Underwritten Applications

Applicant has indicated the best available time (Central Standard Time) for a telephone interview is:

☐ 8 – 10 a.m. ☐ 10 a.m. – 12 p.m. ☐ 1 – 4 p.m.

The preferred phone number to reach the applicant is (_____) _____

PM2471 Rev. 0120

(Home Office Copy) Rev. 0726

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Physicians Life Insurance Company
Physicians Select Insurance Company
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Third Party Designee

I understand I can designate one person other than myself to be notified in the event of an unintentional lapse of my Medicare Supplement insurance policy. I understand the notice to my designee will not be given until 15 days after my premium is due and unpaid. I understand I may elect not to designate any person to receive such notice.

☐ Please notify the following person in the event my policy premium is not paid within 15 days of any premium due date.

Contact's Name _____

Address _____

City State ZIP

☐ I elect not to designate any person to receive such notice.

X _____ _____

Policyowner's Signature Date

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Physicians Mutual Insurance Company, Inc.
Physicians Life Insurance Company
Physicians Select Insurance Company
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Omaha, NE 68131-2671
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Authorization for Automatic Bank Withdrawal

Instructions

1. Select your withdrawal date.
   - If a withdrawal date is not selected, the premium will be withdrawn on or around the scheduled renewal date.
2. Sign and date the Authorization below.
3. Attach a voided check to this form; if a voided check is not available, complete bank information below.

Automatic Bank Withdrawal Date

Requested date of withdrawal _____

Date of the month 1st – 28th

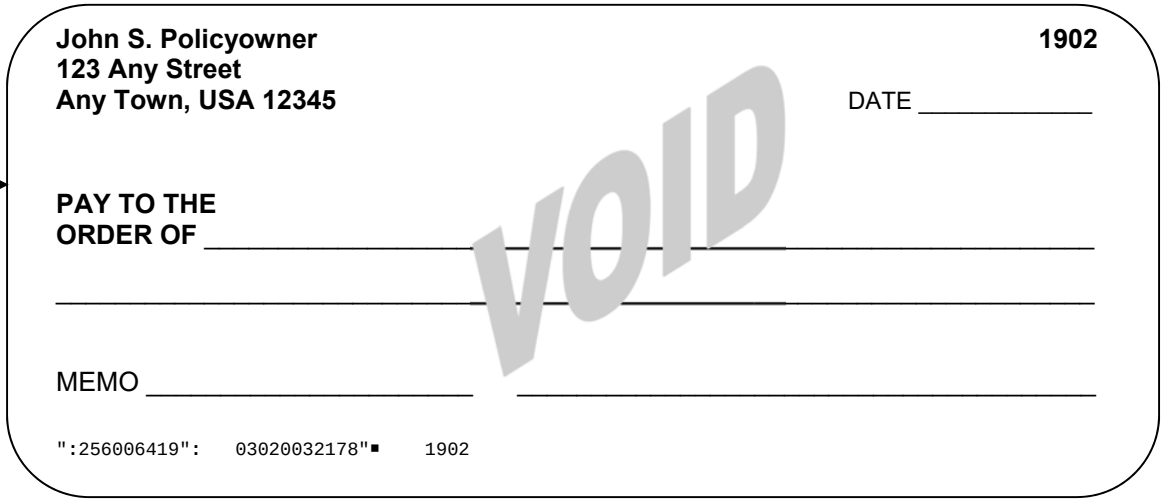
Authorization to Withdraw Funds by Physicians Mutual Insurance Company, Inc, Physicians Life Insurance Company and/or Physicians Select Insurance Company

I authorize the Company to initiate electronic debit entries to my account. I agree the Company's rights regarding each withdrawal will be the same as if I personally withdrew the funds. The withdrawals made by this method may be stopped by me with thirty (30) days written notice and is to remain in effect until you receive notice from me to revoke it. I understand this authorization can be discontinued immediately for any reason by the Company and will be discontinued if my account is closed or if there are insufficient funds on the scheduled date of the withdrawal.

X _____ _____

Bank Account Owner's Signature Date

Attach a voided check here. →



Bank Account Information (Only complete if you do not have a voided check)

Bank Name: _____ ☐ Checking ☐ Savings

City: _____ State: _____

Routing No.: ___ ___ ___ ___ ___ ___ ___ ___ ___ Account No.: _____

Physicians Mutual Insurance Company, Inc.
2600 Dodge Street
Omaha, NE 68131-2671
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HIPAA Authorization for Underwriting Purposes

I, the undersigned, authorize any health plan, licensed physician, medical practitioner, hospital, clinic, medical or medical related facility, pharmacy, pharmacy benefit manager, the Veteran's Administration, insurance company, consumer reporting agency, employer or Government agency to disclose medical and non-medical information about me or my minor children.

This authorization was prepared for the purpose of obtaining medical and non-medical information necessary to underwrite the application for insurance submitted with this authorization. The information subject to this authorization includes any and all medical and non-medical information being requested by Physicians Mutual Insurance Company, Inc. for the purpose stated above, as well as any information provided to Physicians Mutual Insurance Company on previous applications. This authorization includes information about drug and alcohol use, Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), sexually transmitted disease, and mental illness. This authorization excludes psychotherapy notes and any genetic information, as defined by GINA, including any family medical history. The information authorized in this release may include records which may indicate the presence of a communicable or non-communicable disease.

Persons or entities employed by or authorized by Physicians Mutual Insurance Company to perform tasks related to the underwriting process are hereby authorized to use the medical and non-medical information covered by this authorization. I understand that if the person or entity who receives this information is not a health care provider or health plan covered by federal privacy regulations, the information may be redisclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.

I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by Physicians Mutual Insurance Company, so long as Physicians Mutual Insurance Company has a legal right to contest a claim under the coverage or contest the coverage itself. Revocation requests must be sent in writing to: ATTN: Underwriting Department, Physicians Mutual Insurance Company, Inc., 2600 Dodge Street, Omaha, NE 68131-2671.

I understand that my application for insurance may be declined if I choose not to sign this authorization. This authorization is valid for a period of twenty-four (24) months from the date of my signature. A copy of this authorization may be used in place of the original. I acknowledge that I or my authorized representative has received a copy of this authorization.

If this authorization is signed by my personal representative, that individual's authority to act on my behalf is described below.

☐ I elect to be interviewed if an investigative consumer report is prepared. I understand that upon written request, I may obtain a copy of this report.

(Print) Name Applicant #1 Whose Information is Covered by This Authorization _____ Date of Birth _____

X _____

Signature of Applicant #1 or Personal Representative _____ Date _____

(Print) Name of Applicant #2 Whose Information Is Covered by This Authorization _____ Date of Birth _____

X _____

Signature of Applicant #2 or Personal Representative _____ Date _____

(Print) Name of Minor Child _____ Date of Birth _____ (Print) Name of Minor Child _____ Date of Birth _____

(Print) Name of Minor Child _____ Date of Birth _____ (Print) Name of Minor Child _____ Date of Birth _____

(Print) Name of Personal Representative of Applicant(s)/Minor(s) Whose Information is Covered by This Authorization _____

Personal Representative's Relationship to Applicant(s)/Minor(s) or Description of Authority _____

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Physicians Mutual® Insurance for all of us.®

HIPAA Authorization for Underwriting Purposes

I, the undersigned, authorize any health plan, licensed physician, medical practitioner, hospital, clinic, medical or medical related facility, pharmacy, pharmacy benefit manager, the Veteran's Administration, insurance company, consumer reporting agency, employer or Government agency to disclose medical and non-medical information about me or my minor children.

This authorization was prepared for the purpose of obtaining medical and non-medical information necessary to underwrite the application for insurance submitted with this authorization. The information subject to this authorization includes any and all medical and non-medical information being requested by Physicians Mutual Insurance Company, Inc. for the purpose stated above, as well as any information provided to Physicians Mutual Insurance Company on previous applications. This authorization includes information about drug and alcohol use, Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), sexually transmitted disease, and mental illness. This authorization excludes psychotherapy notes and any genetic information, as defined by GINA, including any family medical history. The information authorized in this release may include records which may indicate the presence of a communicable or non-communicable disease.

Persons or entities employed by or authorized by Physicians Mutual Insurance Company to perform tasks related to the underwriting process are hereby authorized to use the medical and non-medical information covered by this authorization. I understand that if the person or entity who receives this information is not a health care provider or health plan covered by federal privacy regulations, the information may be redisclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.

I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by Physicians Mutual Insurance Company, so long as Physicians Mutual Insurance Company has a legal right to contest a claim under the coverage or contest the coverage itself. Revocation requests must be sent in writing to: ATTN: Underwriting Department, Physicians Mutual Insurance Company, Inc., 2600 Dodge Street, Omaha, NE 68131-2671.

I understand that my application for insurance may be declined if I choose not to sign this authorization. This authorization is valid for a period of twenty-four (24) months from the date of my signature. A copy of this authorization may be used in place of the original. I acknowledge that I or my authorized representative has received a copy of this authorization.

If this authorization is signed by my personal representative, that individual's authority to act on my behalf is described below.

☐ I elect to be interviewed if an investigative consumer report is prepared. I understand that upon written request, I may obtain a copy of this report.

(Print) Name Applicant #1 Whose Information is Covered by This Authorization — Date of Birth

X Signature on File

Signature of Applicant #1 or Personal Representative — Date

(Print) Name of Applicant #2 Whose Information Is Covered by This Authorization — Date of Birth

X Signature on File

Signature of Applicant #2 or Personal Representative — Date

(Print) Name of Minor Child — Date of Birth — (Print) Name of Minor Child — Date of Birth

(Print) Name of Minor Child — Date of Birth — (Print) Name of Minor Child — Date of Birth

(Print) Name of Personal Representative of Applicant(s)/Minor(s) Whose Information is Covered by This Authorization

Personal Representative's Relationship to Applicant(s)/Minor(s) or Description of Authority

Physicians Mutual Insurance Company, Inc.
2600 Dodge Street
Omaha, NE 68131-2671
1.800.228.9100

Physicians Mutual® Insurance for all of us.®

Receipt for Medicare Supplement Policy

(This does not create interim insurance)

Received from _____ on ____/____/____
Name on Check Month Day Year

the sum of $ _____ ☐ cash ☐ check for an application for a Medicare Supplement policy offered by Physicians Mutual Insurance Company, Inc. It is understood and agreed, no insurance shall be effective until the policy is issued and the first full premium has been paid. If the application is approved, the policy will become effective according to its terms as of the day the application was dated or on the first day of the month during which you became eligible for Medicare, whichever is later. If this policy is issued to replace an existing Physicians Mutual Insurance Company, Inc. policy, this policy will become effective when your existing coverage terminates.

All premium checks must be payable to Physicians Mutual Insurance Company, Inc. Do not make the check payable to the agent or leave the payee blank.

X _____ _____
Agent's Signature Date

PM2112 Rev. 0726

Telephone Interview

Information about the telephone interview:

- The telephone interview is an important part of your application with Physicians Mutual Insurance Company, Inc. We cannot process your application without the completion of your telephone interview.
- The telephone interview should take approximately 10 minutes.
- We will call you during the time indicated (Central Standard Time):

  ☐ 8 - 10 a.m.
  ☐ 10 a.m. - 12 p.m.
  ☐ 1 - 4 p.m.

  If we are unsuccessful in contacting you, we will attempt to call you at another time.
- "Physicians Mutual" may not display on Caller ID system.

How you can help with the telephone interview process:

- Be prepared to discuss current and past health conditions listed on your application.
- Have all information about prescription medications readily available, such as:
  - Name of medication
  - Amount taken
  - Dosage
  - What the medication is taken for
  - How long you have taken the medication
  - When the medication was last prescribed by your physician

Physicians Mutual® Insurance for all of us.®

Physicians Mutual Insurance Company, Inc.
Physicians Life Insurance Company
Physicians Select Insurance Company
2600 Dodge Street
Omaha, NE 68131-2671
1.800.228.9100

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

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

According to your application, you intend to terminate existing Medicare Supplement or Medicare Advantage insurance and replace it with a policy to be issued by Physicians Mutual Insurance Company, Inc. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

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

Statement to the Applicant by Issuer, Agent or Other Representative

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

☐ Additional benefits
☐ No change in benefits, but lower premiums
☐ Fewer benefits and lower premiums
☐ My plan has outpatient prescription drug coverage and I am enrolling in Part D
☐ Disenrollment from a Medicare Advantage plan. Please explain reasoning for disenrollment:_____

_____

☐ Other (please specify)_____

_____

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

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

Signatures

X _____ _____
Applicant's Signature Date

X _____ _____
Agent or Other Representative's Signature Date
only if purchased through an agent

Physicians Mutual Insurance Company, Inc.
Physicians Life Insurance Company
Physicians Select Insurance Company
2600 Dodge Street
Omaha, NE 68131-2671
1.800.228.9100

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

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☐ Disenrollment from a Medicare Advantage plan. Please explain reasoning for disenrollment:_____

_____

☐ Other (please specify)_____

_____

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

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

Signatures

X Signature on File _____ _____
Applicant's Signature Date

X _____ _____
Agent or Other Representative's Signature Date
only if purchased through an agent

Physicians Mutual® Insurance for all of us.®

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Physicians Life Insurance Company
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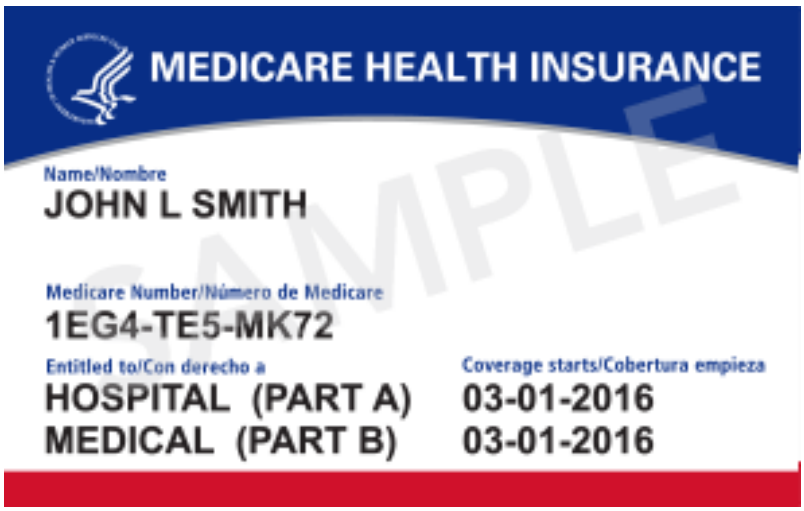
Omaha, NE 68131-2671
1.800.228.9100

Proof of Medicare Eligibility

Valid proof of Medicare enrollment is required to process this application. Use this form to record the information found on the applicant's Medicare Health Insurance card.



MEDICARE	HEALTH INSURANCE

Please submit the following information:

NAME (print) _____

MEDICARE NUMBER ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

HOSPITAL (PART A) EFFECTIVE DATE ____ ____ — 0 1 — ____ ____ ____ ____
M M D D Y Y Y Y

MEDICAL (PART B) EFFECTIVE DATE ____ ____ — 0 1 — ____ ____ ____ ____
M M D D Y Y Y Y

Are both Medicare Parts A & B coverage active? YES ☐ NO ☐

I (we) certify the above information was taken directly from the applicant's Medicare card.

X _____ _____
Applicant's Signature Date

X _____ _____
Agent's Signature Date

PHYSICIANS MUTUAL INSURANCE COMPANY, INC.

Benefit Chart of Medicare Supplement Plans sold on or after January 1, 2020

This chart shows the benefits included in each of the standard Medicare Supplement plans. Some plans may not be available. Only applicants first eligible for Medicare before 2020 may purchase Plans C, F and High Deductible F. We currently offer Plan A, Plan F, Plan G, High Deductible Plan G and Plan N.

Note: a ✓ means 100% of the benefit is paid.

Benefits	Plans Available to All Applicants								Medicare first eligible before 2020 only	
	A	B	D	G[1]	K	L	M	N	C	F[1]
Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Medicare Part B coinsurance or copayment	✓	✓	✓	✓	50%	75%	✓	✓ copays apply[3]	✓	✓
Blood (first three pints)	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Part A hospice care coinsurance or copayment	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Skilled nursing facility coinsurance			✓	✓	50%	75%	✓	✓	✓	✓
Medicare Part A deductible		✓	✓	✓	50%	75%	50%	✓	✓	✓
Medicare Part B deductible									✓	✓
Medicare Part B excess charges				✓						✓
Foreign travel emergency (up to plan limits)			✓	✓			✓	✓	✓	✓
Out-of-pocket limit in 2026					$8,000	$4,000				

[1] Plans F and G also have a high deductible option which require first paying a plan deductible of $2,950 before the plan begins to pay. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High Deductible Plan G does not cover the Medicare Part B deductible. However, high deductible Plans F and G count your payment of the Medicare Part B deductible toward meeting the plan deductible.

Physicians Mutual also offers a Deductible Discount Rider to add to Plan G. The addition of the Rider will provide the same benefits as a High Deductible Plan G from the effective date of the Policy until the Deductible Elimination Date as defined on the Policy Schedule. On or after the Deductible Elimination Date, the benefits provided will be Plan G benefits.

[2] Plans K and L pay 100% of covered services for the rest of the calendar year once you meet the out-of-pocket yearly limit.

[3] Plan N pays 100% of the Part B coinsurance, except for a co-payment of up to $20 for some office visits and up to a $50 co-payment for emergency room visits that do not result in an inpatient admission.

MONTHLY NON-TOBACCO PREMIUMS ZIP CODES: 480-485												
FEMALE						Attained Age	MALE					
Plan A	Plan F	Plan G	Plan G w/ Rider*	Plan HDG	Plan N		Plan A	Plan F	Plan G	Plan G w/ Rider*	Plan HDG	Plan N
$230.18	$295.93	$263.56	$168.30	$70.97	$244.26	65	$254.41	$327.09	$291.31	$186.01	$78.43	$269.98
$236.63	$304.22	$270.94	$173.00	$73.66	$251.10	66	$261.54	$336.24	$299.47	$191.23	$81.41	$277.53
$243.25	$312.73	$278.52	$177.84	$76.46	$258.15	67	$268.86	$345.66	$307.85	$196.57	$84.52	$285.31
$250.06	$321.49	$286.33	$182.84	$79.37	$265.37	68	$276.39	$355.33	$316.47	$202.07	$87.72	$293.30
$257.07	$330.49	$294.34	$187.94	$82.39	$272.80	69	$284.13	$365.28	$325.33	$207.74	$91.06	$301.52
$264.26	$339.75	$302.58	$193.20	$85.52	$280.44	70	$292.08	$375.51	$334.44	$213.55	$94.52	$309.95
$271.66	$349.26	$311.06	$198.62	$88.77	$288.29	71	$300.26	$386.02	$343.81	$219.54	$98.11	$318.64
$279.27	$359.05	$319.77	$204.18	$92.14	$296.36	72	$308.66	$396.83	$353.43	$225.68	$101.84	$327.55
$287.09	$369.09	$328.72	$209.90	$95.64	$304.65	73	$317.30	$407.95	$363.33	$231.99	$105.71	$336.73
$295.13	$379.43	$337.92	$215.77	$99.28	$313.19	74	$326.20	$419.36	$373.50	$238.49	$109.72	$346.16
$303.40	$390.05	$347.39	$221.82	$103.05	$321.96	75	$335.32	$431.11	$383.95	$245.16	$113.90	$355.84
$311.89	$400.97	$357.11	$228.02	$106.96	$330.97	76	$344.72	$443.19	$394.70	$252.02	$118.22	$365.80
$320.62	$412.20	$367.11	$234.41	$111.03	$340.24	77	$354.37	$455.59	$405.76	$259.09	$122.72	$376.06
$329.60	$423.74	$377.40	$240.99	$115.24	$349.77	78	$364.29	$468.35	$417.11	$266.33	$127.39	$386.59
$338.83	$435.61	$387.96	$247.72	$119.63	$359.56	79	$374.49	$481.45	$428.80	$273.80	$132.22	$397.40
$348.31	$447.80	$398.83	$254.67	$124.17	$369.63	80	$384.98	$494.94	$440.81	$281.47	$137.24	$408.54
$358.06	$460.34	$409.99	$261.79	$128.89	$379.97	81	$395.76	$508.80	$453.15	$289.35	$142.46	$419.97
$368.09	$473.23	$421.47	$269.12	$133.78	$390.62	82	$406.84	$523.04	$465.83	$297.44	$147.88	$431.73
$378.40	$486.49	$433.28	$276.66	$138.88	$401.55	83	$418.23	$537.69	$478.88	$305.77	$153.49	$443.82
$388.73	$499.76	$445.10	$284.21	$144.05	$412.51	84	$429.65	$552.37	$491.95	$314.13	$159.21	$455.93
$399.07	$513.05	$456.95	$291.78	$149.32	$423.49	85	$441.07	$567.06	$505.03	$322.47	$165.04	$468.06
$409.40	$526.35	$468.77	$299.32	$154.69	$434.45	86	$452.50	$581.75	$518.12	$330.83	$170.97	$480.19
$419.72	$539.61	$480.58	$306.86	$160.14	$445.40	87	$463.90	$596.40	$531.17	$339.17	$176.98	$492.29
$430.01	$552.82	$492.36	$314.39	$165.65	$456.31	88	$475.27	$611.02	$544.19	$347.49	$183.09	$504.34
$440.23	$565.98	$504.08	$321.87	$171.25	$467.17	89	$486.58	$625.56	$557.14	$355.76	$189.28	$516.36
$450.41	$579.06	$515.72	$329.30	$176.92	$477.97	90	$497.83	$640.02	$570.01	$363.97	$195.54	$528.28
$460.50	$592.03	$527.27	$336.68	$182.65	$488.67	91	$508.97	$654.35	$582.79	$372.14	$201.88	$540.12
$470.48	$604.88	$538.72	$343.99	$188.45	$499.27	92	$520.02	$668.55	$595.42	$380.19	$208.29	$551.83
$480.37	$617.58	$550.03	$351.21	$194.29	$509.76	93	$530.94	$682.59	$607.93	$388.18	$214.74	$563.42
$490.12	$630.12	$561.20	$358.35	$200.18	$520.12	94	$541.71	$696.45	$620.27	$396.06	$221.25	$574.87
$499.72	$642.47	$572.20	$365.37	$206.10	$530.31	95	$552.33	$710.10	$632.43	$403.83	$227.80	$586.13
$509.17	$654.61	$583.01	$372.27	$212.06	$540.33	96	$562.77	$723.52	$644.38	$411.45	$234.39	$597.20
$518.44	$666.53	$593.62	$379.05	$218.03	$550.16	97	$573.01	$736.69	$656.11	$418.94	$240.98	$608.08
$527.51	$678.19	$604.01	$385.68	$224.04	$559.78	98	$583.04	$749.58	$667.59	$426.27	$247.62	$618.72
$536.37	$689.59	$614.16	$392.17	$230.04	$569.19	99+	$592.83	$762.17	$678.81	$433.43	$254.25	$629.11

See Premium Information regarding eligibility for the Household Discount 10%

To calculate other modal premiums, first apply the Household Discount, if eligible, and then for monthly premiums add $5.00 to the A.B.W. premium, or for other modes, multiply the A.B.W. premium by the following factors: Annual – 12, Semiannual – 6, Quarterly – 3.

*Rider is the optional Deductible Discount Rider, only available with Plan G.

MONTHLY TOBACCO PREMIUMS
ZIP CODES: 480-485

FEMALE						Attained Age	MALE					
Plan A	Plan F	Plan G	Plan G w/ Rider*	Plan HDG	Plan N		Plan A	Plan F	Plan G	Plan G w/ Rider*	Plan HDG	Plan N
$255.76	$328.81	$292.85	$187.00	$78.86	$271.40	65	$282.68	$363.43	$323.68	$206.68	$87.15	$299.98
$262.92	$338.02	$301.05	$192.23	$81.85	$279.00	66	$290.60	$373.60	$332.74	$212.47	$90.46	$308.37
$270.28	$347.48	$309.47	$197.60	$84.96	$286.83	67	$298.73	$384.07	$342.06	$218.42	$93.91	$317.01
$277.85	$357.21	$318.14	$203.15	$88.19	$294.86	68	$307.10	$394.81	$351.63	$224.52	$97.47	$325.89
$285.63	$367.21	$327.05	$208.83	$91.54	$303.11	69	$315.70	$405.87	$361.48	$230.82	$101.18	$335.02
$293.62	$377.50	$336.20	$214.67	$95.02	$311.60	70	$324.53	$417.23	$371.60	$237.28	$105.02	$344.39
$301.85	$388.07	$345.62	$220.69	$98.63	$320.32	71	$333.62	$428.91	$382.01	$243.93	$109.01	$354.04
$310.30	$398.94	$355.30	$226.87	$102.38	$329.29	72	$342.96	$440.92	$392.70	$250.76	$113.16	$363.95
$318.99	$410.10	$365.24	$233.22	$106.27	$338.50	73	$352.56	$453.28	$403.70	$257.77	$117.46	$374.14
$327.92	$421.59	$375.47	$239.75	$110.31	$347.99	74	$362.44	$465.96	$415.00	$264.99	$121.91	$384.62
$337.11	$433.39	$385.99	$246.47	$114.50	$357.73	75	$372.58	$479.01	$426.61	$272.40	$126.56	$395.38
$346.54	$445.52	$396.79	$253.36	$118.84	$367.74	76	$383.02	$492.43	$438.56	$280.03	$131.36	$406.45
$356.25	$458.00	$407.90	$260.46	$123.37	$378.04	77	$393.75	$506.21	$450.85	$287.88	$136.36	$417.84
$366.22	$470.82	$419.33	$267.76	$128.05	$388.63	78	$404.77	$520.39	$463.46	$295.93	$141.54	$429.54
$376.48	$484.01	$431.07	$275.25	$132.92	$399.51	79	$416.10	$534.95	$476.44	$304.22	$146.91	$441.56
$387.01	$497.56	$443.14	$282.96	$137.97	$410.70	80	$427.76	$549.93	$489.79	$312.74	$152.49	$453.93
$397.85	$511.49	$455.54	$290.87	$143.21	$422.19	81	$439.73	$565.33	$503.50	$321.50	$158.29	$466.63
$408.99	$525.81	$468.30	$299.02	$148.65	$434.02	82	$452.05	$581.16	$517.59	$330.49	$164.31	$479.70
$420.44	$540.54	$481.42	$307.40	$154.31	$446.17	83	$464.70	$597.43	$532.09	$339.75	$170.54	$493.13
$431.92	$555.29	$494.56	$315.79	$160.06	$458.35	84	$477.39	$613.75	$546.61	$349.03	$176.90	$506.59
$443.41	$570.06	$507.72	$324.20	$165.91	$470.54	85	$490.08	$630.07	$561.15	$358.31	$183.38	$520.07
$454.89	$584.83	$520.86	$332.58	$171.88	$482.72	86	$502.78	$646.39	$575.69	$367.59	$189.97	$533.54
$466.36	$599.57	$533.98	$340.96	$177.93	$494.89	87	$515.45	$662.67	$590.19	$376.86	$196.65	$546.99
$477.79	$614.25	$547.07	$349.32	$184.06	$507.01	88	$528.08	$678.91	$604.66	$386.10	$203.43	$560.38
$489.15	$628.87	$560.09	$357.63	$190.28	$519.08	89	$540.64	$695.07	$619.05	$395.29	$210.31	$573.73
$500.46	$643.40	$573.02	$365.89	$196.58	$531.08	90	$553.14	$711.13	$633.35	$404.42	$217.27	$586.98
$511.67	$657.81	$585.86	$374.09	$202.95	$542.97	91	$565.52	$727.06	$647.54	$413.48	$224.31	$600.13
$522.76	$672.09	$598.58	$382.21	$209.39	$554.75	92	$577.80	$742.83	$661.58	$422.44	$231.43	$613.15
$533.74	$686.20	$611.15	$390.24	$215.88	$566.40	93	$589.93	$758.43	$675.48	$431.31	$238.60	$626.02
$544.58	$700.13	$623.56	$398.17	$222.42	$577.91	94	$601.90	$773.83	$689.19	$440.07	$245.83	$638.74
$555.25	$713.86	$635.78	$405.97	$229.00	$589.23	95	$613.70	$789.00	$702.70	$448.70	$253.11	$651.26
$565.74	$727.34	$647.79	$413.63	$235.62	$600.37	96	$625.30	$803.91	$715.98	$457.17	$260.43	$663.56
$576.05	$740.59	$659.58	$421.17	$242.26	$611.29	97	$636.68	$818.54	$729.01	$465.49	$267.76	$675.64
$586.12	$753.54	$671.12	$428.53	$248.93	$621.98	98	$647.82	$832.87	$741.77	$473.64	$275.13	$687.47
$595.97	$766.21	$682.40	$435.74	$255.60	$632.43	99+	$658.70	$846.86	$754.23	$481.59	$282.50	$699.01

See Premium Information regarding eligibility for the Household Discount 10%
To calculate other modal premiums, first apply the Household Discount, if eligible, and then for monthly premiums add $5.00 to the A.B.W. premium, or for other modes, multiply the A.B.W. premium by the following factors: Annual – 12, Semiannual – 6, Quarterly – 3.
*Rider is the optional Deductible Discount Rider, only available with Plan G.

MONTHLY NON-TOBACCO PREMIUMS
ZIP CODES: 486-489, 492-495

FEMALE						Attained Age	MALE					
Plan A	Plan F	Plan G	Plan G w/ Rider*	Plan HDG	Plan N		Plan A	Plan F	Plan G	Plan G w/ Rider*	Plan HDG	Plan N
$198.79	$255.57	$227.63	$145.35	$61.30	$210.95	65	$219.72	$282.48	$251.59	$160.65	$67.74	$233.16
$204.36	$262.74	$234.00	$149.42	$63.62	$216.86	66	$225.87	$290.39	$258.63	$165.15	$70.32	$239.69
$210.08	$270.09	$240.54	$153.58	$66.04	$222.94	67	$232.19	$298.52	$265.87	$169.77	$72.99	$246.40
$215.96	$277.65	$247.28	$157.90	$68.54	$229.18	68	$238.70	$306.87	$273.31	$174.52	$75.76	$253.30
$222.01	$285.43	$254.20	$162.31	$71.15	$235.59	69	$245.38	$315.47	$280.97	$179.41	$78.64	$260.40
$228.22	$293.42	$261.32	$166.86	$73.85	$242.20	70	$252.25	$324.31	$288.84	$184.44	$81.63	$267.69
$234.62	$301.63	$268.64	$171.54	$76.66	$248.98	71	$259.32	$333.38	$296.93	$189.61	$84.73	$275.18
$241.19	$310.09	$276.16	$176.34	$79.58	$255.94	72	$266.57	$342.72	$305.23	$194.90	$87.96	$282.89
$247.94	$318.76	$283.90	$181.28	$82.60	$263.11	73	$274.03	$352.32	$313.78	$200.35	$91.30	$290.81
$254.88	$327.69	$291.84	$186.35	$85.74	$270.48	74	$281.72	$362.18	$322.57	$205.98	$94.76	$298.95
$262.03	$336.86	$300.02	$191.57	$89.00	$278.05	75	$289.59	$372.32	$331.60	$211.74	$98.37	$307.32
$269.36	$346.29	$308.41	$196.93	$92.38	$285.83	76	$297.71	$382.75	$340.88	$217.66	$102.10	$315.93
$276.90	$355.99	$317.05	$202.44	$95.89	$293.84	77	$306.04	$393.46	$350.43	$223.76	$105.98	$324.77
$284.65	$365.96	$325.93	$208.12	$99.53	$302.08	78	$314.61	$404.49	$360.23	$230.01	$110.02	$333.87
$292.63	$376.21	$335.06	$213.95	$103.32	$310.53	79	$323.42	$415.80	$370.32	$236.46	$114.18	$343.21
$300.82	$386.74	$344.44	$219.93	$107.24	$319.22	80	$332.49	$427.45	$380.70	$243.09	$118.53	$352.83
$309.24	$397.57	$354.08	$226.08	$111.31	$328.16	81	$341.78	$439.42	$391.36	$249.90	$123.04	$362.70
$317.90	$408.70	$364.00	$232.42	$115.54	$337.35	82	$351.36	$451.72	$402.31	$256.88	$127.71	$372.86
$326.80	$420.15	$374.19	$238.93	$119.94	$346.80	83	$361.20	$464.36	$413.58	$264.08	$132.56	$383.30
$335.72	$431.61	$384.41	$245.46	$124.41	$356.26	84	$371.06	$477.04	$424.86	$271.28	$137.50	$393.76
$344.65	$443.10	$394.63	$251.98	$128.96	$365.73	85	$380.92	$489.73	$436.17	$278.51	$142.53	$404.23
$353.57	$454.57	$404.85	$258.51	$133.60	$375.21	86	$390.80	$502.42	$447.46	$285.71	$147.66	$414.71
$362.48	$466.03	$415.05	$265.02	$138.29	$384.67	87	$400.64	$515.08	$458.74	$292.92	$152.85	$425.16
$371.37	$477.44	$425.22	$271.52	$143.06	$394.08	88	$410.46	$527.70	$469.99	$300.11	$158.12	$435.57
$380.20	$488.81	$435.34	$277.98	$147.90	$403.47	89	$420.23	$540.26	$481.17	$307.25	$163.47	$445.94
$388.99	$500.09	$445.39	$284.39	$152.79	$412.79	90	$429.94	$552.74	$492.28	$314.34	$168.88	$456.25
$397.70	$511.30	$455.37	$290.77	$157.75	$422.04	91	$439.56	$565.12	$503.32	$321.39	$174.35	$466.46
$406.33	$522.40	$465.25	$297.07	$162.75	$431.19	92	$449.11	$577.39	$514.23	$328.35	$179.88	$476.59
$414.86	$533.37	$475.03	$303.32	$167.80	$440.24	93	$458.54	$589.51	$525.03	$335.25	$185.45	$486.58
$423.29	$544.19	$484.68	$309.49	$172.88	$449.19	94	$467.84	$601.48	$535.69	$342.06	$191.08	$496.48
$431.58	$554.86	$494.17	$315.55	$177.99	$457.99	95	$477.01	$613.27	$546.19	$348.77	$196.74	$506.20
$439.73	$565.34	$503.51	$321.50	$183.14	$466.65	96	$486.03	$624.86	$556.51	$355.34	$202.42	$515.77
$447.75	$575.64	$512.68	$327.37	$188.31	$475.14	97	$494.87	$636.23	$566.64	$361.82	$208.12	$525.16
$455.58	$585.71	$521.64	$333.08	$193.49	$483.45	98	$503.53	$647.36	$576.56	$368.16	$213.85	$534.35
$463.23	$595.55	$530.41	$338.68	$198.67	$491.57	99+	$511.99	$658.24	$586.24	$374.33	$219.58	$543.32

See Premium Information regarding eligibility for the Household Discount 10%

To calculate other modal premiums, first apply the Household Discount, if eligible, and then for monthly premiums add $5.00 to the A.B.W. premium, or for other modes, multiply the A.B.W. premium by the following factors: Annual – 12, Semiannual – 6, Quarterly – 3.

*Rider is the optional Deductible Discount Rider, only available with Plan G.

MONTHLY TOBACCO PREMIUMS
ZIP CODES: 486-489, 492-495

FEMALE						Attained Age	MALE					
Plan A	Plan F	Plan G	Plan G w/ Rider*	Plan HDG	Plan N		Plan A	Plan F	Plan G	Plan G w/ Rider*	Plan HDG	Plan N
$220.88	$283.97	$252.92	$161.50	$68.11	$234.39	65	$244.13	$313.87	$279.54	$178.50	$75.27	$259.07
$227.07	$291.93	$260.00	$166.02	$70.69	$240.96	66	$250.97	$322.66	$287.37	$183.50	$78.13	$266.32
$233.42	$300.10	$267.27	$170.65	$73.38	$247.71	67	$257.99	$331.69	$295.41	$188.63	$81.10	$273.78
$239.96	$308.50	$274.76	$175.45	$76.16	$254.65	68	$265.22	$340.97	$303.68	$193.91	$84.18	$281.45
$246.68	$317.14	$282.45	$180.35	$79.06	$261.77	69	$272.65	$350.52	$312.19	$199.35	$87.38	$289.33
$253.58	$326.02	$290.36	$185.40	$82.06	$269.11	70	$280.28	$360.34	$320.93	$204.93	$90.70	$297.43
$260.69	$335.15	$298.49	$190.60	$85.18	$276.64	71	$288.13	$370.42	$329.92	$210.67	$94.15	$305.76
$267.99	$344.54	$306.85	$195.94	$88.42	$284.38	72	$296.19	$380.80	$339.15	$216.56	$97.73	$314.32
$275.49	$354.18	$315.44	$201.42	$91.78	$292.34	73	$304.48	$391.47	$348.65	$222.62	$101.44	$323.12
$283.20	$364.10	$324.27	$207.06	$95.27	$300.53	74	$313.02	$402.42	$358.41	$228.86	$105.29	$332.17
$291.14	$374.29	$333.36	$212.86	$98.89	$308.95	75	$321.77	$413.69	$368.44	$235.26	$109.30	$341.47
$299.29	$384.77	$342.68	$218.81	$102.64	$317.59	76	$330.79	$425.28	$378.76	$241.85	$113.45	$351.03
$307.67	$395.54	$352.28	$224.94	$106.54	$326.49	77	$340.05	$437.18	$389.37	$248.63	$117.76	$360.86
$316.28	$406.62	$362.15	$231.25	$110.59	$335.64	78	$349.57	$449.43	$400.26	$255.57	$122.24	$370.97
$325.14	$418.01	$372.29	$237.72	$114.80	$345.03	79	$359.36	$462.00	$411.47	$262.74	$126.87	$381.35
$334.24	$429.71	$382.71	$244.37	$119.16	$354.69	80	$369.43	$474.94	$423.00	$270.10	$131.70	$392.03
$343.60	$441.74	$393.42	$251.20	$123.68	$364.62	81	$379.76	$488.24	$434.84	$277.66	$136.71	$403.00
$353.22	$454.11	$404.44	$258.24	$128.38	$374.83	82	$390.40	$501.91	$447.01	$285.42	$141.90	$414.29
$363.11	$466.83	$415.77	$265.48	$133.27	$385.33	83	$401.33	$515.96	$459.53	$293.42	$147.29	$425.89
$373.02	$479.57	$427.12	$272.73	$138.23	$395.85	84	$412.29	$530.05	$472.07	$301.43	$152.78	$437.51
$382.95	$492.33	$438.48	$279.98	$143.29	$406.37	85	$423.25	$544.15	$484.63	$309.45	$158.37	$449.15
$392.86	$505.08	$449.83	$287.23	$148.44	$416.90	86	$434.22	$558.25	$497.18	$317.46	$164.07	$460.79
$402.76	$517.81	$461.17	$294.47	$153.66	$427.41	87	$445.16	$572.31	$509.71	$325.47	$169.83	$472.40
$412.63	$530.49	$472.47	$301.69	$158.96	$437.87	88	$456.07	$586.33	$522.21	$333.45	$175.69	$483.97
$422.45	$543.12	$483.71	$308.86	$164.33	$448.30	89	$466.92	$600.29	$534.63	$341.38	$181.63	$495.49
$432.21	$555.66	$494.88	$315.99	$169.77	$458.66	90	$477.71	$614.16	$546.98	$349.27	$187.64	$506.94
$441.89	$568.11	$505.97	$323.08	$175.28	$468.93	91	$488.40	$627.91	$559.24	$357.10	$193.72	$518.29
$451.48	$580.44	$516.95	$330.08	$180.83	$479.10	92	$499.01	$641.54	$571.37	$364.84	$199.87	$529.54
$460.96	$592.63	$527.81	$337.02	$186.44	$489.16	93	$509.49	$655.01	$583.37	$372.50	$206.06	$540.65
$470.32	$604.66	$538.53	$343.87	$192.09	$499.10	94	$519.82	$668.31	$595.21	$380.06	$212.31	$551.64
$479.53	$616.51	$549.08	$350.61	$197.77	$508.88	95	$530.01	$681.41	$606.88	$387.52	$218.60	$562.45
$488.59	$628.16	$559.46	$357.23	$203.49	$518.50	96	$540.03	$694.29	$618.35	$394.83	$224.91	$573.08
$497.50	$639.60	$569.64	$363.74	$209.23	$527.93	97	$549.86	$706.92	$629.60	$402.02	$231.25	$583.51
$506.20	$650.79	$579.60	$370.09	$214.99	$537.17	98	$559.48	$719.29	$640.62	$409.06	$237.61	$593.72
$514.70	$661.72	$589.34	$376.31	$220.74	$546.19	99+	$568.88	$731.38	$651.38	$415.92	$243.98	$603.69

See Premium Information regarding eligibility for the Household Discount 10%

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*Rider is the optional Deductible Discount Rider, only available with Plan G.

MONTHLY NON-TOBACCO PREMIUMS
ZIP CODES: 490-491, 496-499

FEMALE						Attained Age	MALE					
Plan A	Plan F	Plan G	Plan G w/ Rider*	Plan HDG	Plan N		Plan A	Plan F	Plan G	Plan G w/ Rider*	Plan HDG	Plan N
$188.33	$242.13	$215.65	$137.70	$58.07	$199.85	65	$208.15	$267.61	$238.35	$152.20	$64.18	$220.90
$193.61	$248.90	$221.68	$141.54	$60.27	$205.45	66	$213.98	$275.11	$245.02	$156.45	$66.62	$227.08
$199.03	$255.87	$227.89	$145.51	$62.57	$211.21	67	$219.97	$282.82	$251.87	$160.83	$69.15	$233.43
$204.60	$263.04	$234.27	$149.59	$64.93	$217.12	68	$226.13	$290.73	$258.92	$165.32	$71.77	$239.97
$210.32	$270.40	$240.83	$153.78	$67.41	$223.20	69	$232.47	$298.86	$266.18	$169.97	$74.50	$246.69
$216.22	$277.97	$247.57	$158.08	$69.97	$229.45	70	$238.98	$307.23	$273.64	$174.73	$77.33	$253.59
$222.27	$285.76	$254.50	$162.51	$72.62	$235.87	71	$245.66	$315.84	$281.29	$179.61	$80.27	$260.70
$228.49	$293.76	$261.63	$167.06	$75.38	$242.48	72	$252.54	$324.68	$289.17	$184.64	$83.32	$267.99
$234.89	$301.99	$268.96	$171.74	$78.25	$249.26	73	$259.61	$333.77	$297.27	$189.82	$86.49	$275.51
$241.47	$310.44	$276.49	$176.55	$81.22	$256.25	74	$266.89	$343.12	$305.59	$195.13	$89.77	$283.22
$248.23	$319.13	$284.23	$181.49	$84.31	$263.42	75	$274.36	$352.72	$314.14	$200.59	$93.19	$291.15
$255.19	$328.07	$292.18	$186.57	$87.52	$270.79	76	$282.04	$362.60	$322.94	$206.20	$96.73	$299.29
$262.32	$337.25	$300.37	$191.79	$90.85	$278.37	77	$289.94	$372.75	$331.98	$211.97	$100.40	$307.68
$269.68	$346.70	$308.78	$197.17	$94.29	$286.17	78	$298.05	$383.19	$341.28	$217.92	$104.22	$316.30
$277.23	$356.41	$317.42	$202.68	$97.88	$294.18	79	$306.40	$393.92	$350.84	$224.03	$108.18	$325.15
$284.98	$366.39	$326.31	$208.36	$101.60	$302.42	80	$314.98	$404.95	$360.66	$230.29	$112.29	$334.25
$292.96	$376.64	$335.45	$214.19	$105.45	$310.89	81	$323.80	$416.29	$370.76	$236.74	$116.56	$343.61
$301.17	$387.19	$344.84	$220.19	$109.47	$319.59	82	$332.87	$427.95	$381.14	$243.37	$120.99	$353.23
$309.60	$398.03	$354.50	$226.36	$113.62	$328.54	83	$342.19	$439.93	$391.81	$250.18	$125.59	$363.12
$318.05	$408.90	$364.18	$232.54	$117.86	$337.51	84	$351.53	$451.94	$402.51	$257.02	$130.27	$373.04
$326.51	$419.78	$373.86	$238.72	$122.17	$346.48	85	$360.88	$463.96	$413.22	$263.86	$135.04	$382.96
$334.97	$430.64	$383.54	$244.90	$126.57	$355.46	86	$370.22	$475.98	$423.92	$270.69	$139.89	$392.89
$343.40	$441.49	$393.21	$251.08	$131.02	$364.42	87	$379.56	$487.97	$434.60	$277.51	$144.80	$402.78
$351.83	$452.31	$402.85	$257.24	$135.54	$373.35	88	$388.85	$499.92	$445.25	$284.31	$149.80	$412.65
$360.19	$463.08	$412.42	$263.34	$140.11	$382.23	89	$398.11	$511.82	$455.84	$291.07	$154.86	$422.47
$368.51	$473.78	$421.96	$269.44	$144.76	$391.07	90	$407.31	$523.65	$466.37	$297.79	$159.99	$432.23
$376.78	$484.39	$431.41	$275.47	$149.44	$399.82	91	$416.43	$535.37	$476.82	$304.47	$165.18	$441.91
$384.95	$494.90	$440.77	$281.44	$154.19	$408.50	92	$425.47	$546.99	$487.17	$311.08	$170.41	$451.50
$393.03	$505.30	$450.03	$287.36	$158.97	$417.08	93	$434.40	$558.48	$497.39	$317.60	$175.70	$460.98
$401.00	$515.55	$459.16	$293.19	$163.78	$425.55	94	$443.21	$569.82	$507.50	$324.06	$181.02	$470.34
$408.86	$525.65	$468.16	$298.93	$168.62	$433.88	95	$451.91	$580.99	$517.45	$330.41	$186.38	$479.56
$416.59	$535.59	$477.01	$304.59	$173.50	$442.09	96	$460.45	$591.97	$527.22	$336.65	$191.77	$488.63
$424.18	$545.34	$485.69	$310.13	$178.40	$450.13	97	$468.83	$602.75	$536.82	$342.78	$197.17	$497.52
$431.60	$554.89	$494.19	$315.55	$183.30	$458.01	98	$477.04	$613.30	$546.22	$348.78	$202.60	$506.22
$438.85	$564.21	$502.49	$320.85	$188.21	$465.70	99+	$485.05	$623.59	$555.38	$354.62	$208.03	$514.72

See Premium Information regarding eligibility for the Household Discount 10%

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MONTHLY TOBACCO PREMIUMS
ZIP CODES: 490-491, 496-499

FEMALE						Attained Age	MALE					
Plan A	Plan F	Plan G	Plan G w/ Rider*	Plan HDG	Plan N		Plan A	Plan F	Plan G	Plan G w/ Rider*	Plan HDG	Plan N
$209.26	$269.03	$239.61	$153.00	$64.52	$222.06	65	$231.28	$297.35	$264.83	$169.11	$71.31	$245.44
$215.12	$276.56	$246.31	$157.27	$66.97	$228.28	66	$237.76	$305.68	$272.24	$173.83	$74.02	$252.31
$221.14	$284.30	$253.21	$161.68	$69.52	$234.68	67	$244.41	$314.24	$279.86	$178.70	$76.83	$259.37
$227.33	$292.27	$260.30	$166.21	$72.15	$241.25	68	$251.26	$323.03	$287.69	$183.69	$79.75	$266.63
$233.69	$300.45	$267.59	$170.87	$74.90	$248.00	69	$258.30	$332.07	$295.76	$188.86	$82.78	$274.10
$240.24	$308.86	$275.08	$175.65	$77.74	$254.94	70	$265.53	$341.37	$304.04	$194.14	$85.92	$281.77
$246.97	$317.51	$282.78	$180.57	$80.69	$262.08	71	$272.96	$350.93	$312.55	$199.57	$89.19	$289.67
$253.88	$326.40	$290.70	$185.62	$83.76	$269.42	72	$280.60	$360.76	$321.30	$205.16	$92.58	$297.77
$260.99	$335.54	$298.84	$190.82	$86.95	$276.96	73	$288.46	$370.86	$330.30	$210.91	$96.10	$306.12
$268.30	$344.93	$307.21	$196.17	$90.25	$284.72	74	$296.54	$381.24	$339.54	$216.81	$99.75	$314.69
$275.81	$354.59	$315.81	$201.65	$93.68	$292.69	75	$304.84	$391.91	$349.05	$222.88	$103.55	$323.50
$283.54	$364.52	$324.65	$207.30	$97.24	$300.88	76	$313.38	$402.89	$358.82	$229.11	$107.48	$332.55
$291.47	$374.72	$333.74	$213.10	$100.94	$309.30	77	$322.16	$414.17	$368.87	$235.53	$111.56	$341.87
$299.64	$385.22	$343.09	$219.08	$104.77	$317.97	78	$331.17	$425.77	$379.20	$242.13	$115.80	$351.44
$308.03	$396.01	$352.69	$225.20	$108.76	$326.87	79	$340.44	$437.69	$389.82	$248.92	$120.20	$361.28
$316.65	$407.10	$362.57	$231.51	$112.89	$336.02	80	$349.98	$449.95	$400.73	$255.87	$124.77	$371.39
$325.51	$418.49	$372.72	$237.99	$117.17	$345.43	81	$359.78	$462.55	$411.96	$263.05	$129.51	$381.79
$334.63	$430.21	$383.16	$244.66	$121.63	$355.10	82	$369.86	$475.50	$423.49	$270.41	$134.43	$392.48
$344.00	$442.26	$393.89	$251.51	$126.25	$365.05	83	$380.21	$488.81	$435.35	$277.98	$139.54	$403.47
$353.39	$454.33	$404.64	$258.37	$130.96	$375.01	84	$390.59	$502.16	$447.23	$285.57	$144.74	$414.49
$362.79	$466.42	$415.40	$265.24	$135.75	$384.98	85	$400.98	$515.51	$459.13	$293.17	$150.04	$425.51
$372.19	$478.49	$426.16	$272.12	$140.63	$394.96	86	$411.36	$528.87	$471.02	$300.76	$155.43	$436.54
$381.56	$490.55	$436.90	$278.98	$145.58	$404.91	87	$421.73	$542.19	$482.89	$308.34	$160.89	$447.53
$390.92	$502.57	$447.61	$285.82	$150.60	$414.83	88	$432.06	$555.47	$494.72	$315.90	$166.45	$458.50
$400.21	$514.53	$458.25	$292.60	$155.68	$424.70	89	$442.34	$568.69	$506.49	$323.41	$172.07	$469.41
$409.46	$526.42	$468.84	$299.37	$160.84	$434.52	90	$452.57	$581.83	$518.19	$330.88	$177.77	$480.26
$418.64	$538.21	$479.34	$306.07	$166.05	$444.25	91	$462.70	$594.86	$529.80	$338.30	$183.53	$491.01
$427.72	$549.89	$489.74	$312.71	$171.32	$453.89	92	$472.74	$607.77	$541.30	$345.64	$189.35	$501.67
$436.70	$561.44	$500.03	$319.28	$176.63	$463.42	93	$482.67	$620.53	$552.66	$352.89	$195.22	$512.20
$445.56	$572.83	$510.18	$325.77	$181.98	$472.83	94	$492.46	$633.13	$563.89	$360.07	$201.13	$522.60
$454.29	$584.06	$520.18	$332.15	$187.36	$482.09	95	$502.12	$645.54	$574.94	$367.12	$207.09	$532.85
$462.88	$595.10	$530.01	$338.43	$192.78	$491.21	96	$511.61	$657.75	$585.80	$374.05	$213.08	$542.92
$471.31	$605.93	$539.66	$344.59	$198.22	$500.15	97	$520.92	$669.72	$596.47	$380.87	$219.08	$552.80
$479.56	$616.54	$549.10	$350.61	$203.67	$508.90	98	$530.04	$681.44	$606.91	$387.53	$225.11	$562.47
$487.61	$626.90	$558.32	$356.50	$209.12	$517.45	99+	$538.94	$692.88	$617.09	$394.02	$231.14	$571.91

See Premium Information regarding eligibility for the Household Discount 10%

To calculate other modal premiums, first apply the Household Discount, if eligible, and then for monthly premiums add $5.00 to the A.B.W. premium, or for other modes, multiply the A.B.W. premium by the following factors: Annual – 12, Semiannual – 6, Quarterly – 3.

*Rider is the optional Deductible Discount Rider, only available with Plan G.

PREMIUM INFORMATION

We, Physicians Mutual Insurance Company, Inc., can only raise your premium if we raise the premium for all Policies of this form and class in your state. Premiums based on Attained Age will also be changed on or after your birthday each year. In addition, premiums may also increase to cover changes in Medicare benefits and inflation. NOTE: All Plans referenced in the rate pages except for Plan A are the Physicians Mutual Insurance Company, Inc. Wellness Plus Policies.

HOUSEHOLD DISCOUNT

If you either reside in a household with your spouse, or with another person (but no more than three) that is age 60 or older and has continuously resided with you for the last 12 months, we will provide you a 10% Household Discount off of your Medicare Supplement premium. The discount is applied prior to adding $5.00 for monthly direct premiums if you select this mode.

If you do not qualify for the Household Discount when your Policy is first issued, you may qualify at a later date if the above qualifications are met and we receive a completed Household Discount Questionnaire that reflects an attestation to the resident information.

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY

This is only an outline describing your Policy's most important features. The Policy is your insurance contract. You must read the Policy itself to understand all of the rights and duties of both you and your insurance company.

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your Policy, you may return it to Physicians Mutual Insurance Company, Inc., 2600 Dodge Street, Omaha, NE 68131. If you send the Policy back to us within 30 days after you receive it, we will treat the Policy as if it had never been issued and return all of your payments.

POLICY REPLACEMENT

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

NOTICE

This Policy may not fully cover all of your medical costs. Neither Physicians Mutual Insurance Company, Inc. nor its agents are connected with Medicare. This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult *Medicare and You* for more details.

LIMITATIONS AND EXCLUSIONS

We will not pay for:

a) Confinement that begins or expenses incurred while your Policy is not in force, or
b) Services of the type not covered by Medicare, unless specifically provided by the Policy.

COMPLETE ANSWERS ARE VERY IMPORTANT

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

PHYSICIANS MUTUAL INSURANCE COMPANY, INC.
MEDICARE SUPPLEMENT OUTLINE OF COVERAGE

Plan A

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

P-070 Series

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,736	$0	$1,736 (Part A Deductible)
61st thru 90 day	All but $434 a day	$434 a day	$0
91st day and after - While using 60 lifetime reserve days	All but $868 a day	$868 a day	$0
Once lifetime reserve days are used: - Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
- Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $217 a day	$0	Up to $217 a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional Amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copay/coinsurance for outpatient drugs and inpatient care	Medicare copayment/coinsurance	$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

Plan A

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed $283 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $283 of Medicare approved amounts*	$0	$0	$283 (Part B Deductible)
Remainder of Medicare approved amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare approved amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $283 of Medicare approved amounts*	$0	$0	$283 (Part B Deductible)
Remainder of Medicare approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
- First $283 of Medicare approved amounts*	$0	$0	$283 (Part B Deductible)
- Remainder of Medicare approved amounts	80%	20%	$0

Plan F
Wellness Plus

PHYSICIANS MUTUAL INSURANCE COMPANY, INC.
MEDICARE SUPPLEMENT OUTLINE OF COVERAGE
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

P-070 Series

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,736	$1,736 (Part A Deductible)	$0
61st thru 90 day	All but $434 a day	$434 a day	$0
91st day and after - While using 60 lifetime reserve days	All but $868 a day	$868 a day	$0
Once lifetime reserve days are used: - Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
- Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $217 a day	Up to $217 a day	$0
101st day and after	$0	$0	All costs
BLOOD First 3 pints	$0	3 pints	$0
Additional Amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copay/coinsurance for outpatient drugs and inpatient care	Medicare copayment/coinsurance	$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

Plan F
Wellness Plus

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed $283 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $283 of Medicare approved amounts*	$0	$283 (Part B Deductible)	$0
Remainder of Medicare approved amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare approved amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $283 of Medicare approved amounts*	$0	$283 (Part B Deductible)	$0
Remainder of Medicare approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
- First $283 of Medicare approved amounts*	$0	$283 (Part B Deductible)	$0
- Remainder of Medicare approved amounts	80%	20%	$0

Plan F
Wellness Plus

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the U.S.A. First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PREVENTIVE HEALTH CARE

We will pay the expenses incurred by You for Preventive Health Care services as defined below, if such expenses are determined to be medically appropriate by an attending Physician and such expenses are not paid for by Medicare or any other provision of this Policy.

Preventive Health Care: Expenses incurred by You for health care services to prevent or detect illness at an early stage, prior to the development of any symptoms, and subject to the following exclusions:

1. Dental services defined by American Dental Association Current Dental Terminology (CDT) codes;
2. Chiropractic services, acupuncture and acupressure services;
3. Weight loss treatment of any type;
4. Prescription drugs or over-the-counter drugs; supplements or tests including COVID tests and colonoscopy prep;
5. All vision services;
6. Experimental preventive services;
7. Any test, screening or procedure to determine the likelihood of developing or passing on to children any disease or disorder, including but not limited to genetic testing
8. Hearing loss testing

ADDITIONAL GOODS & SERVICES

From time to time We may arrange for third-party service providers to provide You access to discounted goods and/or services. There is no additional cost to You. We are not responsible for delivery, failure or negligence issues associated with these goods and services.

To access details about these discounts and third-party service providers, You may contact Us directly. Access to these goods and services will discontinue upon termination of Your insurance or termination of Our arrangements with the providers, whichever comes first.

Plan G
Wellness Plus

PHYSICIANS MUTUAL INSURANCE COMPANY, INC.
MEDICARE SUPPLEMENT OUTLINE OF COVERAGE
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

P-070 Series

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,736	$1,736 (Part A Deductible)	$0
61st thru 90 day	All but $434 a day	$434 a day	$0
91st day and after - While using 60 lifetime reserve days	All but $868 a day	$868 a day	$0
Once lifetime reserve days are used: - Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
- Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $217 a day	Up to $217 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional Amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copay/coinsurance for outpatient drugs and inpatient care	Medicare copayment/coinsurance	$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

Plan G
Wellness Plus

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed $283 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $283 of Medicare approved amounts*	$0	$0	$283 (Part B Deductible)
Remainder of Medicare approved amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare approved amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $283 of Medicare approved amounts*	$0	$0	$283 (Part B Deductible)
Remainder of Medicare approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
- First $283 of Medicare approved amounts*	$0	$0	$283 (Part B Deductible)
- Remainder of Medicare approved amounts	80%	20%	$0

Plan G
Wellness Plus

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the U.S.A. First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PREVENTIVE HEALTH CARE

We will pay the expenses incurred by You for Preventive Health Care services as defined below, if such expenses are determined to be medically appropriate by an attending Physician and such expenses are not paid for by Medicare or any other provision of this Policy.

Preventive Health Care: Expenses incurred by You for health care services to prevent or detect illness at an early stage, prior to the development of any symptoms, and subject to the following exclusions:

1. Dental services defined by American Dental Association Current Dental Terminology (CDT) codes;
2. Chiropractic services, acupuncture and acupressure services;
3. Weight loss treatment of any type;
4. Prescription drugs or over-the-counter drugs; supplements or tests including COVID tests and colonoscopy prep;
5. All vision services;
6. Experimental preventive services;
7. Any test, screening or procedure to determine the likelihood of developing or passing on to children any disease or disorder, including but not limited to genetic testing
8. Hearing loss testing

ADDITIONAL GOODS & SERVICES

From time to time We may arrange for third-party service providers to provide You access to discounted goods and/or services. There is no additional cost to You. We are not responsible for delivery, failure or negligence issues associated with these goods and services.

To access details about these discounts and third-party service providers, You may contact Us directly. Access to these goods and services will discontinue upon termination of Your insurance or termination of Our arrangements with the providers, whichever comes first.

Plan G Wellness Plus with Deductible Discount Rider

PHYSICIANS MUTUAL INSURANCE COMPANY, INC.
MEDICARE SUPPLEMENT OUTLINE OF COVERAGE
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

P-070 Series

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

**This Plan G with the Plan G Deductible Discount Rider pays the same benefits as Plan G after you have first paid a calendar year deductible ($2,950 in 2026, subject to change annually). Benefits will not begin until out-of-pocket expenses meet the deductible. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible. On or after the Deductible Elimination Date as defined on the Policy Schedule, the calendar year deductible is zero.

SERVICES	MEDICARE PAYS	AFTER YOU PAY CALENDAR YEAR DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO CALENDAR YEAR DEDUCTIBLE,** YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,736	$1,736 (Part A Deductible)	$0
61st thru 90 day	All but $434 a day	$434 a day	$0
91st day and after - While using 60 lifetime reserve days	All but $868 a day	$868 a day	$0
Once lifetime reserve days are used: - Additional 365 days	$0	100% of Medicare Eligible Expenses	$0***
- Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $217 a day	Up to $217 a day	$0
101st day and after	$0	$0	All costs

***NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

MEDICARE (PART A) – CONTINUED

SERVICES	MEDICARE PAYS	AFTER YOU PAY CALENDAR YEAR DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO CALENDAR YEAR DEDUCTIBLE,** YOU PAY
BLOOD First 3 pints	$0	3 pints	$0
Additional Amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copay/coinsurance for outpatient drugs and inpatient care	Medicare copayment/coinsurance	$0

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed $283 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

**This Plan G with the Plan G Deductible Discount Rider pays the same benefits as Plan G after you have first paid a calendar year deductible ($2,950 in 2026, subject to change annually). Benefits will not begin until out-of-pocket expenses meet the deductible. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible. On or after the Deductible Elimination Date as defined on the Policy Schedule, the calendar year deductible is zero.

SERVICES	MEDICARE PAYS	AFTER YOU PAY CALENDAR YEAR DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO CALENDAR YEAR DEDUCTIBLE,** YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First $283 of Medicare approved amounts*	$0	$0	$283 (Unless Part B Deductible has been met)
Remainder of Medicare approved amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare approved amounts)	$0	100%	$0

MEDICARE (PART B) – CONTINUED

SERVICES	MEDICARE PAYS	AFTER YOU PAY CALENDAR YEAR DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO CALENDAR YEAR DEDUCTIBLE,** YOU PAY
BLOOD First 3 pints	$0	All costs	$0
Next $283 of Medicare approved amounts*	$0	$0	$283 (Unless Part B Deductible has been met)
Remainder of Medicare approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	AFTER YOU PAY CALENDAR YEAR DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO CALENDAR YEAR DEDUCTIBLE,** YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment - First $283 of Medicare approved amounts*	$0	$0	$283 (Unless Part B Deductible has been met)
- Remainder of Medicare approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY CALENDAR YEAR DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO CALENDAR YEAR DEDUCTIBLE,** YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the U.S.A. First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PREVENTIVE HEALTH CARE

We will pay the expenses incurred by You for Preventive Health Care services as defined below, if such expenses are determined to be medically appropriate by an attending Physician and such expenses are not paid for by Medicare or any other provision of this Policy. Benefits for Preventive Health Care will not be subject to the High Deductible.

Preventive Health Care: Expenses incurred by You for health care services to prevent or detect illness at an early stage, prior to the development of any symptoms, and subject to the following exclusions:

1. Dental services defined by American Dental Association Current Dental Terminology (CDT) codes;
2. Chiropractic services, acupuncture and acupressure services;
3. Weight loss treatment of any type;
4. Prescription drugs or over-the-counter drugs; supplements or tests including COVID tests and colonoscopy prep;
5. All vision services;
6. Experimental preventive services;
7. Any test, screening or procedure to determine the likelihood of developing or passing on to children any disease or disorder, including but not limited to genetic testing
8. Hearing loss testing

ADDITIONAL GOODS & SERVICES

From time to time We may arrange for third-party service providers to provide You access to discounted goods and/or services. There is no additional cost to You. We are not responsible for delivery, failure or negligence issues associated with these goods and services.

To access details about these discounts and third-party service providers, You may contact Us directly. Access to these goods and services will discontinue upon termination of Your insurance or termination of Our arrangements with the providers, whichever comes first.

High Deductible Plan G Wellness Plus

PHYSICIANS MUTUAL INSURANCE COMPANY, INC.
MEDICARE SUPPLEMENT OUTLINE OF COVERAGE
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

P-070 Series

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

**This high deductible plan pays the same benefits as Plan G after you have paid a calendar year $2,950 deductible. Benefits from the high deductible plan G will not begin until out-of-pocket expenses are $2,950. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,950 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO $2,950 DEDUCTIBLE,** YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,736	$1,736 (Part A Deductible)	$0
61st thru 90 day	All but $434 a day	$434 a day	$0
91st day and after - While using 60 lifetime reserve days	All but $868 a day	$868 a day	$0
Once lifetime reserve days are used: - Additional 365 days	$0	100% of Medicare Eligible Expenses	$0***
- Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $217 a day	Up to $217 a day	$0
101st day and after	$0	$0	All costs

***NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

High Deductible
Plan G Wellness
Plus

MEDICARE (PART A) – CONTINUED

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,950 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO $2,950 DEDUCTIBLE,** YOU PAY
BLOOD First 3 pints	$0	3 pints	$0
Additional Amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copay/coinsurance for outpatient drugs and inpatient care	Medicare copayment/coinsurance	$0

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed $283 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

**This high deductible plan pays the same benefits as Plan G after you have paid a calendar year $2,950 deductible. Benefits from the high deductible plan G will not begin until out-of-pocket expenses are $2,950. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,950 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO $2,950 DEDUCTIBLE,** YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First $283 of Medicare approved amounts*	$0	$0	$283 (Unless Part B Deductible has been met)
Remainder of Medicare approved amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare approved amounts)	$0	100%	$0

High Deductible
Plan G Wellness
Plus

MEDICARE (PART B) – CONTINUED

SERVICES	MEDICARE PAYS	AFTER YOU PAY $,2950 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO $2,950 DEDUCTIBLE,** YOU PAY
BLOOD First 3 pints	$0	All costs	$0
Next $283 of Medicare approved amounts*	$0	$0	$283 (Unless Part B Deductible has been met)
Remainder of Medicare approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,950 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO $2,950 DEDUCTIBLE,** YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment - First $283 of Medicare approved amounts*	$0	$0	$283 (Unless Part B Deductible has been met)
- Remainder of Medicare approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY $2,950 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO $2,950 DEDUCTIBLE,** YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the U.S.A. First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PREVENTIVE HEALTH CARE

We will pay the expenses incurred by You for Preventive Health Care services as defined below, if such expenses are determined to be medically appropriate by an attending Physician and such expenses are not paid for by Medicare or any other provision of this Policy. Benefits for Preventive Health Care will not be subject to the High Deductible.

Preventive Health Care: Expenses incurred by You for health care services to prevent or detect illness at an early stage, prior to the development of any symptoms, and subject to the following exclusions:

1. Dental services defined by American Dental Association Current Dental Terminology (CDT) codes;
2. Chiropractic services, acupuncture and acupressure services;
3. Weight loss treatment of any type;
4. Prescription drugs or over-the-counter drugs; supplements or tests including COVID tests and colonoscopy prep;
5. All vision services;
6. Experimental preventive services;
7. Any test, screening or procedure to determine the likelihood of developing or passing on to children any disease or disorder, including but not limited to genetic testing
8. Hearing loss testing

ADDITIONAL GOODS & SERVICES

From time to time We may arrange for third-party service providers to provide You access to discounted goods and/or services. There is no additional cost to You. We are not responsible for delivery, failure or negligence issues associated with these goods and services.

To access details about these discounts and third-party service providers, You may contact Us directly. Access to these goods and services will discontinue upon termination of Your insurance or termination of Our arrangements with the providers, whichever comes first.

Plan N
Wellness Plus

PHYSICIANS MUTUAL INSURANCE COMPANY, INC.
MEDICARE SUPPLEMENT OUTLINE OF COVERAGE
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

P-070 Series

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,736	$1,736 (Part A Deductible)	$0
61st thru 90 day	All but $434 a day	$434 a day	$0
91st day and after - While using 60 lifetime reserve days	All but $868 a day	$868 a day	$0
Once lifetime reserve days are used: - Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
- Beyond the Additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $217 a day	Up to $217 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional Amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copay/coinsurance for outpatient drugs and inpatient care	Medicare copayment/coinsurance	$0

**NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

Plan N
Wellness Plus

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed $283 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First $283 of Medicare approved amounts*	$0	$0	$283 (Part B Deductible)
Remainder of Medicare approved amounts	Generally 80%	Balance, other than up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency room visit is covered as a Medicare Part A expense.	Up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense
PART B EXCESS CHARGES (Above Medicare approved amounts)	$0	$0	All costs
BLOOD First 3 pints	$0	All costs	$0
Next $283 of Medicare approved amounts*	$0	$0	$283 (Part B Deductible)
Remainder of Medicare approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

Plan N
Wellness Plus

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment - First $283 of Medicare approved amounts*	$0	$0	$283 (Part B Deductible)
- Remainder of Medicare approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the U.S.A. First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

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2. Chiropractic services, acupuncture and acupressure services;
3. Weight loss treatment of any type;
4. Prescription drugs or over-the-counter drugs; supplements or tests including COVID tests and colonoscopy prep;
5. All vision services;
6. Experimental preventive services;
7. Any test, screening or procedure to determine the likelihood of developing or passing on to children any disease or disorder, including but not limited to genetic testing
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Physicians Mutual Insurance Company, Inc.
2600 Dodge Street
Omaha, NE 68131-2671
1.800.228.9100

Physicians Mutual® Insurance for all of us.®

Physicians Mutual Medicare Supplement Height/Weight Chart

Build Chart			
Height	Weight		
	Decline if Under Minimum	Accept	Decline if Over Maximum
4’ 10”	86	86 – 194	194
4’ 11”	89	89 – 201	201
5’ 0”	92	92 – 208	208
5’ 1”	95	95 – 215	215
5’ 2”	98	98 – 222	222
5’ 3”	101	101 – 229	229
5’ 4”	105	105 – 236	236
5’ 5”	108	108 – 243	243
5’ 6”	112	112 – 251	251
5’ 7”	115	115 – 258	258
5’ 8”	119	119 – 266	266
5’ 9”	122	122 – 274	274
5’ 10”	126	126 – 282	282
5’ 11”	130	130 – 290	290

Build Chart			
Height	Weight		
	Decline if Under Minimum	Accept	Decline if Over Maximum
6’ 0”	133	133 – 298	298
6’ 1”	137	137 – 306	306
6’ 2”	141	141 – 315	315
6’ 3”	145	145 – 323	323
6’ 4”	149	149 – 332	332
6’ 5”	153	153 – 340	340
6’ 6”	157	157 – 349	349
6’ 7”	161	161 – 358	358
6’ 8”	165	165 – 367	367
6’ 9”	170	170 – 376	376
6’ 10”	174	174 – 386	386
6’ 11”	178	178 – 395	395
7’ 0”	183	183 – 404	404

A person’s build below the minimum or over our maximum acceptable limits for height and weight will not be eligible for coverage.