LifeShield
NATIONAL INSURANCE CO

Home Office: PO BOX 14240,
Oklahoma City, OK 73113-0240

☐ **New Business** ☐ **Reinstatement**
☐ **Coverage Change** **Policy #:**_____

MEDICARE SUPPLEMENT INSURANCE APPLICATION

Part I – Personal Information

Gender	Last Name	First Name	MI	Date of Birth
☐ M ☐ F	•	•	•	/ /

Age	Social Security No.	Medicare ID No.
•	•	•

Address
•

City	State	Zip Code
•	•	•

Mailing Address (if different than residential address)
•

City	State	Zip Code
•	•	•

Daytime Phone Number	Cell Phone Number	E-Mail Address
•	•	•

Have you used any tobacco products, including cigarettes, cigars, chewing tobacco, a pipe, electronic cigarette (e-cig) or other nicotine product in the past 12 months? Yes ☐ No ☐

Part II – Plan Selection

Plan Applied For:

☐ A ☐ F* ☐ G ☐ N

Plan F is available **ONLY to those first eligible for Medicare before 1/1/2020.*

Part III – Eligibility

To the best of your knowledge:

1. Are you covered under Medicare Part A? Yes ☐ No ☐
   a) If YES, what is your Part A effective date: _____/_____/_____
   b) If NO, what is your eligibility date: _____/_____/_____
2. Are you covered under Medicare Part B? Yes ☐ No ☐
   a) If YES, what is your Part B effective date: _____/_____/_____
   b) If NO, what is your eligibility date: _____/_____/_____
3. Did you turn age 65 in the last 6 months? Yes ☐ No ☐

Part IV – Medicare & Insurance Information

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you are eligible for guaranteed issue of a Medicare Supplement Insurance policy, or 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 this Application. *Please mark "Yes" or "No" below with an "X", to the best of your knowledge.*

PLEASE ANSWER ALL QUESTIONS

Yes	No		
☐	☐	1)	Are you applying during a guaranteed issue period? (If YES, please attach proof of eligibility).
☐	☐	2)	Are you covered for Medical Assistance through the state Medicaid program?

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

☐	☐	a) Will Medicaid pay your premiums for this Medicare Supplement policy?
☐	☐	b) Do you receive any benefits from Medicaid, OTHER THAN payments toward your Part B Premium?

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

If you are still covered under this plan, leave *"Paid to"* blank.

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

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

If so, with which company? _____

Company Address: _____

☐	☐	c) Was this your first time in this type of Medicare Plan?
☐	☐	d) Did you drop a Medicare Supplement policy/certificate to enroll in the Medicare Plan?
☐	☐	4) a) Do you have another Medicare Supplement policy/certificate in force?

b) If so, with which company? _____ Paid to _____/_____/_____

Company Address: _____

What plan do you have: _____

☐	☐	c) If so, do you intend to replace your current Medicare Supplement policy/certificate with this policy? (If Yes, complete Replacement Notice.)
☐	☐	5) Have you had coverage under any other health insurance within the past 63 days? (for example, an employer, union or individual plan)

a) If so, with which company? _____

What kind of policy/certificate? _____

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

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

Which type of eligibility is the applicant qualified for: ☐ Open Enrollment ☐ Guaranteed Issue ☐ Underwritten

Requested Effective Date _____/_____/_____ (mm/dd/yyyy)

Part V – General Information

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, effective as of the date of termination of Medicaid, if requested within 90 days of losing your Medicaid eligibility. If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage but will otherwise be substantially equivalent to your coverage before the date of suspension.
5. If you are eligible for, and have enrolled in a Medicare Supplement policy 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).

Part VI – Household Premium Discount Information

You may be eligible for a policy with a lower premium rate based on your answers to the questions in this section.

1. Do you currently live with your spouse, including validly recognized civil union and domestic partners, or do you currently have a household resident (at least one, no more than three) with whom you have continuously resided for the last 12 months? Yes ☐ No ☐

2. If you answered "YES" to question 1 above, please fill out the following information about the household resident:

   Name (First/Middle/Last): _____

   Relationship to Applicant: _____

Part VII – Premium Payment & Administration

PREMIUM MODE: ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly EFT (Electronic Funds Transfer)

Premium: $ _____

Policy Fee*: (+) $ 25.00

Initial Total Premium (Includes the one-time Policy Fee**):** (=) $ _____

☐ Draft Initial Premium on _____/_____/_____

*This one-time fee will be refunded, along with your premium, if the policy is not issued or you return it during your 30-day free look.

Subsequent Premiums Paid By:

☐ Direct Bill ☐ EFT

☐ I authorize EFT Payments

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

☐ Draft Upon Approval ☐ Draft Upon Effective Date

☐ Premium Payment by Social Security Schedule ☐ Yes ☐ No (If "Yes", please choose only one below)

☐ 1st Monday	☐ 2nd Monday	☐ 3rd Monday	☐ 4th Monday
☐ 1st Tuesday	☐ 2nd Tuesday	☐ 3rd Tuesday	☐ 4th Tuesday
☐ 1st Wednesday	☐ 2nd Wednesday	☐ 3rd Wednesday	☐ 4th Wednesday
☐ 1st Thursday	☐ 2nd Thursday	☐ 3rd Thursday	☐ 4th Thursday
☐ 1st Friday	☐ 2nd Friday	☐ 3rd Friday	☐ 4th Friday

Account Type: ☐ Checking ☐ Savings

Bank Routing # (9 digits)

•

Bank Account # (do not include check #)

•

Bank Name

•

Name(s) of Depositor(s)

•

The first draft will occur on the date your Application is approved by the Company (unless specified otherwise). The Company will draft premiums due in the mode and from the account identified above for the life of the policy unless instructed in writing to do otherwise.

Please attach a voided check, if available.

Part VIII – Medical Questions

If this is an Open Enrollment or Guaranteed Issue application, DO NOT answer questions in this section.

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

Height: _____ Weight: _____

1. Are you currently hospitalized, in a nursing home or assisted living facility, confined to a bed, a wheelchair or any motorized device? Yes ☐ No ☐
2. Have you been diagnosed by a licensed medical professional with emphysema, chronic obstructive pulmonary disease (COPD), cardiopulmonary disorder requiring oxygen or other chronic pulmonary disorders? Yes ☐ No ☐
3. Have you been diagnosed by a licensed medical professional with cerebral palsy, systemic lupus, myasthenia gravis, multiple or lateral sclerosis, scleroderma, Huntington's disease, cirrhosis or chronic hepatitis? Yes ☐ No ☐
4. Have you been diagnosed by a licensed medical professional with Parkinson's disease, Alzheimer's disease, senile dementia, or any other cognitive disorder? Yes ☐ No ☐
5. Have you been diagnosed with or treated by a licensed medical professional for acquired immune deficiency syndrome (AIDS) or AIDS related complex (ARC) or tested positive for Human Immunodeficiency Virus (HIV)? Yes ☐ No ☐
6. Have you been advised by a licensed medical professional that surgery may be required within 12 months for cataracts? Yes ☐ No ☐
7. Have you been advised by a licensed medical professional to have treatment, further diagnostic evaluation, diagnostic testing, follow up visits or any surgery that has not been performed? Yes ☐ No ☐
8. Have you been hospital confined three or more times in the last two years? Yes ☐ No ☐
9. Have you had an organ or stem cell transplant or been advised by a licensed medical professional to have an organ or stem cell transplant (excluding cornea implants)? Yes ☐ No ☐
10. Have you been diagnosed with or treated by a licensed medical professional for chronic kidney disease, kidney failure, or kidney disease requiring dialysis? Yes ☐ No ☐
11. Do you have osteoporosis, and as a result, experienced a fracture? Yes ☐ No ☐
12. Do you have diabetes that has ever required more than 50 units of insulin daily or do you have diabetes in addition to the following: neuropathy, retinopathy, peripheral venous thrombotic disease, peripheral artery disease, any heart disorder, stroke, transient ischemic attack (TIA), or kidney disease? **If you do not have diabetes, this question should be answered "No".** Yes ☐ No ☐
13. Do you have diabetes with high blood pressure and have you:
    a. Taken more than two medications for either condition (insulin dependent or oral medications)? Yes ☐ No ☐
    b. Have there been any changes in your medications within the past two years? **If you do not have diabetes this question should be answered "No".** Yes ☐ No ☐
14. Within the past two years, have you been treated for or been advised by a licensed medical professional to have treatment for:
    a. Heart attack, coronary artery disease, angina, cardiac angioplasty, bypass surgery, enlarged heart or stent placement? Yes ☐ No ☐
    b. Cardiomyopathy, congestive heart failure, aortic or cardiac aneurysm, any heart or valve disorder, atrial fibrillation, other heart rhythm disorder or implantation of a pacemaker? Yes ☐ No ☐
    c. Peripheral artery disease, peripheral vascular disease, peripheral venous thrombotic disease, vascular angioplasty, carotid artery disease, endarterectomy, stroke or transient ischemic attack (TIA)? Yes ☐ No ☐
    d. Degenerative bone disease, spinal stenosis, rheumatoid arthritis, psoriatic arthritis, arthritis that restricts mobility or have you been advised to have a joint replacement? Yes ☐ No ☐
    e. Treatment for internal cancer, leukemia, lymphoma, multiple myeloma, melanoma, alcoholism, drug abuse, any mental or nervous disorder requiring treatment (including hospital confinement), psychiatric care, or have you had any amputation caused by disease? Yes ☐ No ☐
15. Do you have an implanted cardiac defibrillator? Yes ☐ No ☐

Part VIII – Medical Questions (continued)

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

Medication Name (copy off pharmacy label) • ______

Date Originally Prescribed ___/___/___

Dosage and Frequency • ______

Diagnosis/Medical Condition • ______

Medication Name (copy off pharmacy label) • ______

Date Originally Prescribed ___/___/___

Dosage and Frequency • ______

Diagnosis/Medical Condition • ______

Medication Name (copy off pharmacy label) • ______

Date Originally Prescribed ___/___/___

Dosage and Frequency • ______

Diagnosis/Medical Condition • ______

Medication Name (copy off pharmacy label) • ______

Date Originally Prescribed ___/___/___

Dosage and Frequency • ______

Diagnosis/Medical Condition • ______

Medication Name (copy off pharmacy label) • ______

Date Originally Prescribed ___/___/___

Dosage and Frequency • ______

Diagnosis/Medical Condition • ______

Medication Name (copy off pharmacy label) • ______

Date Originally Prescribed ___/___/___

Dosage and Frequency • ______

Diagnosis/Medical Condition • ______

PRIMARY CARE PHYSICIAN INFORMATION

Physician's Name: ______ Telephone Number: ______

Part IX – Agreement & Acknowledgement

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

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

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

Signed at (City and State): _____ Date: _____/_____/_____

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

Producer's Signature _____ Producer Number: _____

Producer's Phone: _____

Part X – Explanation of Benefits Delivery Agreement & Acknowledgement

By checking "Yes", I elect electronic delivery of all contractual, regulatory and administrative correspondence regarding my Medicare Supplement policy, to include claim correspondence, Explanations of Benefits, periodic notices (such as privacy notices) and other correspondence. If electronically delivered, I understand that I will receive communications at the last email address I provided.

☐ **Yes** ☐ **No**

I understand and agree that to receive electronic delivery, I must have a computer with internet access, a web browser that is Microsoft Internet Explorer version 9.0 or greater, an e-mail account, and the ability to download PDF files using Adobe Acrobat Reader version 5.0 or higher and a printer or other device to download and print or save any documents I wish to retain.

I understand and I agree that my consent is valid while I remain covered. At any time, I may withdraw my consent for any reason and receive future correspondence in paper to include a paper copy of my policy, free of charge, by calling toll-free: 1-844-649-1897; or by writing to: Customer Care Center, LifeShield National, PO Box 14574, Oklahoma City, OK 73113-0574.

Applicant's Signature:_____ Date: _____

Producer's Signature: _____ Producer Number: _____

Part XI – Producer Supplement

Yes	No	All questions must be completed.
☐	☐	1. Did you meet with the Applicant in person?
☐	☐	2. Did you complete this Application over the phone?
		3. State the name and relationship of any other person present when this application was taken.

Name: _____ Relationship to Applicant: _____

☐	☐	4. Did you review the Application for correctness and any omissions?
☐	☐	5. Did the Applicant review the application for correctness and any omissions?
☐	☐	6. Are you related to Applicant?

If "Yes", provide relationship: _____

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

Company	Type of Policy/Certificate	Effective Date	In Force
•	•	/ /	☐ Yes ☐ No
•	•	/ /	☐ Yes ☐ No
•	•	/ /	☐ Yes ☐ No

Producer #1 Name (please print)	Producer Number	Split %
•	•	•
Producer #2 Name (please print)	**Producer Number**	**Split %**
•	•	•

Part XII – Producer Comments

List any additional comments or information below.

Applicant Name (please print) _____

Producer's Signature: _____

LifeShield
NATIONAL INSURANCE CO
Home Office: 5500 N. Western Ave., Ste. 200, Oklahoma City, OK 73113

HEALTH INFORMATION AUTHORIZATION
APPLICANT / INSURED DECLARATIONS

- This is a HIPAA required authorization.
- Please read these statements carefully.
- Print clearly using blue or black ink.
- Applicant / Insured must submit a completed, signed copy and should keep a copy for their records.

PLEASE READ THESE STATEMENTS CAREFULLY

I authorize the use and disclosure of health information about me as described below.

Health Information to be Used or Disclosed: I understand this authorization applies to information about: my past, present, or future physical or mental health or condition and may include facts about my other insurance coverage, hazardous activities, finances, vocation, and other personal traits. This information may come from my medical records including, but not limited to prescription history, diagnoses and treatment for illnesses and conditions including, but not limited to, mental illness and the use of drugs, alcohol and tobacco, HIV/AIDS, and sexually transmitted diseases, but excluding psychotherapy notes or other information not permitted to be disclosed under applicable law.

Who May Request or Use Information: This information may be disclosed to and used and or disclosed by: LifeShield National Insurance Co., ("LifeShield"); its insurance support organizations; its affiliates and reinsurers; care providers, treatment facilities, insurers, pharmacy benefit managers, the Medical Information Bureau (MIB) and consumer reporting agencies.

Who is Authorized to Disclose Information: All of the following persons or entities are authorized to disclose health information or records about me: care providers or evaluators, physicians, chiropractors, physical therapists, psychologists, drug, alcohol, and mental health counselors, pharmacy benefit managers and other health professionals; treatment facilities including hospitals, clinics, drug or alcohol treatment or consultation facilities, nursing homes, mental health facilities, ambulatory care centers and other medical or medically related facilities.

In addition, I authorize LifeShield to disclose collected information to other insurers, reinsurers and the Medical Information Bureau (MIB). The Medical Information Bureau (MIB) and consumer reporting agencies may only disclose information as set forth in a contract with a member company or organization.

Purpose: This health information may be used or disclosed to: evaluate and underwrite my insurance application; determine premium amounts, adjudicate claims and to support the operations of health plans.

Statements of Understanding: I understand that: (1) I will receive a copy of this Authorization and that a copy of it is as valid as the original; (2) this Authorization will be valid for 30 months from the date signed; (3) I may revoke this Authorization by sending a written request for revocation to LifeShield at the Medicare Supplement Administrative Office identified above; (4) if I do not sign this Authorization, or revoke it as provided for above, my application may be declined; (5) If I revoke this Authorization, my revocation is not effective for any information that might have been used or disclosed in reliance on this Authorization; and (6) some of the health information obtained may be disclosed to persons or organizations that are not subject to federal health information privacy laws, resulting in the information no longer being protected under such laws. I further understand that such information may be redisclosed only in accordance with applicable laws or regulations.

Applicant/Insured please complete this section.

Signature of Applicant/Insured ✖ _____ Date _____

Printed Name of Applicant/Insured _____ Policy Number (if known) _____

City _____ State _____ Zip _____

LifeShield
NATIONAL INSURANCE CO
Home Office: 5500 N. Western Ave., Suite 200, Oklahoma City, OK 73118

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

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

According to information you have furnished, you intend to terminate existing Medicare Supplement or Medicare Advantage insurance and replace it with a policy to be issued by LifeShield National Insurance Co., ("LifeShield"). 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 coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare Supplement coverage is a wise decision, you should terminate your present Medicare Supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

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

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

_____

- ☐ Other (please specify)

_____

(1) **NOTE:** If the issuer of the Medicare supplement policy being applied for does not, or is otherwise prohibited from imposing pre-existing condition limitations, please skip to statement 2 below. Health conditions that you may presently have (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy/certificate.

(2) State law provides that your replacement policy may not contain new pre-existing conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to pre-existing conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy/certificate.

(3) If, you still wish to terminate your present policy/certificate 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/certificate until you have received your new policy and are sure that you want to keep it.

✖ _____
Signature of Agent Date

✖ _____
Signature of Applicant Date

_____
Printed Name and Address of Agent

LIFESHIELD NATIONAL INSURANCE CO. ("LifeShield")

Outline of Coverage
Medicare Supplement Benefit Plans A, F, G and N
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.

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

Benefits	Plans Available to All Applicants								Plans Available ONLY to those first eligible before 01/01/2020	
	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 2024[2]					$7,060[2]	$3,530[2]				

[1] Plans F and G also have a high deductible option which require first paying a plan deductible of $2,800 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.

[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.

LIFESHIELD NATIONAL INSURANCE CO. ("LifeShield")

Monthly Premium Rates*
ZIP Codes starting with: 820-831, 834
Standard Plans – Preferred
Effective Date: 03/01/2023

FEMALE				Attained	MALE			
Plan A	Plan F	Plan G	Plan N	Age	Plan A	Plan F	Plan G	Plan N
104.35	126.56	104.87	81.81	65	120.00	145.54	120.60	94.09
104.35	126.56	104.87	82.96	66	120.00	145.54	120.60	95.40
104.35	126.56	104.87	84.83	67	120.00	145.54	120.60	97.55
104.35	126.56	104.87	86.58	68	120.00	145.54	120.60	99.57
105.76	128.38	106.29	88.20	69	121.63	147.64	122.24	101.43
107.32	131.11	107.86	91.29	70	123.42	150.78	124.04	104.98
111.80	135.28	112.37	94.66	71	128.58	155.57	129.22	108.86
116.33	140.01	116.92	98.42	72	133.78	161.01	134.46	113.19
121.64	145.34	122.25	102.62	73	139.88	167.14	140.58	118.02
127.05	151.06	127.69	107.10	74	146.11	173.71	146.84	123.16
132.57	157.18	133.24	112.20	75	152.46	180.75	153.23	129.03
136.73	162.15	137.42	116.23	76	157.24	186.47	158.03	133.67
140.97	167.56	141.68	120.36	77	162.11	192.69	162.93	138.41
146.44	173.78	147.17	124.58	78	168.40	199.85	169.25	143.26
152.07	180.19	152.83	128.90	79	174.88	207.22	175.76	148.23
157.87	186.78	158.66	133.32	80	181.55	214.80	182.46	153.32
164.29	194.06	165.12	138.44	81	188.94	223.17	189.89	159.20
170.92	201.56	171.77	143.67	82	196.55	231.79	197.54	165.22
177.74	209.27	178.63	149.03	83	204.40	240.66	205.42	171.39
184.76	217.22	185.69	154.52	84	212.47	249.80	213.54	177.70
191.99	225.40	192.96	160.15	85	220.79	259.21	221.90	184.17
198.58	232.88	199.57	165.16	86	228.36	267.81	229.51	189.94
205.35	240.57	206.38	170.30	87	236.15	276.66	237.34	195.84
212.31	248.48	213.38	175.55	88	244.16	285.75	245.38	201.88
219.47	256.61	220.57	180.92	89	252.39	295.10	253.66	208.05
224.39	264.96	227.97	186.41	90	258.05	304.70	262.16	214.37
226.07	272.95	235.02	191.60	91	259.98	313.89	270.28	220.34
227.75	281.16	242.27	196.91	92	261.91	323.33	278.61	226.45
229.43	289.58	249.71	202.34	93	263.84	333.02	287.17	232.69
231.11	298.23	257.36	207.88	94	265.77	342.96	295.96	239.07
232.79	307.11	265.21	213.55	95	267.70	353.18	304.99	245.58
234.48	316.25	273.30	219.37	96	269.65	363.69	314.29	252.27
236.18	325.67	281.63	225.35	97	271.61	374.52	323.88	259.15
237.89	335.37	290.22	231.49	98	273.58	385.67	333.76	266.21
239.62	345.35	299.07	237.80	99	275.57	397.15	343.93	273.47

Add a One-Time Policy Fee of $25
A 7% Household Discount is available to those that qualify

LIFESHIELD NATIONAL INSURANCE CO. ("LifeShield")

Monthly Premium Rates*
ZIP Codes starting with: 820-831, 834
Standard Plans – Standard
Effective Date: 03/01/2023

FEMALE				Attained	MALE			
Plan A	Plan F	Plan G	Plan N	Age	Plan A	Plan F	Plan G	Plan N
120.00	145.54	120.60	94.09	65	138.00	167.38	138.69	108.20
120.00	145.54	120.60	95.40	66	138.00	167.38	138.69	109.71
120.00	145.54	120.60	97.55	67	138.00	167.38	138.69	112.19
120.00	145.54	120.60	99.57	68	138.00	167.38	138.69	114.50
121.63	147.64	122.24	101.43	69	139.87	169.78	140.57	116.64
123.42	150.78	124.04	104.98	70	141.94	173.40	142.65	120.73
128.58	155.57	129.22	108.86	71	147.86	178.91	148.60	125.19
133.78	161.01	134.46	113.19	72	153.85	185.16	154.63	130.17
139.88	167.14	140.58	118.02	73	160.86	192.22	161.67	135.72
146.11	173.71	146.84	123.16	74	168.02	199.77	168.87	141.64
152.46	180.75	153.23	129.03	75	175.33	207.87	176.21	148.39
157.24	186.47	158.03	133.67	76	180.83	214.44	181.74	153.71
162.11	192.69	162.93	138.41	77	186.43	221.60	187.37	159.17
168.40	199.85	169.25	143.26	78	193.67	229.83	194.64	164.75
174.88	207.22	175.76	148.23	79	201.11	238.30	202.12	170.47
181.55	214.80	182.46	153.32	80	208.78	247.02	209.83	176.32
188.94	223.17	189.89	159.20	81	217.28	256.64	218.37	183.08
196.55	231.79	197.54	165.22	82	226.03	266.56	227.17	190.01
204.40	240.66	205.42	171.39	83	235.05	276.76	236.24	197.10
212.47	249.80	213.54	177.70	84	244.34	287.27	245.57	204.36
220.79	259.21	221.90	184.17	85	253.91	298.09	255.19	211.79
228.36	267.81	229.51	189.94	86	262.62	307.99	263.94	218.43
236.15	276.66	237.34	195.84	87	271.57	318.16	272.94	225.22
244.16	285.75	245.38	201.88	88	280.78	328.62	282.19	232.16
252.39	295.10	253.66	208.05	89	290.25	339.36	291.70	239.26
258.05	304.70	262.16	214.37	90	296.76	350.41	301.49	246.52
259.98	313.89	270.28	220.34	91	298.98	360.98	310.82	253.39
261.91	323.33	278.61	226.45	92	301.20	371.83	320.40	260.42
263.84	333.02	287.17	232.69	93	303.42	382.97	330.25	267.59
265.77	342.96	295.96	239.07	94	305.64	394.41	340.36	274.93
267.70	353.18	304.99	245.58	95	307.86	406.15	350.74	282.42
269.65	363.69	314.29	252.27	96	310.10	418.24	361.43	290.11
271.61	374.52	323.88	259.15	97	312.35	430.70	372.46	298.02
273.58	385.67	333.76	266.21	98	314.62	443.52	383.82	306.14
275.57	397.15	343.93	273.47	99	316.90	456.73	395.53	314.49

Add a One-Time Policy Fee of $25
A 7% Household Discount is available to those that qualify

LIFESHIELD NATIONAL INSURANCE CO. ("LifeShield")

Outline of Coverage
Medicare Supplement Benefit Plans A, F, G and N

Disclosures. Use this outline to compare benefits and premiums among policies.

Premium Information. LifeShield can only raise Your premium if We raise the premium for all policies like Yours in the same geographic area of the state where You live. Premiums for this policy will increase due to the increase in Your age.

Household Premium Discount. You may be eligible for a Household Premium Discount if You live with Your spouse, including validly recognized civil union and domestic partners, or You currently have a household resident (at least one, no more than three) with whom You have continuously resided for the last twelve (12) months. We may request additional documentation to determine eligibility. The discounted rate will be 7 percent lower than the individual rates as long as these requirements are met.

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 Us.

Right to Return Policy. If You find that You are not satisfied with Your policy, You may return it to us at Our Medicare Supplement Administrative Office PO Box 14574, Oklahoma City, OK 73113-0574. 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 certificate/policy, do NOT cancel it until You have actually received Your new policy and are sure You want to keep it.

Notice. The policy may not fully cover all of Your medical costs. Neither We nor Our agents are connected with Medicare. This outline does not give all the details of Medicare coverage. Contact Your local Social Security office or consult "Medicare & You" for more details.

Complete Answers Are Very Important. When You fill out the application for the new policy, be sure to answer truthfully and completely all questions about Your medical and health history. We 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.**

PLEASE REFER TO YOUR POLICY FOR DETAILS.

LIFESHIELD NATIONAL INSURANCE CO. ("LifeShield")

Outline of Coverage
Medicare Supplement Benefit Plans A, F, G and N

Plan A

Medicare Part A – Hospital Services Per Benefit Period

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

Services	Medicare Pays	Plan A Pays	You Pay
Hospitalization Semiprivate room and board, general nursing and miscellaneous services and supplies.			
First 60 days	All but $1,632	$0	$1,632 Part A Deductible
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after			
- While using 60 lifetime reserve days	All but $816 a day	$816 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 days	All but $204 a day	$0	Up to $204 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 copayment/coinsurance for outpatient drugs and inpatient respite care.	Medicare copayment/coinsurance	$0

**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.

LIFESHIELD NATIONAL INSURANCE CO. ("LifeShield")

Outline of Coverage
Medicare Supplement Benefit Plans A, F, G and N

Plan A

Medicare Part B – Medical Services per Calendar Year

*Once You have been billed $240 of Medicare Eligible Expenses for covered services (which are noted with an asterisk), Your Medicare Part B Deductible will have been met for the calendar year.

Services	Medicare Pays	Plan A 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 $240 of Medicare approved amounts* Remainder of Medicare approved amounts	 $0 Generally 80%	 $0 Generally 20%	 $240 Part B Deductible $0
Part B Excess Charges (above Medicare approved amounts)	$0	$0	All costs
Blood First 3 pints Next $240 of Medicare approved amounts* Remainder of Medicare approved amounts	 $0 $0 80%	 All costs $0 20%	 $0 $240 Part B Deductible $0
Clinical Laboratory Services – Tests for diagnostic services	100%	$0	$0

Parts A & B

Services	Medicare Pays	Plan A Pays	You Pay
Home Health Care Medicare Approved Services - Medically necessary skilled care services and medical supplies - Durable medical equipment ▪ First $240 of Medicare approved amounts* ▪ Remainder of Medicare approved amounts	 100% $0 80%	 $0 $0 20%	 $0 $240 Part B Deductible $0

LIFESHIELD NATIONAL INSURANCE CO. ("LifeShield")

Outline of Coverage
Medicare Supplement Benefit Plans A, F, G and N

Plan F

Medicare Part A – Hospital Services Per Benefit Period

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

Services	Medicare Pays	Plan F Pays	You Pay
Hospitalization Semiprivate room and board, general nursing and miscellaneous services and supplies.			
First 60 days	All but $1,632	$1,632 Part A Deductible	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after			
- While using 60 lifetime reserve days	All but $816 a day	$816 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 days	All but $204 a day	Up to $204 a day	$0
101st day and after	$0	$0	All Costs
Blood			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
Hospice Care You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care.	Medicare copayment/coinsurance	$0

**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.

LIFESHIELD NATIONAL INSURANCE CO. ("LifeShield")

Outline of Coverage
Medicare Supplement Benefit Plans A, F, G and N

Plan F

Medicare Part B – Medical Services per Calendar Year

*Once You have been billed $240 of Medicare Approved amounts for covered services (which are noted with an asterisk), Your Medicare Part B Deductible will have been met for the calendar year.

Services	Medicare Pays	Plan F 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 $240 of Medicare approved amounts* Remainder of Medicare approved amounts	 $0 Generally 80%	 $240 Part B Deductible Generally 20%	 $0 $0
Part B Excess Charges (above Medicare approved amounts)	$0	100%	$0
Blood First 3 pints Next $240 of Medicare approved amounts* Remainder of Medicare approved amounts	 $0 $0 80%	 All costs $240 Part B Deductible $20%	 $0 $0 $0
Clinical Laboratory Services – Tests for Diagnostic services	100%	$0	$0

Parts A & B

Services	Medicare Pays	Plan F Pays	You Pay
Home Health Care Medicare Approved Services - Medically necessary skilled care services and medical supplies - Durable medical equipment ▪ First $240 of Medicare approved amounts* ▪ Remainder of Medicare approved amounts	 100% $0 80%	 $0 $240 Part B Deductible 20%	 $0 $0 $0

Other Benefits Not Covered by Medicare

Services	Medicare Pays	Plan F 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 USA. First $250 each calendar year Remainder of charges	 $0 $0	 $0 80% to a lifetime maximum benefit of $50,000.	 $250 20% and amounts over the $50,000 lifetime maximum.

LIFESHIELD NATIONAL INSURANCE CO. ("LifeShield")

Outline of Coverage
Medicare Supplement Benefit Plans A, F, G and N

Plan G

Medicare Part A – Hospital Services Per Benefit Period

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

Services	Medicare Pays	Plan G Pays	You Pay
Hospitalization Semiprivate room and board, general nursing and miscellaneous services and supplies.			
First 60 days	All but $1,632	$1,632 Part A Deductible	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after			
- While using 60 lifetime reserve days	All but $816 a day	$816 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 days	All but $204 a day	Up to $204 a day	$0
101st day and after	$0	$0	All Costs
Blood			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
Hospice Care You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care.	Medicare copayment/coinsurance	$0

**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.

LIFESHIELD NATIONAL INSURANCE CO. ("LifeShield")

Outline of Coverage
Medicare Supplement Benefit Plans A, F, G and N

Plan G

Medicare Part B – Medical Services per Calendar Year

*Once You have been billed $240 of Medicare Approved amounts for covered services (which are noted with an asterisk), Your Medicare Part B Deductible will have been met for the calendar year.

Services	Medicare Pays	Plan G 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 $240 of Medicare approved amounts*	$0	$0	$240 (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
Blood			
First 3 pints	$0	All costs	$0
Next $240 of Medicare approved amounts*	$0	$0	$240 (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	Plan G Pays	You Pay
Home Health Care Medicare Approved Services			
- Medically necessary skilled care services and medical supplies	100%	$0	$0
- Durable medical equipment			
▪ First $240 of Medicare approved amounts*	$0	$0	$240 (Unless Part B Deductible has been met)
▪ Remainder of Medicare approved amounts	80%	20%	$0

Plan G

Other Benefits Not Covered by Medicare

Services	Medicare Pays	Plan G 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 USA.			
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.

LIFESHIELD NATIONAL INSURANCE CO. ("LifeShield")

Outline of Coverage
Medicare Supplement Benefit Plans A, F, G and N

Plan N

Medicare Part A – Hospital Services Per Benefit Period
*A benefit period begins on the first day You receive service as an inpatient in a hospital and ends after You have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

Services	Medicare Pays	Plan N Pays	You Pay
Hospitalization Semiprivate room and board, general nursing and miscellaneous services and supplies.			
First 60 days	All but $1,632	$1,632 Part A Deductible	$0
61st thru 90th day	All but $408 a day	$408 a day	$0
91st day and after			
- While using 60 lifetime reserve days	All but $816 a day	$816 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 100 days	All but $204 a day	Up to $204 a day	$0
101st day and after	$0	$0	All Costs
Blood			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
Hospice Care You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care.	Medicare copayment/coinsurance	$0

**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.

LIFESHIELD NATIONAL INSURANCE CO. ("LifeShield")

Outline of Coverage
Medicare Supplement Benefit Plans A, F, G and N

Plan N

Medicare Part B – Medical Services per Calendar Year

*Once You have been billed $240 of Medicare Approved amounts for covered services (which are noted with an asterisk), Your Medicare Part B Deductible will have been met for the calendar year.

Services	Medicare Pays	Plan N 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 $240 of Medicare approved amounts*	$0	$0	$240 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 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 $240 of Medicare approved amounts*	$0	$0	$240 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 N Pays	You Pay
Home Health Care Medicare Approved Services			
- Medically necessary skilled care services and medical supplies	100%	$0	$0
- Durable medical equipment			
▪ First $240 of Medicare approved amounts*	$0	$0	$240 Part B Deductible
▪ Remainder of Medicare approved amounts	80%	20%	$0

Plan N

Other Benefits Not Covered by Medicare

Services	Medicare Pays	Plan N 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 USA. First $250 each calendar year Remainder of charges	 $0 $0	 $0 80% to a lifetime maximum benefit of $50,000.	 $250 20% and amounts over the $50,000 lifetime maximum.