



## Open Enrollment and Guaranteed Issue Worksheet

**If any of the following situations apply, applicant is in an open enrollment or guaranteed issue period:** (Situations may vary by state and coverage may be limited. Please refer to the Underwriting Guide for more information.)

### **ELIGIBILITY FOR OPEN ENROLLMENT**

#### **Applicant is:**

- at least 64 ½ years of age (in most states) and within six months before or after his/her effective date for Medicare Part B, or
- covered under Medicare Part B prior to age 65 (eligible for a six-month open enrollment period upon reaching age 65)

**Note: Coverage cannot be effective until your Medicare coverage is effective.**

### **ELIGIBILITY FOR GUARANTEED ISSUE**

**Evidence of eligibility is required for the following situations.**

#### **Applicant:**



- is in the original Medicare plan, has an employer group health plan (including retiree or COBRA coverage) or union coverage that pays after Medicare pays, and that coverage is ending
- is in the original Medicare plan, has a Medicare Select policy, and moves out of the Select plan's service area
- loses coverage due to their Medicare supplement insurance company's insolvency or at no fault of the applicant
- the applicant leaves their Medicare supplement plan because the company has not followed rules, or has misled the applicant

*Applicant has the right to buy Medicare supplement Plan A, B, C, F, K or L that is sold in the applicant's state by any insurance company.*

#### **Applicant was enrolled in a Medicare Advantage (MA) plan, and:**

- the plan is leaving the Medicare program or stops service in the applicant's area, or the applicant moves out of the plan's service area (applicant must switch back to original Medicare)
- the applicant leaves the plan because the company has not followed rules, or has misled the applicant

*Applicant has the right to buy Medicare supplement Plan A, B, C, F, K or L that is sold in the applicant's state by any insurance company.*

- the applicant decided to switch to original Medicare within the first year of joining a MA plan when first eligible for Medicare Part A at age 65

*Applicant has the right to buy any Medicare supplement plan that is sold in the applicant's state by any insurance company.*

- after dropping their Medicare supplement policy to join a MA plan for the first time, has been on the MA plan less than one year and wants to switch back

*Applicant has the right to obtain their Medicare supplement policy back if that carrier still sells it or, if not available, buy any Medicare supplement Plan A, B, C, F, K or L that is sold in the applicant's state by any insurance company.*

#### **Acceptable Evidence of Eligibility:**

- a. Copy of the applicant's MA plan's termination notice
- b. Copy of the letter the applicant sent to his/her MA plan requesting disenrollment
- c. Signed statement that the applicant has requested to be disenrolled from his/her MA plan
- d. Certification of group coverage
- e. Copy of the termination letter from employer or group carrier
- f. Image of insurance ID card (ONLY allowed if your MA plan is being terminated)



# Height and Weight Chart

## Eligibility

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

## Rate Adjustment

The column heading above your weight will indicate your appropriate rate adjustment, if any (risk class).

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

Medicare supplement insurance is underwritten by  
**UNITED OF OMAHA LIFE INSURANCE COMPANY**  
 A MUTUAL of OMAHA COMPANY  
 Mutual of Omaha Plaza  
 Omaha, Nebraska 68175  
[mutualofomaha.com](http://mutualofomaha.com)





## B. Applicant Information (continued)

**Applicant A**

**Applicant B**

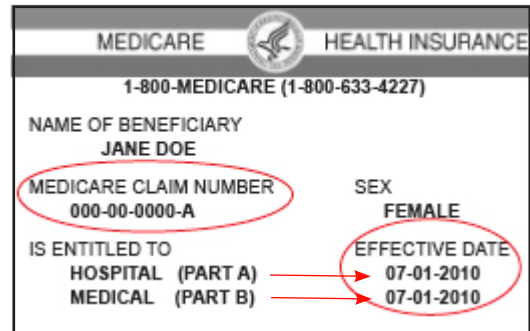
**Go paperless!** To receive your Explanation of Benefits (EOBs) online, select "YES" below and provide your current e-mail address in Section B. If you subscribe, you will not receive paper EOBs, but instead, will receive an e-mail notification when new EOBs become available with a link to access each specific EOB. We will continue to mail EOBs if you are entitled to receive any monetary reimbursement from United of Omaha.

Receive statement online? .....  Y  N

Receive statement online? .....  Y  N

## C. Medicare Information

Please reference your Medicare card to complete this section.



**Applicant A**

**Applicant B**

Medicare Claim Number	Medicare Claim Number
Medicare Part A Effective Date <input type="text"/> / <input type="text"/> / <input type="text"/> If you are not covered under Medicare Part A, what is your eligibility date <input type="text"/> / <input type="text"/> / <input type="text"/>	Medicare Part A Effective Date <input type="text"/> / <input type="text"/> / <input type="text"/> If you are not covered under Medicare Part A, what is your eligibility date <input type="text"/> / <input type="text"/> / <input type="text"/>
Medicare Part B Effective Date <input type="text"/> / <input type="text"/> / <input type="text"/> If you are not covered under Medicare Part B, indicate the date you plan to enroll <input type="text"/> / <input type="text"/> / <input type="text"/>	Medicare Part B Effective Date <input type="text"/> / <input type="text"/> / <input type="text"/> If you are not covered under Medicare Part B, indicate the date you plan to enroll <input type="text"/> / <input type="text"/> / <input type="text"/>

## D. Household Premium Discount Information

<p><b>You may be eligible for a policy with a lower premium rate based on your answers to the statements in this section.</b></p> <p>1. Does a member of your household:</p> <p>(a) with whom you have continuously resided for the last 12 months; or</p> <p>(b) to whom you are married</p> <p>either have an existing Medicare supplement plan with, or are applying for coverage with United of Omaha Life Insurance Company, United World Life Insurance Company or Mutual of Omaha Insurance Company?.....</p> <p>2. If you answered "YES" to Question 1 above, please fill out the following information, except if both applicants are both applying for coverage on this application.</p>	<p><b>Applicant A</b></p> <p><input type="checkbox"/> Y <input type="checkbox"/> N</p>	<p><b>Applicant B</b></p> <p><input type="checkbox"/> Y <input type="checkbox"/> N</p>
	<p>Name (First/Middle/Last)</p> <p>Policy Number</p> <p>Street Address</p> <p>City/State/ZIP</p>	

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# E. Previous or Existing Coverage Information

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 certificate, or that you had certain rights to buy such a policy or certificate, you may be guaranteed acceptance in one or more of our Medicare supplement plans. **Please include a copy of the notice from your prior insurer with your application.** PLEASE ANSWER ALL QUESTIONS. Please mark "YES" or "NO" with an "X" to the questions below.

To the Best of Your Knowledge and Belief:	Applicant A	Applicant B
3. 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 Cost," please answer "NO" to this question.) <b>If "YES," answer the following about this existing coverage:</b>	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
(a) Will Medicaid pay your premiums for this Medicare supplement policy?.....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
(b) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?.....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N

### Please answer questions regarding another Medicare supplement or Select plan:

4. Do you have another Medicare supplement or Medicare Select insurance policy or certificate in force?.....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
<b>If "YES," answer the following about this existing coverage:</b>		
(a) Do you intend to replace your current Medicare supplement policy/certificate with this policy?.....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
(b) Indicate planned termination or disenrollment date.....	Applicant A	Applicant B
	<input type="text"/>	<input type="text"/>
(c) With what company, and what plan do you have?		

Applicant A	Applicant B
Name of Company	Name of Company
Plan	Plan

### Please answer questions regarding Medicare plan coverage (other than Medicare supplement):

	Applicant A	Applicant B
5. Have you had coverage from any Medicare plan other than Medicare Part A or B within the past 63 days? (for example, a Medicare Advantage plan, or a Medicare HMO or PPO).....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
<b>If "YES," answer the following about this previous or existing coverage:</b>		
(a) Fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.....	Applicant A	Applicant B
	START	START
	<input type="text"/>	<input type="text"/>
	END	END
	<input type="text"/>	<input type="text"/>
(b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy?.....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
(c) Planned date of termination/disenrollment?.....	Applicant A	Applicant B
	<input type="text"/>	<input type="text"/>
(d) Was this your first time in this type of Medicare plan?.....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
(e) Did you drop a Medicare supplement or Medicare Select policy/certificate to enroll in this Medicare plan?.....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
(f) Did you drop a union group or employer health plan to enroll in this Medicare plan?..	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N

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- (g) Please indicate reason for termination/disenrollment:
- Your Medicare Advantage plan is leaving the Medicare program.....
  - Your Medicare Advantage organization stopped offering Medicare Advantage plans.....
  - Your Medicare Advantage organization stopped offering coverage in the area in which you live.....
  - You moved out of the geographic service area of your Medicare Advantage plan.....
  - You had a Medicare Advantage plan with Medicare Part D benefits and are enrolling in a stand-alone Medicare Part D plan.....
  - Other: \_\_\_\_\_  
 Applicant A \_\_\_\_\_  
 Applicant B \_\_\_\_\_

**Check box(s) below if applicable**

Applicant A	Applicant B
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

**Please answer questions regarding other health insurance:**

6. Have you had coverage under any other health insurance within the past 63 days?.....  
 (For example, an employer group health plan, union plan, or individual non-Medicare supplement plan.)

	Applicant A	Applicant B
	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N

**If "YES," answer the following about this previous or existing coverage:**

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

Applicant A	START	END
	___/___/___	___/___/___
Applicant B	START ___/___/___	END ___/___/___

(b) Planned date of termination/disenrollment?.....

Applicant A	Applicant B
___/___/___	___/___/___

(c) With what company and what kind of policy/certificate? (List below.)

Applicant A	Applicant B
Name of Company	Name of Company
Policy/Certificate type	Policy/Certificate type

**F. Please answer all of the following questions:**

To the Best of Your Knowledge and Belief:

7. Are you applying during a guaranteed issue period?.....  
 (NOTE: Refer to the guaranteed issue worksheet to help identify if you are eligible. If the answer above is "YES," attach proof of eligibility.)

8. Did you turn age 65 in the last six months?.....

9. Did you enroll in Medicare Part B in the last six months?.....

	Applicant A	Applicant B
	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N

**If "YES," indicate your effective date.....**

Applicant A	Applicant B
___/___/___	___/___/___



**IF EITHER YOU OR APPLICANT B ANSWERED "YES" TO QUESTION 7 OR BOTH QUESTIONS 8 AND 9 IN SECTION F, SKIP SECTIONS G & H AND GO TO SECTION I.**



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**If you are applying during an open enrollment or guaranteed issue period:  
SKIP SECTIONS G & H and GO TO SECTION I.**

**G. Health Information**



**For all plans, answer questions 10-20.**

(If "YES" is answered to any of the following questions 10-18, that person is not eligible for coverage.)

To the Best of Your Knowledge and Belief:	<b>Applicant A</b>	<b>Applicant B</b>
10. Are you currently confined to a wheelchair or any motorized mobility device?.....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
11. Are you currently hospitalized, confined to a bed, in a nursing home or assisted living facility where you receive skilled nursing care, or receiving any occupational or physical therapy? .....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
12. Have you been advised by a medical professional to have treatment, further diagnostic evaluation, diagnostic testing or any surgery that has not been performed? .....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
13. At any time have you been medically diagnosed with, treated for, or had surgery for any of the following:		
A. Chronic kidney disease, kidney failure, or kidney disease requiring dialysis? .....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
B. Emphysema, Chronic Obstructive Pulmonary Disease (COPD), any other chronic pulmonary disorder or any cardio-pulmonary disorder requiring oxygen?.....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
C. Alzheimer's Disease, dementia or any other cognitive disorder? .....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
D. Parkinson's Disease, Multiple Sclerosis or Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease)?.....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
E. Systemic Lupus or Myasthenia Gravis? .....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
F. Acquired Immune Deficiency Syndrome (AIDS)? .....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
G. An organ transplant or been advised to have an organ transplant (excluding cornea transplants)? .....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
H. Chronic hepatitis or cirrhosis? .....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
I. Osteoporosis with fractures? .....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
14. Do you have diabetes with complications including retinopathy, neuropathy, peripheral vascular disease, any related heart disorder (Including hypertension/high blood pressure) or kidney disease? .....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
15. Do you have an implanted cardiac defibrillator? .....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
16. Within the past two years, have you been treated for, or been advised by a physician to have treatment for:		
A. Coronary artery disease, angina, heart attack, cardiac angioplasty, bypass surgery or stent placement? .....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
B. Cardiomyopathy, Congestive Heart Failure, aortic or cardiac aneurysm, peripheral vascular disease, vascular angioplasty, endarterectomy, carotid artery disease, heart or heart valve disorder, atrial fibrillation, other heart rhythm disorder, or implantation of a pacemaker?.....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
C. Alcoholism or drug abuse? .....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
D. Any mental or nervous disorder requiring treatment (including hospital confinement) by a psychiatrist, psychologist, counselor or therapist? .....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
E. Internal cancer, lymphoma or melanoma? .....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
F. A stroke or transient ischemic attack (TIA)? .....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
G. Degenerative bone disease, spinal stenosis, rheumatoid arthritis, psoriatic arthritis, arthritis that restricts mobility or have you been advised to have a joint replacement?...	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
17. Have you been advised by a medical professional that surgery may be required within the next 12 months for cataracts? .....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
18. Have you been hospital confined three or more times in the past two years for a same or similar condition? .....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
19. Have you used tobacco in any form in the past 12 months?.....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
20. Applicant A (Height) Ft <input type="text"/> In <input type="text"/> <input type="text"/> (Weight) Lbs <input type="text"/> <input type="text"/> <input type="text"/>		
Applicant B (Height) Ft <input type="text"/> In <input type="text"/> <input type="text"/> (Weight) Lbs <input type="text"/> <input type="text"/> <input type="text"/>		

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## H. Medication Information

If you are applying for ANY plan OUTSIDE of an open enrollment or guaranteed issue period, please list all over-the-counter or prescription medications you have taken in the past 24 months in the table below.

### Applicant A

Medication Name (copy off pharmacy label)	Dosage	Frequency	Have you taken this medication for more than 2 years?	Prescribed by Primary Physician?	Diagnosis/Condition
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	

### Applicant B

Medication Name (copy off pharmacy label)	Dosage	Frequency	Have you taken this medication for more than 2 years?	Prescribed by Primary Physician?	Diagnosis/Condition
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
			<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	

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# I. Agreement and Authorization



## IMPORTANT STATEMENTS

- You do not need more than one Medicare supplement policy.
- If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverage.
- You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.
- If, after purchasing the 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 reinstated 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 reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- 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 reinstated 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 reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- 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).

## AUTHORIZATION TO DISCLOSE PERSONAL INFORMATION TO UNITED OF OMAHA LIFE INSURANCE COMPANY

- I authorize any physician, medical or dental practitioners, hospitals, clinics, pharmacies, pharmacy benefit managers, other medical care facilities, health maintenance organizations and all other providers of medical or dental services, the group of companies which presently includes Mutual of Omaha Insurance Company, United of Omaha Life Insurance Company, United World Life Insurance Company, Companion Life Insurance Company, and any additional companies which may become part of this group of companies and their successors, along with other persons and entities which act on behalf of those companies to provide services to them, employers, consumer reporting agencies, and other insurance companies to disclose Personal Information about me to United of Omaha. Unless revoked earlier, this authorization will remain in effect for 24 months from the date I sign this application. I understand that I may revoke this authorization at any time, by written notice to: ATTN: Individual Underwriting, United of Omaha Life Insurance Company, P.O. Box 3608, Omaha, NE 68103-3608. I realize that my right to revoke this authorization is limited to the extent that United of Omaha has taken action in reliance on the authorization or the law allows United of Omaha to contest the issuance of the policy or a claim under the policy.
- "Personal Information" means all health information, such as medical history, mental and physical condition, including the presence of HIV infection, AIDS or ARC, prescription drug records, drug and alcohol use and other information such as finances, occupation, general reputation and insurance claims information about me. Personal Information does not include Psychotherapy Notes, which are notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a counseling session, which notes are separated from the rest of the person's medical record. Certain information, such as that relating to prescriptions, diagnosis and functional status, is not included in the term Psychotherapy Notes.
- The Personal Information will be used to determine my eligibility for insurance and to resolve or contest any issues of incomplete, incorrect or misrepresented information on my application which may arise during the processing of my application or in connection with claims for insurance benefits. This authorization will not be used if the applicant is in an open enrollment or guaranteed issue period.
- If the person or entity to whom Personal Information is disclosed is not a health care provider or health plan subject to federal privacy regulations, the Personal Information may then be subject to further disclosure by that person or entity without the protections of the federal privacy regulations.
- I understand that I may refuse to sign this application. I realize that if I refuse to sign, the insurance for which I am applying will not be issued.
- I understand that I will receive a copy of the signed application. A copy of this application is as effective as the original. I acknowledge and agree that if there is more than one applicant on this application, all information provided may be reviewed or shared with the other applicant. I understand that, upon acceptance of the completed application, each applicant will receive a separate policy and a completed and signed application will become part of each applicant's policy.

I represent that my answers and statements on this application are true and complete to the best of my knowledge and belief. I understand that my policy benefits can start no earlier than my Medicare effective date, my first month's premium has been received and/or processed and my application has been approved by United of Omaha.

I acknowledge receipt of **A Guide to Health Insurance for People with Medicare** and an Outline of Coverage.

Dated at \_\_\_\_\_, on \_\_\_\_/\_\_\_\_/\_\_\_\_, \_\_\_\_\_  
 City State Month Day Year Applicant A's Signature

Dated at \_\_\_\_\_, on \_\_\_\_/\_\_\_\_/\_\_\_\_, \_\_\_\_\_  
 City State Month Day Year Applicant B's Signature (if applying)

UA5978-20





# UNITED OF OMAHA LIFE INSURANCE COMPANY

A MUTUAL of OMAHA COMPANY



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

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

### Statement to Applicant by Issuer, Agent, Broker 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):

<b>Applicant</b>	<b>Applicant B</b>
<input type="checkbox"/> Additional benefits	<input type="checkbox"/> Additional benefits
<input type="checkbox"/> No change in benefits, but lower premiums	<input type="checkbox"/> No change in benefits, but lower premiums
<input type="checkbox"/> Fewer benefits and lower premiums	<input type="checkbox"/> Fewer benefits and lower premiums
<input type="checkbox"/> My plan has outpatient prescription drug coverage and I am enrolling in Part D	<input type="checkbox"/> My plan has outpatient prescription drug coverage and I am enrolling in Part D
<input type="checkbox"/> Disenrollment from a Medicare Advantage Plan Please explain reason for disenrollment	<input type="checkbox"/> Disenrollment from a Medicare Advantage Plan Please explain reason for disenrollment
<input type="checkbox"/> Other (please specify)	<input type="checkbox"/> Other (please specify)
_____	_____
_____	_____
_____	_____

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



\_\_\_\_\_  
**Signature of Agent, Broker or Other Representative\***

\_\_\_\_\_  
**Date**

UNITED of OMAHA LIFE INSURANCE COMPANY, Mutual of Omaha Plaza, Omaha, NE 68175

<b>Applicant</b>	<b>Applicant B</b>
Signature	Signature
Date	Date

\*Signature not required for direct response sales.

U7563

## IMPORTANT DOCUMENTS

LEAVE THE FOLLOWING REMAINING PAGES WITH CLIENT(S)

As part of the application process, the applicant has signed multiple forms. Applicant copies of these forms and client notifications on the following pages are to be given to the applicant(s) if applicable.

**Replacement Notice**

If replacing, both you and the applicant must sign the customer copy of the replacement notice.

**Premium Receipt / Notice of Information Practices**



# UNITED OF OMAHA LIFE INSURANCE COMPANY

A MUTUAL of OMAHA COMPANY



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

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

### Statement to Applicant by Issuer, Agent, Broker 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):

<b>Applicant</b>	<b>Applicant B</b>
<input type="checkbox"/> Additional benefits	<input type="checkbox"/> Additional benefits
<input type="checkbox"/> No change in benefits, but lower premiums	<input type="checkbox"/> No change in benefits, but lower premiums
<input type="checkbox"/> Fewer benefits and lower premiums	<input type="checkbox"/> Fewer benefits and lower premiums
<input type="checkbox"/> My plan has outpatient prescription drug coverage and I am enrolling in Part D	<input type="checkbox"/> My plan has outpatient prescription drug coverage and I am enrolling in Part D
<input type="checkbox"/> Disenrollment from a Medicare Advantage Plan Please explain reason for disenrollment	<input type="checkbox"/> Disenrollment from a Medicare Advantage Plan Please explain reason for disenrollment
<input type="checkbox"/> Other (please specify)	<input type="checkbox"/> Other (please specify)
_____	_____
_____	_____
_____	_____

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



\_\_\_\_\_  
**Signature of Agent, Broker or Other Representative\***

\_\_\_\_\_  
**Date**

UNITED of OMAHA LIFE INSURANCE COMPANY, Mutual of Omaha Plaza, Omaha, NE 68175

<b>Applicant</b>	<b>Applicant B</b>
Signature	Signature
Date	Date

\*Signature not required for direct response sales.

U7563

# UNITED OF OMAHA LIFE INSURANCE COMPANY

A MUTUAL of OMAHA COMPANY

## Premium Receipt

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All premiums must be made payable to United of Omaha Life Insurance Company.

**Do not make check payable to the agent or leave the payee blank.**

### Applicant A

Received from \_\_\_\_\_  
this \_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_  
an application for Form \_\_\_\_\_ Policy  
and/or Riders \_\_\_\_\_ and \_\_\_\_\_  
Check for \_\_\_\_\_ Dollars.

### Applicant B

Received from \_\_\_\_\_  
this \_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_  
an application for Form \_\_\_\_\_ Policy  
and/or Riders \_\_\_\_\_ and \_\_\_\_\_  
Check for \_\_\_\_\_ Dollars.

 Agent \_\_\_\_\_

 Agent \_\_\_\_\_

**No insurance of any kind shall take effect until a policy is issued and delivered to the applicant, and the initial premium is paid, all during the life of the applicant. If no policy is issued, United of Omaha Life Insurance Company shall have no liability except to refund the initial premium to the applicant. This is a receipt of your application and initial premium.**



## Notice of Information Practices

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In the course of properly underwriting and administering your insurance coverage, we will rely heavily on information provided by you. We may also collect information from others, such as medical professionals who have treated you, hospitals, other insurance companies, and consumer reporting agencies.

In certain circumstances, and in compliance with applicable law, we or our reinsurers may also release your personal or privileged information in our/their files, to third parties without your authorization. Upon request, you have the right to be told about and to see a copy of items of personal information about you which appear in our files, including information contained in investigative consumer reports. You also have the right to seek correction of personal information you believe to be inaccurate.

In compliance with applicable law, we or our reinsurers may also release information in our/their files, including information in an application, to other insurance companies to which you apply for life or health insurance or to which a claim is submitted.

So that there will be no question that the insurance benefits will be payable at the time a claim is made, we urge you to review your application carefully to be sure the answers are correct and complete.

**THE ABOVE IS A GENERAL DESCRIPTION OF OUR INFORMATION PRACTICES. IF YOU WOULD LIKE TO RECEIVE A MORE DETAILED EXPLANATION OF THESE PRACTICES, PLEASE SEND YOUR REQUEST TO: UNITED OF OMAHA LIFE INSURANCE COMPANY, DIRECTOR OF INDIVIDUAL UNDERWRITING, MUTUAL OF OMAHA PLAZA, OMAHA, NE 68175.**

**Provide the completed premium receipt, if applicable, and notice to the applicant.**

**UNITED OF OMAHA LIFE INSURANCE COMPANY**  
**A Mutual of Omaha Company**  
**OUTLINE OF MEDICARE SUPPLEMENT COVERAGE – COVER PAGE**  
**BENEFIT PLANS A, C, F, G, and M**

These charts show the benefits included in each of the standard Medicare supplement plans. Every company must make available Plan “A.” Some plans may not be available in your state. See Outlines of Coverage sections for details about ALL plans.

**Basic Benefits:**

Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.  
 Medical Expenses: Part B coinsurance (generally 20% of Medicare-approved expenses) or copayments for hospital outpatient services. Plans K, L, and N require insureds to pay a portion of Part B coinsurance or copayments.  
 Blood: First 3 pints of blood each year.  
 Hospice: Part A coinsurance.

Plan A	Plan B	Plan C	Plan D	Plan F	F*	Plan G
<b>Basic, including 100% Part B co-insurance</b>	Basic, including 100% Part B co-insurance	<b>Basic, including 100% Part B co-insurance</b>	Basic, including 100% Part B co-insurance	<b>Basic, including 100% Part B co-insurance *</b>		<b>Basic, including 100% Part B co-insurance</b>
		<b>Skilled Nursing Facility Co-insurance</b>	Skilled Nursing Facility Co-insurance	<b>Skilled Nursing Facility Co-insurance</b>		<b>Skilled Nursing Facility Co-insurance</b>
	Part A Deductible	<b>Part A Deductible</b>	Part A Deductible	<b>Part A Deductible</b>		<b>Part A Deductible</b>
		<b>Part B Deductible</b>		<b>Part B Deductible</b>		
				<b>Part B Excess (100%)</b>		<b>Part B Excess (100%)</b>
		<b>Foreign Travel Emergency</b>	Foreign Travel Emergency	<b>Foreign Travel Emergency</b>		<b>Foreign Travel Emergency</b>

Plan K	Plan L	Plan M	Plan N
Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	<b>Basic, including 100% Part B co-insurance</b>	Basic, including 100% Part B co-insurance, except up to \$20 copayment for office visit, and up to \$50 copayment for ER
50% Skilled Nursing Facility Co-insurance	75% Skilled Nursing Facility Co-insurance	<b>Skilled Nursing Facility Co-insurance</b>	Skilled Nursing Facility Co-insurance
50% Part A Deductible	75% Part A Deductible	<b>50% Part A Deductible</b>	Part A Deductible
		<b>Foreign Travel Emergency</b>	Foreign Travel Emergency
Out-of-pocket limit \$4,660; paid at 100% after limit reached	Out-of-pocket limit \$2,330; paid at 100% after limit reached		

\*Plan F also has an option called a high deductible Plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year \$2,070 deductible. Benefits from high deductible Plan F will not begin until out-of-pocket expenses exceed \$2,070. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy/certificate. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plans' separate foreign travel emergency deductible.

**MONTHLY PREMIUMS\***  
**NON-TOBACCO PREMIUMS**  
**ZIP CODES: 490-491, 493-499**

FEMALE					Attained Age	MALE				
Plan A UM20	Plan C UM21	Plan F UM23	Plan G UM24	Plan M UM30		Plan A UM20	Plan C UM21	Plan F UM23	Plan G UM24	Plan M UM30
90.41	129.71	131.03	107.40	102.31	65	95.16	136.53	137.92	113.04	107.68
90.41	129.71	131.03	107.40	102.31	66	95.16	136.53	137.92	113.04	107.68
93.92	134.77	136.14	111.57	106.30	67	99.93	143.37	144.82	118.70	113.08
97.61	140.05	141.48	115.96	110.46	68	104.96	150.61	152.12	124.69	118.77
101.43	145.53	147.00	120.49	114.78	69	110.25	158.18	159.79	130.97	124.77
105.20	150.92	152.46	124.95	119.04	70	115.60	165.86	167.55	137.33	130.81
108.90	156.24	157.82	129.34	123.23	71	120.99	173.61	175.36	143.73	136.92
112.66	161.63	163.27	133.82	127.48	72	126.58	181.62	183.45	150.37	143.25
116.43	167.05	168.73	138.30	131.75	73	132.32	189.83	191.75	157.16	149.72
120.20	172.47	174.21	142.79	136.03	74	138.15	198.23	200.22	164.12	156.34
123.72	177.52	179.31	146.97	140.01	75	143.88	206.43	208.52	170.91	162.81
126.73	181.83	183.67	150.54	143.41	76	149.10	213.92	216.08	177.12	168.72
128.94	185.00	186.86	153.17	145.90	77	151.69	217.65	219.83	180.19	171.65
131.13	188.15	190.04	155.77	148.39	78	154.28	221.36	223.59	183.26	174.58
133.52	191.58	193.50	158.62	151.09	79	157.09	225.38	227.66	186.60	177.75
135.82	194.88	196.85	161.35	153.70	80	159.79	229.27	231.57	189.82	180.82
138.81	199.16	201.17	164.89	157.07	81	161.40	231.57	233.91	191.73	182.64
141.71	203.31	205.35	168.32	160.35	82	162.87	233.68	236.05	193.48	184.31
144.49	207.31	209.40	171.65	163.50	83	164.19	235.57	237.97	195.05	185.81
147.19	211.18	213.30	174.83	166.54	84	165.36	237.28	239.67	196.44	187.13
149.76	214.88	217.05	177.90	169.47	85	166.40	238.75	241.17	197.67	188.30
152.22	218.41	220.61	180.83	172.26	86	167.28	240.01	242.43	198.70	189.29
154.56	221.76	224.01	183.62	174.91	87	168.00	241.06	243.49	199.58	190.11
156.77	224.94	227.21	186.23	177.40	88	168.57	241.86	244.31	200.25	190.76
158.83	227.89	230.19	188.67	179.73	89	168.97	242.43	244.88	200.71	191.20
160.73	230.61	232.93	190.91	181.87	90+	169.19	242.74	245.19	200.97	191.45

\*See PREMIUM INFORMATION regarding Risk Class and Household Premium Discount rating.  
 To obtain annual, semiannual, and quarterly premiums, multiply the above-quoted premiums by 12, 6, and 3, respectively.

**MONTHLY PREMIUMS\***  
**TOBACCO PREMIUMS**  
**ZIP CODES: 490-491, 493-499**

FEMALE					Attained Age	MALE				
Plan A UM20	Plan C UM21	Plan F UM23	Plan G UM24	Plan M UM30		Plan A UM20	Plan C UM21	Plan F UM23	Plan G UM24	Plan M UM30
97.74	140.23	141.65	116.11	110.60	65	102.88	147.60	149.10	122.21	116.42
97.74	140.23	141.65	116.11	110.60	66	102.88	147.60	149.10	122.21	116.42
101.54	145.70	147.18	120.62	114.92	67	108.03	155.00	156.57	128.33	122.25
105.52	151.41	152.95	125.37	119.42	68	113.47	162.82	164.46	134.80	128.40
109.66	157.33	158.92	130.26	124.09	69	119.19	171.01	172.75	141.59	134.89
113.73	163.16	164.82	135.09	128.69	70	124.98	179.31	181.13	148.47	141.42
117.73	168.91	170.62	139.83	133.22	71	130.80	187.69	189.57	155.38	148.02
121.79	174.74	176.51	144.67	137.82	72	136.84	196.35	198.33	162.56	154.86
125.87	180.60	182.41	149.52	142.43	73	143.05	205.22	207.30	169.90	161.86
129.94	186.45	188.34	154.36	147.06	74	149.35	214.30	216.46	177.43	169.02
133.75	191.91	193.85	158.89	151.36	75	155.55	223.17	225.43	184.77	176.01
137.01	196.57	198.56	162.75	155.03	76	161.19	231.26	233.60	191.48	182.40
139.39	200.00	202.01	165.59	157.73	77	163.99	235.29	237.66	194.80	185.56
141.76	203.41	205.45	168.40	160.42	78	166.79	239.30	241.72	198.12	188.74
144.35	207.11	209.19	171.48	163.34	79	169.82	243.65	246.12	201.73	192.17
146.83	210.68	212.81	174.43	166.16	80	172.75	247.85	250.35	205.21	195.48
150.07	215.31	217.48	178.26	169.81	81	174.49	250.35	252.87	207.28	197.45
153.20	219.80	222.00	181.97	173.35	82	176.08	252.63	255.19	209.17	199.26
156.21	224.12	226.38	185.56	176.76	83	177.51	254.68	257.26	210.86	200.87
159.12	228.31	230.59	189.01	180.05	84	178.77	256.52	259.10	212.37	202.30
161.91	232.30	234.65	192.32	183.21	85	179.89	258.11	260.72	213.70	203.57
164.56	236.12	238.50	195.49	186.22	86	180.84	259.47	262.09	214.81	204.63
167.09	239.74	242.17	198.51	189.09	87	181.62	260.60	263.24	215.76	205.53
169.49	243.18	245.63	201.33	191.78	88	182.24	261.47	264.12	216.48	206.23
171.71	246.37	248.86	203.97	194.31	89	182.67	262.09	264.73	216.98	206.70
173.76	249.31	251.81	206.39	196.62	90+	182.91	262.42	265.07	217.27	206.97

\*See PREMIUM INFORMATION regarding Risk Class and Household Premium Discount rating.  
 To obtain annual, semiannual, and quarterly premiums, multiply the above-quoted premiums by 12, 6, and 3, respectively.

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

FEMALE					Attained Age	MALE				
Plan A UM20	Plan C UM21	Plan F UM23	Plan G UM24	Plan M UM30		Plan A UM20	Plan C UM21	Plan F UM23	Plan G UM24	Plan M UM30
98.72	141.64	143.08	117.28	111.72	65	103.91	149.09	150.60	123.44	117.59
98.72	141.64	143.08	117.28	111.72	66	103.91	149.09	150.60	123.44	117.59
102.56	147.16	148.66	121.83	116.07	67	109.11	156.56	158.14	129.62	123.48
106.58	152.93	154.48	126.63	120.62	68	114.62	164.46	166.11	136.15	129.70
110.76	158.91	160.52	131.57	125.34	69	120.39	172.73	174.48	143.02	136.24
114.87	164.80	166.48	136.44	129.99	70	126.23	181.11	182.96	149.96	142.84
118.91	170.61	172.33	141.23	134.56	71	132.12	189.57	191.48	156.95	149.51
123.02	176.50	178.28	146.13	139.20	72	138.22	198.33	200.32	164.19	156.42
127.14	182.41	184.25	151.02	143.86	73	144.48	207.29	209.38	171.61	163.49
131.25	188.33	190.23	155.92	148.54	74	150.86	216.45	218.63	179.21	170.72
135.10	193.84	195.80	160.49	152.89	75	157.11	225.42	227.69	186.63	177.78
138.39	198.55	200.56	164.39	156.59	76	162.81	233.59	235.95	193.40	184.23
140.79	202.02	204.05	167.25	159.32	77	165.64	237.66	240.05	196.76	187.43
143.18	205.45	207.52	170.09	162.03	78	168.47	241.71	244.15	200.11	190.64
145.80	209.20	211.30	173.20	164.99	79	171.53	246.10	248.60	203.76	194.10
148.31	212.80	214.95	176.18	167.83	80	174.48	250.35	252.87	207.27	197.45
151.58	217.47	219.67	180.06	171.51	81	176.24	252.87	255.42	209.36	199.43
154.74	222.01	224.23	183.80	175.09	82	177.85	255.17	257.76	211.27	201.26
157.78	226.37	228.66	187.43	178.54	83	179.29	257.24	259.85	212.98	202.90
160.72	230.60	232.91	190.91	181.86	84	180.57	259.10	261.71	214.50	204.34
163.54	234.64	237.01	194.26	185.06	85	181.70	260.71	263.34	215.85	205.62
166.22	238.49	240.90	197.46	188.10	86	182.66	262.08	264.72	216.97	206.69
168.77	242.15	244.61	200.50	191.00	87	183.45	263.22	265.88	217.93	207.60
171.19	245.63	248.10	203.35	193.71	88	184.07	264.10	266.77	218.66	208.30
173.44	248.84	251.36	206.02	196.26	89	184.50	264.72	267.40	219.16	208.78
175.50	251.81	254.35	208.47	198.60	90+	184.75	265.06	267.74	219.45	209.06

\*See PREMIUM INFORMATION regarding Risk Class and Household Premium Discount rating.  
 To obtain annual, semiannual, and quarterly premiums, multiply the above-quoted premiums by 12, 6, and 3, respectively.

**MONTHLY PREMIUMS\***  
**TOBACCO PREMIUMS**  
**ZIP CODES: 486-489, 492**

FEMALE					Attained Age	MALE				
Plan A UM20	Plan C UM21	Plan F UM23	Plan G UM24	Plan M UM30		Plan A UM20	Plan C UM21	Plan F UM23	Plan G UM24	Plan M UM30
106.72	153.12	154.68	126.79	120.77	65	112.34	161.18	162.81	133.45	127.12
106.72	153.12	154.68	126.79	120.77	66	112.34	161.18	162.81	133.45	127.12
110.87	159.10	160.71	131.71	125.49	67	117.96	169.25	170.96	140.13	133.49
115.23	165.33	167.01	136.90	130.40	68	123.91	177.79	179.58	147.19	140.21
119.74	171.80	173.54	142.23	135.50	69	130.15	186.73	188.63	154.61	147.29
124.18	178.16	179.98	147.51	140.52	70	136.47	195.80	197.79	162.12	154.42
128.55	184.44	186.30	152.68	145.47	71	142.83	204.94	207.01	169.67	161.63
132.99	190.81	192.74	157.98	150.49	72	149.43	214.41	216.56	177.51	169.10
137.45	197.20	199.19	163.27	155.52	73	156.20	224.10	226.36	185.53	176.75
141.89	203.59	205.66	168.56	160.58	74	163.09	234.00	236.36	193.74	184.56
146.05	209.56	211.68	173.50	165.28	75	169.85	243.69	246.15	201.76	192.19
149.61	214.64	216.82	177.72	169.29	76	176.01	252.53	255.08	209.09	199.17
152.21	218.40	220.59	180.81	172.24	77	179.07	256.93	259.51	212.71	202.63
154.79	222.11	224.34	183.88	175.17	78	182.12	261.31	263.95	216.33	206.09
157.62	226.16	228.43	187.25	178.36	79	185.44	266.06	268.76	220.28	209.84
160.33	230.05	232.38	190.47	181.44	80	188.63	270.65	273.37	224.08	213.46
163.87	235.11	237.48	194.66	185.42	81	190.53	273.37	276.13	226.34	215.60
167.29	240.01	242.41	198.70	189.29	82	192.27	275.86	278.65	228.40	217.58
170.57	244.73	247.20	202.63	193.01	83	193.83	278.09	280.92	230.25	219.35
173.76	249.30	251.80	206.39	196.60	84	195.21	280.11	282.93	231.90	220.90
176.80	253.66	256.22	210.01	200.06	85	196.43	281.85	284.70	233.35	222.29
179.69	257.83	260.43	213.47	203.35	86	197.47	283.33	286.19	234.56	223.45
182.46	261.78	264.44	216.76	206.48	87	198.32	284.56	287.44	235.60	224.43
185.07	265.54	268.21	219.84	209.42	88	199.00	285.51	288.40	236.39	225.19
187.50	269.02	271.74	222.73	212.17	89	199.46	286.19	289.08	236.93	225.71
189.73	272.23	274.97	225.37	214.70	90+	199.73	286.55	289.45	237.24	226.01

\*See PREMIUM INFORMATION regarding Risk Class and Household Premium Discount rating.  
 To obtain annual, semiannual, and quarterly premiums, multiply the above-quoted premiums by 12, 6, and 3, respectively.

**MONTHLY PREMIUMS\***  
**NON-TOBACCO PREMIUMS**  
**ZIP CODES: 480-485**

FEMALE					Attained Age	MALE				
Plan A UM20	Plan C UM21	Plan F UM23	Plan G UM24	Plan M UM30		Plan A UM20	Plan C UM21	Plan F UM23	Plan G UM24	Plan M UM30
119.50	171.46	173.20	141.97	135.23	65	125.79	180.48	182.31	149.43	142.34
119.50	171.46	173.20	141.97	135.23	66	125.79	180.48	182.31	149.43	142.34
124.15	178.15	179.96	147.48	140.51	67	132.09	189.52	191.43	156.90	149.48
129.02	185.12	187.01	153.29	146.01	68	138.75	199.08	201.08	164.82	157.00
134.08	192.37	194.32	159.27	151.72	69	145.73	209.09	211.22	173.13	164.92
139.05	199.50	201.53	165.17	157.35	70	152.81	219.24	221.47	181.53	172.91
143.95	206.53	208.61	170.97	162.89	71	159.94	229.48	231.79	189.99	180.99
148.91	213.65	215.81	176.89	168.51	72	167.32	240.08	242.49	198.76	189.35
153.90	220.81	223.04	182.82	174.15	73	174.90	250.93	253.46	207.74	197.91
158.88	227.97	230.28	188.74	179.81	74	182.61	262.02	264.66	216.94	206.66
163.54	234.65	237.03	194.27	185.07	75	190.19	272.87	275.63	225.92	215.21
167.52	240.34	242.78	199.00	189.56	76	197.08	282.77	285.63	234.12	223.02
170.43	244.55	247.00	202.46	192.86	77	200.51	287.69	290.59	238.18	226.89
173.33	248.71	251.20	205.90	196.15	78	203.93	292.60	295.55	242.24	230.77
176.50	253.24	255.78	209.67	199.72	79	207.64	297.91	300.94	246.65	234.96
179.53	257.60	260.20	213.27	203.17	80	211.22	303.05	306.11	250.91	239.01
183.49	263.26	265.92	217.96	207.62	81	213.35	306.11	309.19	253.44	241.42
187.32	268.75	271.44	222.49	211.95	82	215.29	308.89	312.02	255.75	243.63
191.00	274.03	276.80	226.89	216.12	83	217.04	311.39	314.55	257.82	245.61
194.56	279.15	281.95	231.10	220.14	84	218.58	313.65	316.81	259.66	247.35
197.96	284.03	286.90	235.15	224.02	85	219.95	315.59	318.78	261.29	248.91
201.21	288.70	291.62	239.03	227.70	86	221.11	317.25	320.46	262.65	250.21
204.30	293.13	296.11	242.72	231.21	87	222.07	318.64	321.86	263.81	251.30
207.23	297.34	300.33	246.16	234.49	88	222.82	319.70	322.93	264.69	252.15
209.95	301.23	304.28	249.40	237.58	89	223.35	320.46	323.69	265.30	252.74
212.45	304.83	307.89	252.35	240.41	90+	223.64	320.86	324.10	265.65	253.07

\*See PREMIUM INFORMATION regarding Risk Class and Household Premium Discount rating.  
To obtain annual, semiannual, and quarterly premiums, multiply the above-quoted premiums by 12, 6, and 3, respectively.

**MONTHLY PREMIUMS\***  
**TOBACCO PREMIUMS**  
**ZIP CODES: 480-485**

FEMALE					Attained Age	MALE				
Plan A UM20	Plan C UM21	Plan F UM23	Plan G UM24	Plan M UM30		Plan A UM20	Plan C UM21	Plan F UM23	Plan G UM24	Plan M UM30
129.19	185.36	187.24	153.48	146.20	65	135.99	195.11	197.09	161.54	153.88
129.19	185.36	187.24	153.48	146.20	66	135.99	195.11	197.09	161.54	153.88
134.22	192.59	194.55	159.44	151.90	67	142.80	204.88	206.95	169.63	161.60
139.48	200.13	202.17	165.72	157.85	68	149.99	215.22	217.38	178.18	169.73
144.95	207.97	210.07	172.18	164.02	69	157.55	226.04	228.34	187.16	178.30
150.33	215.67	217.87	178.56	170.11	70	165.20	237.02	239.43	196.25	186.93
155.62	223.27	225.53	184.83	176.10	71	172.90	248.09	250.59	205.39	195.66
160.99	230.98	233.31	191.23	182.17	72	180.88	259.54	262.15	214.88	204.70
166.38	238.72	241.12	197.64	188.27	73	189.08	271.27	274.01	224.58	213.96
171.76	246.46	248.95	204.04	194.38	74	197.42	283.27	286.12	234.53	223.41
176.80	253.68	256.24	210.02	200.08	75	205.61	295.00	297.98	244.24	232.66
181.10	259.83	262.46	215.13	204.93	76	213.06	305.69	308.79	253.10	241.10
184.25	264.37	267.03	218.88	208.50	77	216.76	311.02	314.15	257.50	245.28
187.38	268.87	271.57	222.59	212.05	78	220.47	316.32	319.52	261.88	249.48
190.81	273.77	276.52	226.67	215.91	79	224.48	322.07	325.34	266.65	254.01
194.09	278.48	281.30	230.56	219.64	80	228.34	327.62	330.92	271.25	258.39
198.36	284.60	287.48	235.64	224.46	81	230.64	330.92	334.26	273.99	260.99
202.50	290.54	293.45	240.53	229.14	82	232.75	333.94	337.32	276.48	263.38
206.48	296.25	299.24	245.28	233.65	83	234.63	336.64	340.06	278.73	265.52
210.34	301.78	304.81	249.84	237.99	84	236.30	339.08	342.49	280.72	267.41
214.02	307.06	310.17	254.22	242.18	85	237.79	341.18	344.63	282.47	269.09
217.52	312.11	315.26	258.41	246.16	86	239.04	342.98	346.44	283.95	270.49
220.87	316.89	320.11	262.40	249.95	87	240.07	344.47	347.96	285.20	271.68
224.03	321.45	324.68	266.12	253.51	88	240.89	345.62	349.12	286.15	272.60
226.98	325.66	328.95	269.62	256.84	89	241.45	346.44	349.93	286.81	273.23
229.68	329.54	332.86	272.81	259.90	90+	241.78	346.87	350.38	287.19	273.59

\*See PREMIUM INFORMATION regarding Risk Class and Household Premium Discount rating.  
 To obtain annual, semiannual, and quarterly premiums, multiply the above-quoted premiums by 12, 6, and 3, respectively.

### **Disclosures**

Use this outline to compare benefits and premiums among policies.

### **Premium Information**

We, United of Omaha, can only raise your premium if we raise the premium for all the policies like yours in the same geographic area of the state where you live. Until you are age 90, your premium may change each year. This change will only be made on the first renewal date that coincides with or follows each anniversary of the policy date. Schedules of rates may vary depending upon your policy date.

### **Risk Class Rating**

If, according to our underwriting standards, you are overweight or underweight for your height, you will be considered to be a greater insurable risk. In such a case, your premium will be priced either as Class I - 10% or Class II - 20% higher than the rates illustrated, based on your Body Mass Index (BMI) reading. Risk class rating will not be applicable when you apply for coverage during an open enrollment or guaranteed issue period.

### **Household Premium Discount**

If you resided with at least one, but no more than three, other Medicare eligible adults for the past year, or you are married, and at least one of these other adults or your spouse also owns or is issued a Medicare Supplement policy underwritten by United of Omaha or its affiliates, you will be eligible for a household premium discount. The discounted premium will be priced 7% lower than the rates illustrated. Your policy's household premium discount will be removed if your spouse or the other Medicare Supplement policyholder chooses to terminate their Medicare Supplement policy or he or she no longer resides with you (other than in the case of their death).

### **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 United of Omaha Life Insurance Company, Mutual of Omaha Plaza, Omaha, NE 68175. 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**

The policy may not fully cover all of your medical costs. Neither United of Omaha 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 & 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. 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.

**PLANS A AND C**  
**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	Plan C Pays	You Pay
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days	All but \$1,156	\$0	\$1,156 (Part A Deductible)	\$1,156 (Part A Deductible)	\$0
61 <sup>st</sup> through 90 <sup>th</sup> day	All but \$289 a day	\$289 a day	\$0	\$289 a day	\$0
91 <sup>st</sup> day and after: While using 60 lifetime reserve days	All but \$578 a day	\$578 a day	\$0	\$578 a day	\$0
Once lifetime reserve days are used: Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0**	100% of Medicare Eligible Expenses	\$0**
Beyond the additional 365 days	\$0	\$0	All costs	\$0	All costs
<b>SKILLED NURSING FACILITY CARE*</b> 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	\$0	\$0
21 <sup>st</sup> through 100 <sup>th</sup> day	All but \$144.50 a day	\$0	Up to \$144.50 a day	Up to \$144.50 a day	\$0
101 <sup>st</sup> day and after	\$0	\$0	All costs	\$0	All costs
<b>BLOOD</b>					
First 3 pints	\$0	3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0	\$0	\$0
<b>HOSPICE CARE</b> 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	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/certificate'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.

**PLANS A AND C**  
**MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR**

\*Once you have been billed \$140 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 A Pays	You Pay	Plan C Pays	You Pay
<b>MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , such as physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment					
First \$140 of Medicare Approved Amounts*	\$0	\$0	\$140 (Part B Deductible)	\$140 (Part B Deductible)	\$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0	Generally 20%	\$0
<b>Part B Excess Charges</b> (above Medicare Approved Amounts)	\$0	\$0	All costs	\$0	All costs
<b>BLOOD</b>					
First 3 pints	\$0	All costs	\$0	All costs	\$0
Next \$140 of Medicare Approved Amounts*	\$0	\$0	\$140 (Part B Deductible)	\$140 (Part B Deductible)	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0	20%	\$0
<b>CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0	\$0	\$0

**PARTS A AND B**

<b>HOME HEALTH CARE—MEDICARE APPROVED SERVICES</b> Medically necessary skilled care services and medical supplies	100%	\$0	\$0	\$0	\$0
Durable medical equipment					
First \$140 of Medicare Approved Amounts*	\$0	\$0	\$140 (Part B Deductible)	\$140 (Part B Deductible)	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0	20%	\$0

**PLANS A AND C  
MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR**

**OTHER BENEFITS – NOT COVERED BY MEDICARE**

<b>Services</b>	<b>Medicare Pays</b>	<b>Plan A Pays</b>	<b>You Pay</b>	<b>Plan C Pays</b>	<b>You Pay</b>
<b>FOREIGN TRAVEL—NOT COVERED BY MEDICARE</b> Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA					
First \$250 each calendar year	\$0	N/A	All Costs	\$0	\$250
Remainder of charges	\$0	N/A	All Costs	80% to a lifetime Maximum Benefit of \$50,000	20% and amounts over the \$50,000 lifetime Maximum Benefit

**PLANS F AND 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 F Pays	You Pay	Plan G Pays	You Pay
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days	All but \$1,156	\$1,156 (Part A Deductible)	\$0	\$1,156 (Part A Deductible)	\$0
61 <sup>st</sup> through 90 <sup>th</sup> day	All but \$289 a day	\$289 a day	\$0	\$289 a day	\$0
91 <sup>st</sup> day and after: While using 60 lifetime reserve days	All but \$578 a day	\$578 a day	\$0	\$578 a day	\$0
Once lifetime reserve days are used: Additional 365 days	\$0	100% of Medicare Eligible Expenses	\$0**	100% of Medicare Eligible Expenses	\$0**
Beyond the additional 365 days	\$0	\$0	All costs	\$0	All costs
<b>SKILLED NURSING FACILITY CARE*</b> 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	\$0	\$0
21 <sup>st</sup> through 100 <sup>th</sup> day	All but \$144.50 a day	Up to \$144.50 a day	\$0	Up to \$144.50 a day	\$0
101 <sup>st</sup> day and after	\$0	\$0	All costs	\$0	All costs
<b>BLOOD</b> First 3 pints	\$0	3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0	\$0	\$0
<b>HOSPICE CARE</b> 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	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/certificate'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.

**PLANS F AND G**  
**MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR**

\*Once you have been billed \$140 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 F Pays	You Pay	Plan G Pays	You Pay
<b>MEDICAL EXPENSES</b> —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 \$140 of Medicare Approved Amounts*	\$0	\$140 (Part B Deductible)	\$0	\$0	\$140 (Part B Deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0	Generally 20%	\$0
<b>Part B Excess Charges</b> (above Medicare Approved Amounts)	\$0	100%	\$0	100%	\$0
<b>BLOOD</b>					
First 3 pints	\$0	All costs	\$0	All costs	\$0
Next \$140 of Medicare Approved Amounts*	\$0	\$140 (Part B Deductible)	\$0	\$0	\$140 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0	20%	\$0
<b>CLINICAL LABORATORY SERVICES</b> —TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0	\$0	\$0

**PARTS A AND B**

<b>HOME HEALTH CARE</b> —MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	\$0	\$0	\$0	\$0
Durable medical equipment					
First \$140 of Medicare Approved Amounts*	\$0	\$140 (Part B Deductible)	\$0	\$0	\$140 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0	20%	\$0

**PLANS F AND G  
 MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR**

**OTHER BENEFITS – NOT COVERED BY MEDICARE**

<b>Services</b>	<b>Medicare Pays</b>	<b>Plan F Pays</b>	<b>You Pay</b>	<b>Plan G Pays</b>	<b>You Pay</b>
<b>FOREIGN TRAVEL—NOT COVERED BY MEDICARE</b> 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	\$0	\$250
Remainder of charges	\$0	80% to a lifetime Maximum Benefit of \$50,000	20% and amounts over the \$50,000 lifetime Maximum Benefit	80% to a lifetime Maximum Benefit of \$50,000	20% and amounts over the \$50,000 lifetime Maximum Benefit

**PLAN M**  
**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 M Pays	You Pay
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days	All but \$1,132	\$566 (50% of Part A Deductible)	\$566 (50% of Part A deductible)
61 <sup>st</sup> through 90 <sup>th</sup> day	All but \$283 a day	\$283 a day	\$0
91 <sup>st</sup> day and after: While using 60 lifetime reserve days	All but \$566 a day	\$566 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
<b>SKILLED NURSING FACILITY CARE*</b> 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
21 <sup>st</sup> through 100 <sup>th</sup> day	All but \$141.50 a day	Up to \$141.50 a day	\$0
101 <sup>st</sup> day and after	\$0	\$0	All costs
<b>BLOOD</b> First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
<b>HOSPICE CARE</b> 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

\*\*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/certificate'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 M**  
**MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR**

\*Once you have been billed \$162 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 M Pays	You Pay
<b>MEDICAL EXPENSES</b> —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 \$162 of Medicare Approved Amounts*	\$0	\$0	\$162 (Part B Deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
<b>Part B Excess Charges</b> (above Medicare Approved Amounts)	\$0	\$0	All costs
<b>BLOOD</b> First 3 pints	\$0	All costs	\$0
Next \$162 of Medicare Approved Amounts*	\$0	\$0	\$162 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
<b>CLINICAL LABORATORY SERVICES</b> —TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

**PARTS A AND B**

Services	Medicare Pays	Plan M Pays	You Pay
<b>HOME HEALTH CARE</b> —MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment First \$162 of Medicare Approved Amounts*	\$0	\$0	\$162 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

**OTHER BENEFITS – NOT COVERED BY MEDICARE**

<b>FOREIGN TRAVEL</b> —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 Benefit