Underwritten by
Omaha Insurance Company
A Mutual of Omaha Company

3300 Mutual of Omaha Plaza
Omaha, Nebraska 68175

APPLICATION for MEDICARE SUPPLEMENT INSURANCE AND DENTAL INSURANCE WITH OPTIONAL VISION RIDER

MINNESOTA

NAP22_MN
12/13/2023

OMAHA INSURANCE COMPANY

3300 Mutual of Omaha Plaza
OMAHA, NEBRASKA 68175

OUTLINE OF MEDICARE SUPPLEMENT COVERAGE – COVER PAGE

EXTENDED BASIC PLAN

The Commissioner of Insurance of the State of Minnesota has established two categories of Medicare Supplements and minimum standards for each, with the extended basic Medicare Supplement being the most comprehensive and the basic Medicare Supplement being the least comprehensive. This chart shows the benefits in the Extended Basic Medicare Supplement plan.

Extended Basic—Policy Form NM27
Hospitalization: Part A Coinsurance
Medical Expenses: Part B Coinsurance
Blood: First 3 pints of blood each year
Skilled Nursing Coinsurance
Part A Deductible
Part B Deductible (Medicare first eligible before 2020 only)
Part B Excess (100%)
Foreign Travel
Hospice Care
Preventive Care

PREMIUM INFORMATION

We, Omaha Insurance Company, will renew the policy each time you pay us the premium. It must be by the date it is due or during the 31 days that follow. Your policy stays in force during this 31-day period. Your premium cannot be changed unless we make the same change on all policies of this form owned by persons in your classification which are renewed in the state where you live at the time we change the premium. Any such change can be made on any renewal date. We will give you 30 days advance written notice required by your state prior to any premium change. Any premium change is subject to approval by the Minnesota Department of Commerce.

"Persons in Your Classification" means all persons having the same benefits geographic variations and tobacco use.

OMAHA INSURANCE COMPANY
OMAHA, NEBRASKA
MONTHLY PREMIUMS

ZIP CODES: 550-551, 553-554, 556 - 567

NON-TOBACCO—MONTHLY PREMIUMS		TOBACCO—MONTHLY PREMIUMS	
Extended Basic—Policy Form NM27 All Ages	$ 298.79	**Extended Basic—Policy Form NM27** All Ages	$ 343.44

To obtain annual, semiannual, and quarterly premiums, multiply the above-quoted premiums by 12, 6, and 3, respectively.

The policy provides an anticipated loss ratio of 65%. This means that, on average, Policyholders may expect that at least $65.00 of every $100.00 in premium will be returned as benefits to the Policyholders over the life of the contract. The lowest percentage permitted by state law for this policy or certificate is 65%.

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY

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

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to Omaha Insurance Company, 3300 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, within 10 days.

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 Omaha Insurance Company 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.

RENEWABILITY OF POLICY

Your policy is guaranteed renewable. Unless there has been a material misrepresentation, we cannot cancel your policy as long as you pay the required premium when it is due.

THE POLICY DOES NOT COVER ALL MEDICAL EXPENSES BEYOND THOSE COVERED BY MEDICARE. THE POLICY DOES NOT COVER ALL SKILLED NURSING HOME CARE EXPENSES AND DOES NOT COVER CUSTODIAL OR RESIDENTIAL NURSING CARE. READ YOUR POLICY CAREFULLY TO DETERMINE WHICH NURSING HOME FACILITIES AND EXPENSES ARE COVERED BY YOUR POLICY.

We will not pay for services for which a charge is normally not made where there is no insurance. In addition, no benefits are payable for expense incurred before the coverage effective date.

LIMITATION ON OUT-OF-POCKET EXPENSE

When your out-of-pocket expense equals $1,000.00 in a calendar year, we will pay 100% of additional covered expense you incur during the remainder of such calendar year.

EXTENDED BASIC PLAN – NM27
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 NM27 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 $0
61st through 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
Beyond the additional 150 days	$0	100% of Medicare Eligible Expenses	$0
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 through 100th day	All but $204 a day	Up to $204 a day	$0
101st day and after	$0	80% of covered expenses up to 120 days per year	Expenses not paid by policy
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

EXTENDED BASIC PLAN – NM27
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

Services	Medicare Pays	Plan NM27 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	$240 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	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	$240 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

**Part B coinsurance (generally 20% of Medicare approved expenses), or in the case of hospital outpatient department services under a prospective payment system, applicable copayments.

EXTENDED BASIC PLAN – NM27
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR (continued)
PARTS A AND B

Services	Medicare Pays	Plan NM27 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	$240 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary care services during travel outside the USA	$0	80% of covered expenses	Expenses not paid by Medicare or the policy
PREVENTIVE MEDICAL CARE BENEFIT – NOT COVERED BY MEDICARE Annual physical and preventive tests and services such as: fecal occult blood test, digital rectal exam, mammogram, hearing screening, dipstick urinalysis, diabetes screening, thyroid function test, influenza shot, tetanus and diphtheria booster and education, administered or ordered by your doctor when not covered by Medicare.			
First $120 each calendar year	$0	$120	$0
Additional Charges	$0	$0	All Costs

The charts summarizing Medicare benefits only briefly describe the benefits. The Health Care Financing Administration or its Medicare publication should be consulted for further details and limitations.
Your Policy also provides the following benefits:

1. **Alcoholism and Chemical Dependency Treatment Benefit.** We will pay the usual and customary charge for the treatment of alcoholism or chemical dependency on the same basis as any other sickness or injury and as if Medicare paid benefits when treatment is provided in: (a) a licensed hospital; (b) a residential treatment program licensed by the state of Minnesota pursuant to diagnosis or recommendation by a doctor of medicine; or (c) a nonresidential treatment program approved or licensed by the state of Minnesota. Benefits under this provision are not payable for any portion of expense that is paid under any other part of your policy.

2. **Scalp Hair Prosthesis.** We will pay the expense incurred on the same basis as any other Sickness or Injury and as if Medicare paid benefits for a scalp hair prosthesis needed because of hair loss suffered as a result of alopecia areata. This benefit is limited to a maximum of one scalp hair prosthesis per benefit year. Amounts in excess of the Usual and Customary Charge are not considered expense. Benefits are not payable for that portion of expense that is paid by Medicare or paid under any other part of this policy.

3. **Routine Screening Procedures for Cancer.** We will pay the expense incurred that is not paid by Medicare or paid under any other part of your policy for routine screening procedures for cancer and the office or facility visit, including mammograms, digital breast tomosynthesis, surveillance tests for ovarian cancer for women at risk for ovarian cancer, Pap smears and colorectal screening tests for men and women when ordered or provided by a physician in accordance with the standard practice of medicine.

4. **Temporomandibular Joint Disorder and Craniomandibular Disorder.** Benefits are payable for the surgical and nonsurgical treatment of temporomandibular joint disorder and craniomandibular disorder on the same basis as that for treatment to any other joint in the body. Such treatment must be administered or prescribed by a physician or dentist. Benefits are not payable under this part of your policy for any expense payable under another part of the policy.

5. **Reconstructive Surgery.** Benefits are payable for reconstructive surgery on the same basis as that for any other surgery if the reconstructive surgery is incidental to or follows surgery resulting from injury, sickness or other disease of the involved part. This benefit includes reconstructive surgery following a mastectomy, for all stages of reconstruction of the breast on which the mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prosthesis and physical complications at all stages of a mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and you. Benefits are not payable under this policy for an expense payable under another part of the policy.

6. **Outpatient Services Benefit.** We will pay the usual and customary charge for a health care treatment or surgery on an outpatient basis at a facility equipped to perform these services, whether or not the facility is part of a hospital. We will pay benefits on the same basis as if you had received the health care treatment or surgery at a hospital. Benefits under this provision are not payable for any portion of expense that is paid under any other part of your policy.

7. **Immunization Benefits.** We will pay the usual and customary charge for immunizations you receive when recommended by a physician and not covered under Part D of Medicare. Benefits under this provision are not payable for any portion of expense that is paid under any other part of your policy.

8. **Phenylketonuria Treatment.** Benefits are payable for special dietary treatment for phenylketonuria when recommended by a physician.

9. **Diabetes Equipment and Supplies**. We will pay 80% of the usual and customary charge not covered by Medicare or Medicare Part D for all physician-prescribed medically appropriate and necessary equipment and supplies used in the management and treatment of diabetes, including gestational, type I or type II diabetes. We will also pay diabetes outpatient self-management training and education, including medical nutrition therapy, that is provided by certified, registered, or licensed health care professional working in a program consistent with the national standards of diabetes self-management education as established by the American Diabetes Association. This benefit is limited to equipment and supplies not covered by Medicare Part D, whether or not you are enrolled in Medicare Part D. Benefits under this provision are not payable for any portion of expense that is paid under any other part of your policy.

10. **Routine Prostate Cancer Screening.** We will pay the usual and customary charge for prostate cancer screening for: (a) men who are 50 years of age or older; and (b) men who are 40 years of age or older who are symptomatic or at a high risk of developing prostate cancer. Screening must consist of at least: (a) a prostate-specific antigen blood test; and (b) a digital rectal examination.

11. **Court Ordered Mental Health Treatment Benefits.** Are payable for court ordered mental health treatment that is based on an evaluation and recommendation for such treatment or services by a physician or licensed psychologist. Benefits are not payable for any portion of expense that is paid under any other part of the policy.

12. **Physical and Occupational Therapy Services**. We will pay the allowable amount not paid by Medicare, less the Part B Deductible if applicable.

13. **Treatment of Lyme Disease.** We will pay benefits for diagnosed Lyme disease as any other medical service. Benefits will not be payable for that portion of expense that is paid by Medicare or under any other part of your policy.

14. **Ventilator Dependency.** Benefits are payable for up to 120 hours of services provided by a private duty nurse or personal care assistant to a ventilator dependent person during the time the ventilator dependent person is in a hospital. Benefits are not payable for any portion of expense that is paid under any other part of your policy.

ADDITIONAL BENEFITS UNDER EXTENDED BASIC PLAN - NM27 We will pay 80% of the usual and customary charges for the following articles and services prescribed by a physician which are not paid by Medicare or payable under any other provision of your policy.

1. Hospital services.
2. Professional services for the diagnosis or treatment of injuries, sickness or conditions when such services are given by a physician or are under a physician's direction.
3. Services of a nursing home for not more than 120 days each year. Such services must qualify as reimbursable under Medicare.
4. Services of a home health agency. Such services must qualify as reimbursable under Medicare.
5. Use of radium or other radioactive materials.
6. Oxygen.
7. Anesthetics.
8. Prosthetic devices other than dental.
9. Rental or purchase, as appropriate, of durable medical equipment other than eyeglasses and hearing aids.
10. Diagnostic X-rays and lab tests.
11. Oral surgery for: (a) partially or completely unerupted impacted teeth, (b) a tooth root without the extraction of the entire root or (c) the gums or tissues of the mouth when not performed in connection with the extraction or repair of teeth.
12. Services of a physical therapist.
13. Professional ambulance for service to the nearest facility qualified to treat the condition, or a reasonable mileage rate for transportation to a kidney dialysis center for treatment.
14. Up to $500.00 for a second surgical opinion. Not included is the repetition of diagnostic tests.
15. Services of an occupational therapist.

The above Additional Benefits are not payable for:

(a) cosmetic surgery, other than for reconstructive surgery, as provided under the Reconstructive Surgery Benefit,
(b) care which is primarily for custodial or for domiciliary purposes which would not qualify as eligible services under Medicare,
(c) any charge for confinement in a private room to the extent it is in excess of the institutions' charge for its most common semiprivate room unless the private room is prescribed as medically necessary by a physician.
(d) any charges for services or articles the provision of which is not within the scope of authorized practice of the institution or individual rendering the services or articles.

OMAHA INSURANCE COMPANY

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OUTLINE OF MEDICARE SUPPLEMENT COVERAGE – COVER PAGE

BASIC PLAN

The Commissioner of Insurance of the State of Minnesota has established two categories of Medicare Supplements and minimum standards for each, with the extended basic Medicare Supplement being the most comprehensive and the basic Medicare Supplement being the least comprehensive. This chart shows the benefits in the Basic Medicare Supplement plan.

Basic—Policy Form NM26
Hospitalization: Part A Coinsurance

Medical Expenses: Part B Coinsurance

Blood: First 3 pints of blood each year

Skilled Nursing Coinsurance

0NR3F Part A Deductible Rider*

0NR4F Part B Deductible Rider* (Medicare first eligible before 2020 only)

0NR5F Preventive Care Rider*

Foreign Travel Emergency

Hospice Care

0NR6F REV Part B Excess Rider*

PREMIUM INFORMATION

We, Omaha Insurance Company, will renew the policy each time you pay us the premium. It must be by the date it is due or during the 31 days that follow. Your policy stays in force during this 31-day period. Your premium cannot be changed unless we make the same change on all policies of this form owned by persons in your classification which are renewed in the state where you live at the time we change the premium. Any such change can be made on any renewal date. We will give you 30 days advance written notice required by your state prior to any premium change. Any premium change is subject to approval by the Minnesota Department of Commerce. Schedules of rates may vary depending on your Policy Date.

"Persons in Your Classification" means all persons having the same benefits geographic variations and tobacco use.

*Optional riders available for Part A Deductible, Part B Excess, Medicare Part B Deductible and Preventive Health Services.

OMAHA INSURANCE COMPANY
OMAHA, NEBRASKA
MONTHLY PREMIUMS

ZIP CODES: 550-551, 553-554, 556 - 567

NON-TOBACCO—MONTHLY PREMIUMS			TOBACCO—MONTHLY PREMIUMS		
Basic—Policy Form NM26	$	251.80	**Basic—Policy Form NM26**	$	289.43
All Ages			All Ages		
Optional Riders			Optional Riders		
Part A Deductible Rider 0NR3F	$	38.03	Part A Deductible Rider 0NR3F	$	43.71
Preventative Medical Care Rider 0NR5F	$	5.79	Preventative Medical Care Rider 0NR5F	$	6.66
Part B Excess Rider 0NR6F REV	$	-	Part B Excess Rider 0NR6F REV	$	-
Part B Deductible Rider 0NR4F	$	18.83	Part B Deductible Rider 0NR4F	$	18.83

To obtain annual, semiannual, and quarterly premiums, multiply the above-quoted premiums by 12, 6, and 3, respectively.

The policy provides an anticipated loss ratio of 65%. This means that, on average, Policyholders may expect that at least $65.00 of every $100.00 in premium will be returned as benefits to the Policyholders over the life of the contract. The lowest percentage permitted by state law for this policy or certificate is 65%.

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY

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

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to Omaha Insurance Company, 3300 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, within 10 days.

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 Omaha Insurance Company 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.

RENEWABILITY OF POLICY

Your policy is guaranteed renewable. Unless there has been a material misrepresentation, we cannot cancel your certificate as long as you pay the required premium when it is due.

THE POLICY DOES NOT COVER ALL MEDICAL EXPENSES BEYOND THOSE COVERED BY MEDICARE. THE POLICY DOES NOT COVER ALL SKILLED NURSING HOME CARE EXPENSES AND DOES NOT COVER CUSTODIAL OR RESIDENTIAL NURSING CARE. READ YOUR POLICY CAREFULLY TO DETERMINE WHICH NURSING HOME FACILITIES AND EXPENSES ARE COVERED BY YOUR POLICY.

We will not pay for services for which a charge is normally not made where there is no insurance. In addition, no benefits are payable for expense incurred before the coverage effective date.

BASIC PLAN – NM26
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 NM26 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 with Optional Part A Deductible Benefit Rider 0NR3F	$1,632 (Part A Deductible) $0
61st through 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
Beyond the additional 150 days	$0	100% of Medicare Eligible Expenses	$0
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 through 100th day	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

BASIC PLAN – NM26
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

Services	Medicare Pays	Plan NM26 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 with Optional Benefit Rider 0NR4F	$240 (Part B Deductible) $0
Remainder of Medicare Approved Amounts	80%	20%***	$0
Part B Excess Charges (above Medicare Approved Amounts)	$0	$0 100% with Rider 0NR6F REV	All costs $0
BLOOD			
First 3 pints	$0	All costs	$0
Next $240 of Medicare Approved Amounts**	$0	$0 $240 with Optional Benefit Rider 0NR4F	$240 (Part B Deductible) $0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

**Once you have been billed $240 of Medicare Approved Amounts for covered services, your Part B Deductible will have been met for the calendar year.
*** Part B coinsurance (generally 20% of Medicare approved expenses), or in the case of hospital outpatient department services under a prospective payment system, applicable copayments.

BASIC PLAN – NM26
PARTS A AND B

Services	Medicare Pays	Plan NM26 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 with Optional Benefit Rider 0NR4F	$240 (Part B Deductible) $0
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during travel outside the USA (hospital, medical expense and supplies)	$0	80% of covered expenses	Expenses not paid by Medicare or the policy
PREVENTIVE MEDICAL CARE BENEFIT – NOT COVERED BY MEDICARE Annual physical and preventive tests and services administered or ordered by your doctor when not covered by Medicare. First $120 each calendar year	$0	$0 $120 with Optional Benefit Rider 0NR5F	$120 $0
Additional Charges	$0	$0 $0 with Optional Benefit Rider 0NR5F	All Costs All Costs

The charts summarizing Medicare benefits only briefly describe the benefits. The Health Care Financing Administration or its Medicare publication should be consulted for further details and limitations.
Your Policy also provides the following benefits:

1. **Alcoholism and Chemical Dependency Treatment Benefit.** We will pay the usual and customary charge for the treatment of alcoholism or chemical dependency on the same basis as any other sickness or injury and as if Medicare paid benefits when treatment is provided in: (a) a licensed hospital; (b) a residential treatment program licensed by the state of Minnesota pursuant to diagnosis or recommendation by a doctor of medicine; or (c) a nonresidential treatment program approved or licensed by the state of Minnesota. Benefits under this provision are not payable for any portion of expense that is paid under any other part of your policy.

2. **Scalp Hair Prosthesis.** We will pay the expense incurred on the same basis as any other Sickness or Injury and as if Medicare paid benefits for a scalp hair prosthesis needed because of hair loss suffered as a result of alopecia areata. This benefit is limited to a maximum of one scalp hair prosthesis per benefit year. Amounts in excess of the Usual and Customary Charge are not considered expense. Benefits are not payable for that portion of expense that is paid by Medicare or paid under any other part of this policy.

3. **Routine Screening Procedures for Cancer.** We will pay the expense incurred that is not paid by Medicare or paid under any other part of your policy for routine screening procedures for cancer and the office or facility visit, including mammograms, digital breast tomosynthesis, surveillance tests for ovarian cancer for women at risk for ovarian cancer, Pap smears and colorectal screening tests for men and women when ordered or provided by a physician in accordance with the standard practice of medicine.

4. **Temporomandibular Joint Disorder and Craniomandibular Disorder.** Benefits are payable for the surgical and nonsurgical treatment of temporomandibular joint
disorder and craniomandibular disorder on the same basis as that for treatment to any other joint in the body. Such treatment must be administered or prescribed by a physician or dentist. Benefits are not payable under this part of your policy for any expense payable under another part of the policy.

5. **Reconstructive Surgery.** Benefits are payable for reconstructive surgery on the same basis as that for any other surgery if the reconstructive surgery is incidental
to or follows surgery resulting from injury, sickness or other disease of the involved part. This benefit includes reconstructive surgery following a mastectomy, for all stages of reconstruction of the breast on which the mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prosthesis and physical complications at all stages of a mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and you. Benefits are not payable under this policy for an expense payable under another part of the policy.

6. **Outpatient Services Benefit.** We will pay the usual and customary charge for a health care treatment or surgery on an outpatient basis at a facility equipped to perform these services, whether or not the facility is part of a hospital. We will pay benefits on the same basis as if you had received the health care treatment or surgery at a hospital. Benefits under this provision are not payable for any portion of expense that is paid under any other part of your policy.

7. **Immunization Benefits.** We will pay the usual and customary charge for immunizations you receive when recommended by a physician and not covered under Part D of Medicare. Benefits under this provision are not payable for any portion of expense that is paid under any other part of your policy.

8. **Phenylketonuria Treatment.** Benefits are payable for special dietary treatment for phenylketonuria when recommended by a physician.

9. **Diabetes Equipment and Supplies**. We will pay 80% of the usual and customary charge not covered by Medicare or Medicare Part D for all physician-prescribed medically appropriate and necessary equipment and supplies used in the management and treatment of diabetes, including gestational, type I or type II diabetes. We will also pay diabetes outpatient self-management training and education, including medical nutrition therapy, that is provided by certified, registered, or licensed health care professional working in a program consistent with the national standards of diabetes self-management education as established by the American Diabetes Association. This benefit is limited to equipment and supplies not covered by Medicare Part D, whether or not you are enrolled in Medicare Part D. Benefits under this provision are not payable for any portion of expense that is paid under any other part of your policy.

10. **Routine Prostate Cancer Screening.** We will pay the usual and customary charge for prostate cancer screening for: (a) men who are 50 years of age or older; and (b) men who are 40 years of age or older who are symptomatic or at a high risk of developing prostate cancer. Screening must consist of at least: (a) a prostate-specific antigen blood test; and (b) a digital rectal examination.

11. **Court Ordered Mental Health Treatment Benefits.** Are payable for court ordered mental health treatment that is based on an evaluation and recommendation for such treatment or services by a physician or licensed psychologist. Benefits are not payable for any portion of expense that is paid under any other part of the policy.

12. **Physical and Occupational Therapy Services**. We will pay the allowable amount not paid by Medicare, less the Part B Deductible if applicable.

13. **Treatment of Lyme Disease.** We will pay benefits for diagnosed Lyme disease as any other medical service. Benefits will not be payable for that portion of expense that is paid by Medicare or under any other part of your policy.

14. **Ventilator Dependency.** Benefits are payable for up to 120 hours of services provided by a private duty nurse or personal care assistant to a ventilator dependent person during the time the ventilator dependent person is in a hospital. Benefits are not payable for any portion of expense that is paid under any other part of your policy.

OPTIONAL COVERAGE AVAILABLE FOR BASIC PLAN - NM26 (check if applied for)

☐ **0NR6F REV - Part B Excess Rider**

We will pay 100% of the difference between the actual charge billed to Medicare Part B for your medical expenses and the amount approved by Medicare Part B. The excess charges we will pay may not exceed any charge limitation established by Medicare or state law.

☐ **0NR3F - Medicare Part A Hospital Deductible Benefits Rider**

If you are confined in a hospital, we will pay 100% of the Medicare Part A inpatient hospital deductible amount due for each benefit period.

☐ **0NR5F - Preventive Medical Care Rider**

We will pay 100% of the Medicare-approved amount of the actual charges, as if Medicare were to cover the service, as identified in the American Medical Association's Current Procedural Terminology (AMA CPT) codes, to a maximum of $120.00 per calendar year. Benefits under this rider are not payable for any portion of expense that is paid under any part of your policy.

We will provide coverage for:
(a) preventive screening tests and preventive services that your attending physician determines to be medically appropriate in selection and frequency; and
(b) an annual clinical preventive medical history and physical examination that may include preventive screening tests and preventive services, and patient education to address preventive health care measures.

☐ **0NR4F - Medicare Part B Deductible Rider**

We will pay 100% of the Medicare Part B deductible amount due each calendar year for Part B Medicare-eligible expenses you incur.

OMAHA INSURANCE COMPANY

3300 Mutual of Omaha Plaza
OMAHA, NEBRASKA 68175

OUTLINE OF MEDICARE SUPPLEMENT COVERAGE – COVER PAGE

2020 EXTENDED BASIC PLAN

The Commissioner of Insurance of the State of Minnesota has established two categories of Medicare Supplements and minimum standards for each, with the extended basic Medicare Supplement being the most comprehensive and the basic Medicare Supplement being the least comprehensive. This chart shows the benefits in the Extended Basic Medicare Supplement plan.

2020 Extended Basic—Policy Form NM37
Hospitalization: Part A Coinsurance
Medical Expenses: Part B Coinsurance
Blood: First 3 pints of blood each year
Skilled Nursing Coinsurance
Part A Deductible
Part B Excess (100%)
Foreign Travel
Hospice Care
Preventive Care

PREMIUM INFORMATION

We, Omaha Insurance Company, will renew the policy each time you pay us the premium. It must be by the date it is due or during the 31 days that follow. Your policy stays in force during this 31-day period. Your premium cannot be changed unless we make the same change on all policies of this form owned by persons in your classification which are renewed in the state where you live at the time we change the premium. Any such change can be made on any renewal date. We will give you 30 days advance written notice required by your state prior to any premium change. Any premium change is subject to approval by the Minnesota Department of Commerce.

"Persons in Your Classification" means all persons having the same benefits geographic variations and tobacco use.

OMAHA INSURANCE COMPANY
OMAHA, NEBRASKA
MONTHLY PREMIUMS

ZIP CODES: 550-551, 553-554, 556 - 567

NON-TOBACCO—MONTHLY PREMIUMS		TOBACCO—MONTHLY PREMIUMS	
2020 Extended Basic—Policy Form NM37 All Ages	$ 252.33	**2020 Extended Basic—Policy Form NM37** All Ages	$ 290.03

To obtain annual, semiannual, and quarterly premiums, multiply the above-quoted premiums by 12, 6, and 3, respectively.

The policy provides an anticipated loss ratio of 65%. This means that, on average, Policyholders may expect that at least $65.00 of every $100.00 in premium will be returned as benefits to the Policyholders over the life of the contract. The lowest percentage permitted by state law for this policy or certificate is 65%.

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY

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

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to Omaha Insurance Company, 3300 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, within 10 days.

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 Omaha Insurance Company 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.

RENEWABILITY OF POLICY

Your policy is guaranteed renewable. Unless there has been a material misrepresentation, we cannot cancel your policy as long as you pay the required premium when it is due.

THE POLICY DOES NOT COVER ALL MEDICAL EXPENSES BEYOND THOSE COVERED BY MEDICARE. THE POLICY DOES NOT COVER ALL SKILLED NURSING HOME CARE EXPENSES AND DOES NOT COVER CUSTODIAL OR RESIDENTIAL NURSING CARE. READ YOUR POLICY CAREFULLY TO DETERMINE WHICH NURSING HOME FACILITIES AND EXPENSES ARE COVERED BY YOUR POLICY.

We will not pay for services for which a charge is normally not made where there is no insurance. In addition, no benefits are payable for expense incurred before the coverage effective date.

LIMITATION ON OUT-OF-POCKET EXPENSE

When your out-of-pocket expense equals $1,000.00 in a calendar year, we will pay 100% of additional covered expense you incur during the remainder of such calendar year.

2020 EXTENDED BASIC PLAN – NM37
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 NM37 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 $0
61st through 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
Beyond the additional 150 days	$0	100% of Medicare Eligible Expenses	$0
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 through 100th day	All but $204 a day	Up to $204 a day	$0
101st day and after	$0	80% of covered expenses up to 120 days per year	Expenses not paid by policy
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

2020 EXTENDED BASIC PLAN – NM37
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

Services	Medicare Pays	Plan NM37 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	80%	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 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

**Part B coinsurance (generally 20% of Medicare approved expenses), or in the case of hospital outpatient department services under a prospective payment system, applicable copayments.

2020 EXTENDED BASIC PLAN – NM37
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR (continued)
PARTS A AND B

Services	Medicare Pays	Plan NM37 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

OTHER BENEFITS – NOT COVERED BY MEDICARE

FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary care services during travel outside the USA	$0	80% of covered expenses	Expenses not paid by Medicare or the policy
PREVENTIVE MEDICAL CARE BENEFIT – NOT COVERED BY MEDICARE Annual physical and preventive tests and services such as: fecal occult blood test, digital rectal exam, mammogram, hearing screening, dipstick urinalysis, diabetes screening, thyroid function test, influenza shot, tetanus and diphtheria booster and education, administered or ordered by your doctor when not covered by Medicare.			
First $120 each calendar year	$0	$120	$0
Additional Charges	$0	$0	All Costs

The charts summarizing Medicare benefits only briefly describe the benefits. The Health Care Financing Administration or its Medicare publication should be consulted for further details and limitations.
Your Policy also provides the following benefits:

1. **Alcoholism and Chemical Dependency Treatment Benefit.** We will pay the usual and customary charge for the treatment of alcoholism or chemical dependency on the same basis as any other sickness or injury and as if Medicare paid benefits when treatment is provided in: (a) a licensed hospital; (b) a residential treatment program licensed by the state of Minnesota pursuant to diagnosis or recommendation by a doctor of medicine; or (c) a nonresidential treatment program approved or licensed by the state of Minnesota. Benefits under this provision are not payable for any portion of expense that is paid under any other part of your policy.

2. **Scalp Hair Prosthesis.** We will pay the expense incurred on the same basis as any other Sickness or Injury and as if Medicare paid benefits for a scalp hair prosthesis needed because of hair loss suffered as a result of alopecia areata. This benefit is limited to a maximum of one scalp hair prosthesis per benefit year. Amounts in excess of the Usual and Customary Charge are not considered expense. Benefits are not payable for that portion of expense that is paid by Medicare or paid under any other part of this policy.

3. **Routine Screening Procedures for Cancer.** We will pay the expense incurred that is not paid by Medicare or paid under any other part of your policy for routine screening procedures for cancer and the office or facility visit, including mammograms, digital breast tomosynthesis, surveillance tests for ovarian cancer for women at risk for ovarian cancer, Pap smears and colorectal screening tests for men and women when ordered or provided by a physician in accordance with the standard practice of medicine.

4. **Temporomandibular Joint Disorder and Craniomandibular Disorder.** Benefits are payable for the surgical and nonsurgical treatment of temporomandibular joint disorder and craniomandibular disorder on the same basis as that for treatment to any other joint in the body. Such treatment must be administered or prescribed by a physician or dentist. Benefits are not payable under this part of your policy for any expense payable under another part of the policy.

5. **Reconstructive Surgery.** Benefits are payable for reconstructive surgery on the same basis as that for any other surgery if the reconstructive surgery is incidental to or follows surgery resulting from injury, sickness or other disease of the involved part. This benefit includes reconstructive surgery following a mastectomy, for all stages of reconstruction of the breast on which the mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prosthesis and physical complications at all stages of a mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and you. Benefits are not payable under this policy for an expense payable under another part of the policy.

6. **Outpatient Services Benefit.** We will pay the usual and customary charge for a health care treatment or surgery on an outpatient basis at a facility equipped to perform these services, whether or not the facility is part of a hospital. We will pay benefits on the same basis as if you had received the health care treatment or surgery at a hospital. Benefits under this provision are not payable for any portion of expense that is paid under any other part of your policy.

7. **Immunization Benefits.** We will pay the usual and customary charge for immunizations you receive when recommended by a physician and not covered under Part D of Medicare. Benefits under this provision are not payable for any portion of expense that is paid under any other part of your policy.

8. **Phenylketonuria Treatment.** Benefits are payable for special dietary treatment for phenylketonuria when recommended by a physician.

9. **Diabetes Equipment and Supplies**. We will pay 80% of the usual and customary charge not covered by Medicare or Medicare Part D for all physician-prescribed medically appropriate and necessary equipment and supplies used in the management and treatment of diabetes, including gestational, type I or type II diabetes. We will also pay diabetes outpatient self-management training and education, including medical nutrition therapy, that is provided by certified, registered, or licensed health care professional working in a program consistent with the national standards of diabetes self-management education as established by the American Diabetes Association. This benefit is limited to equipment and supplies not covered by Medicare Part D, whether or not you are enrolled in Medicare Part D. Benefits under this provision are not payable for any portion of expense that is paid under any other part of your policy.

10. **Routine Prostate Cancer Screening.** We will pay the usual and customary charge for prostate cancer screening for: (a) men who are 50 years of age or older; and (b) men who are 40 years of age or older who are symptomatic or at a high risk of developing prostate cancer. Screening must consist of at least: (a) a prostate-specific antigen blood test; and (b) a digital rectal examination.

11. **Court Ordered Mental Health Treatment Benefits.** Are payable for court ordered mental health treatment that is based on an evaluation and recommendation for such treatment or services by a physician or licensed psychologist. Benefits are not payable for any portion of expense that is paid under any other part of the policy.

12. **Physical and Occupational Therapy Services**. We will pay the allowable amount not paid by Medicare, less the Part B Deductible if applicable.

13. **Treatment of Lyme Disease.** We will pay benefits for diagnosed Lyme disease as any other medical service. Benefits will not be payable for that portion of expense that is paid by Medicare or under any other part of your policy.

14. **Ventilator Dependency.** Benefits are payable for up to 120 hours of services provided by a private duty nurse or personal care assistant to a ventilator dependent person during the time the ventilator dependent person is in a hospital. Benefits are not payable for any portion of expense that is paid under any other part of your policy.

ADDITIONAL BENEFITS UNDER 2020 EXTENDED BASIC PLAN – NM37 We will pay 80% of the usual and customary charges for the following articles and services prescribed by a physician which are not paid by Medicare or payable under any other provision of your policy.

1. Hospital services.
2. Professional services for the diagnosis or treatment of injuries, sickness or conditions when such services are given by a physician or are under a physician's direction.
3. Services of a nursing home for not more than 120 days each year. Such services must qualify as reimbursable under Medicare.
4. Services of a home health agency. Such services must qualify as reimbursable under Medicare.
5. Use of radium or other radioactive materials.
6. Oxygen.
7. Anesthetics.
8. Prosthetic devices other than dental.
9. Rental or purchase, as appropriate, of durable medical equipment other than eyeglasses and hearing aids.
10. Diagnostic X-rays and lab tests.
11. Oral surgery for: (a) partially or completely unerupted impacted teeth, (b) a tooth root without the extraction of the entire root or (c) the gums or tissues of the mouth when not performed in connection with the extraction or repair of teeth.
12. Services of a physical therapist.
13. Professional ambulance for service to the nearest facility qualified to treat the condition, or a reasonable mileage rate for transportation to a kidney dialysis center for treatment.
14. Up to $500.00 for a second surgical opinion. Not included is the repetition of diagnostic tests.
15. Services of an occupational therapist.

The above Additional Benefits are not payable for:

(a) cosmetic surgery, other than for reconstructive surgery, as provided under the Reconstructive Surgery Benefit,
(b) care which is primarily for custodial or for domiciliary purposes which would not qualify as eligible services under Medicare,
(c) any charge for confinement in a private room to the extent it is in excess of the institutions' charge for its most common semiprivate room unless the private room is prescribed as medically necessary by a physician,
(d) any charges for services or articles the provision of which is not within the scope of authorized practice of the institution or individual rendering the services or articles.

Minnesota — Producer Information – Please Complete

Producer Name	Agent Writing Number or Social Security Number	Commission Share	Commission Code Required only if you are not appointed or licensed or are changing brokerage firms
		%	
		%	

Preferred Method of Communication (Select one)

☐ Phone ☐ Fax ☐ Email Contact info: _____

Note: Producers must be under the same commission code to share or split commissions. Please update your contact information at http://www.mutualofomaha.com/.

Application Submission Checklist – Omaha Ins. Co. Medicare Supplement Coverage

☐ **Provide Applicant with the Guide to Health Insurance for People with Medicare**

☐ **Provide Applicant with the Outline of Coverage**
- Calculate the premium based on age at application date

☐ **Application (complete in full)**

Sections A & B: Plan and Applicant Information
- Select plan
- Enter Requested Effective Date
- Indicate where the policy is to be mailed

Section C: Medicare Information
- Include applicant's Medicare number on the application. This number is required for electronic claim processing. If this number is not available at time of application, the applicant/agent must provide this number by calling 1-877-617-5587 once it is received. If not already covered by Medicare, indicate "eligibility" and "enrollment" dates.

Section D: Previous or Existing Coverage Information
- Please complete ALL questions in full

For Sections E and F – Refer to the Open Enrollment/Guaranteed Issue worksheet to help identify eligibility.

Section E: Please answer all of the following questions
- If applicant answered "YES" to question 7 OR BOTH questions 8 and 9 in Section E, they can skip to Section H

Sections F & G: Health/Medication Information
- Do NOT answer if applicant is in an open enrollment or guaranteed issue period

Section H: Agreement and Authorization
- Make sure applicant signs and dates the application

Section J: To be Completed by Producer
- Make sure producer(s) sign and date the application

☐ **Complete the Method of Payment form and return with the completed application**
- Use premium determined by the **Outline of Coverage**
- The full modal premium is collected at the time of application

☐ **Complete Replacement Notice and leave a copy with the applicant (if applicable)**

☐ **Provide Applicant with Premium Receipt signed by agent (if applicable), and provide Applicant with Notice of Information Practices**

☐ **Complete the Agent Information Form and leave with the applicant**

☐ **Provide applicant with completed and signed copy of application before submitting original application for processing.**

Note: An interviewer may call to verify/confirm the information provided on the application.

NAP175_MN_0320

Open Enrollment and Guaranteed Issue Worksheet

If <u>any</u> 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

<u>If Medicare Part A eligibility date is before 01/01/2020, applicant has the right to buy Medicare supplement Plan A, B, C, F, High Deductible F, K or L that is sold in the applicant's state by any insurance company.</u>

<u>If Medicare Part A eligibility date is on or after 01/01/2020, applicant has the right to buy Medicare</u> supplement Plan A, B, D, G, High Deductible G, 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

If Medicare Part A eligibility date is before 01/01/2020, applicant has the right to buy Medicare supplement Plan A, B, C, F, High Deductible F, K or L that is sold in the applicant's state by any insurance company.

If Medicare Part A eligibility date is on or after 01/01/2020, applicant has the right to buy Medicare supplement Plan A, B, D, G, High Deductible G, 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 obtain their Medicare supplement policy back if that carrier still sells it or, if not available:

- *If Medicare Part A eligibility date is before 01/01/2020, applicant has the right to buy Medicare supplement Plan A, B, C, F, High Deductible F, K or L that is sold in the applicant's state by any insurance company.*
- *If Medicare Part A eligibility date is on or after 01/01/2020, applicant has the right to buy Medicare supplement Plan A, B, D, G, High Deductible G, K or L that is sold in the applicant's state by any insurance company.*

Applicant was enrolled in a Medicaid plan or state-specific variation of a Medicaid plan, and:

- the applicant's state has Guaranteed Issue or Open Enrollment Rights for the loss of Medicaid or state-specific variation of a Medicaid plan

Reference the Underwriting Guidelines for states that have Guarantee Issue or Open Enrollment Rights for loss of Medicaid or state-specific variation of a Medicaid plan.

Acceptable Evidence of Eligibility (Can vary by situation, refer to Underwriting Guide):

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 (<u>ONLY</u> allowed if your MA plan is being terminated)
g. Copy of the termination letter that the applicant received regarding their state Medicaid plan or state-specific variation of a Medicaid plan

M27788_0819

DNIS _____ Auth # _____

Agent Writing # _____ Group # (if applicable) _____ Keyline _____

Underwritten by
Omaha Insurance Company
A Mutual of Omaha Company

3300 Mutual of Omaha Plaza
Omaha, Nebraska 68175

Application for Medicare Supplement Coverage

Applicant acknowledges and agrees that if there is more than one applicant on this application, all information provided may be viewed or shared with the other applicant.

How Did You Hear About Us?

Please select all that apply. Thank you for providing this helpful information.

☐ Agent/Broker/Producer ☐ Family Member/Friend ☐ Physician Referral ☐ Social Media

☐ Direct Mail ☐ Internet Search ☐ Radio ☐ TV

A. Plan Information (to be completed by Producer)

Plan

☐ Basic Policy - NM26

☐ 2020 Extended Basic Policy - NM37

Optional Riders (only available for Basic Policy)

☐ Part A Deductible - 0NR3F

☐ Preventative Care - 0NR5F

☐ Part B Excess - 0NR6F

OR

If your Medicare Part A eligibility date is before 01/01/2020, this **additional** rider or plan are available options:

Plan

☐ Extended Basic Policy - NM27

Optional Rider (only available for Basic Policy)

☐ Part B Deductible - 0NR4F

Requested Effective Date ___ / ___ / ____

Deliver Policy to

Applicant A ☐ Producer ☐

B. Applicant Information

Name (First/Middle Initial/Last)

Residence Address

City

State ZIP

Mailing Address (if different from residence address)

City

State ZIP

Home Phone ___ – ___ – ____
(area code)

E-mail Address

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B. Applicant Information (continued)

Current Age _____

Date of Birth ___ / ___ / _____
mo day yr

☐ Male ☐ Female

Social Security # ___ – ___ – ____

Height Ft ___ In ___ Weight Lbs ___

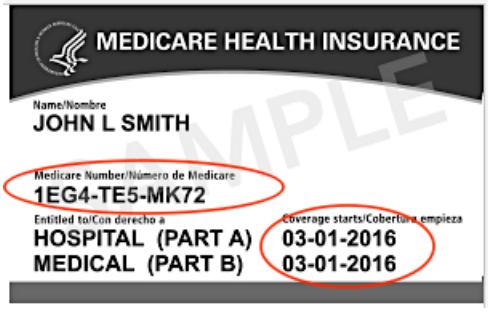
Have you used tobacco in any form in the past 12 months? ..... ☐ Y ☐ N

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 Omaha Insurance Company.

Receive statement online? ..... ☐ Y ☐ N

C. Medicare Information

Please reference your Medicare card to complete this section.



Medicare Claim Number

Medicare Part A Effective Date ___/___/_____

If you are not covered under Medicare Part A, what is your eligibility date ___/___/_____

Medicare Part B Effective Date ___/___/_____

If you are not covered under Medicare Part B, indicate the date you plan to enroll ___/___/_____

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D. 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:

3. Are you covered for medical assistance through the state Medicaid program? ..... ☐ Y ☐ N
   (NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer "NO" to this question.)
   If "YES," answer the following about this existing coverage:
   (a) Will Medicaid pay your premiums for this Medicare supplement policy?..... ☐ Y ☐ N
   (b) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium? ..... ☐ Y ☐ 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?..... ☐ Y ☐ N
   If "YES," answer the following about this existing coverage:
   (a) Do you intend to replace your current Medicare supplement policy/certificate with this policy? ..... ☐ Y ☐ N
   (b) Indicate planned termination or disenrollment date ..... __ __/__ __/__ __ __ __
   (c) With what company, and what plan do you have?

Name of Company

Plan

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

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) ..... ☐ Y ☐ N
   If "YES," answer the following about this previous or existing coverage:
   (a) Fill in your start and end dates below. If you are still covered under this plan, leave "END" blank..... START __ __/__ __/__ __ __ __
   END __ __/__ __/__ __ __ __
   (b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy? ..... ☐ Y ☐ N
   (c) Planned date of termination/disenrollment?..... __ __/__ __/__ __ __ __
   (d) Was this your first time in this type of Medicare plan? ..... ☐ Y ☐ N
   (e) Did you drop a Medicare supplement or Medicare Select policy/certificate to enroll in this Medicare plan?..... ☐ Y ☐ N
   (f) Is your former Medicare supplement or Medicare Select policy certificate still available? ..... ☐ Y ☐ N
   (g) Please indicate reason for termination/disenrollment: **Check box(s) below if applicable**
   - 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: _____

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Please answer questions regarding other health insurance:

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

   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. START ___/___/_____
   END ___/___/_____

   (b) Planned date of termination/disenrollment? ___/___/_____

   (c) Have you disenrolled from your current coverage voluntarily? ☐ Y ☐ N

   (d) Please state the reason for your disenrollment:

   _____

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

Name of Company
Policy/Certificate type

E. Please answer all of the following questions:

To the Best of Your Knowledge and Belief:

7. Are you applying during a guaranteed issue period? ☐ Y ☐ N
   (NOTE: [Refer to the guaranteed issue worksheet to help identify if you are eligible.]
   If the answer above is "YES," attach proof of eligibility, such as your coverage termination letter.)
8. Did you turn age 65 in the last six months? ☐ Y ☐ N
9. Did you enroll in Medicare Part B in the last six months? ☐ Y ☐ N

If "YES," indicate your Part B effective date ___/___/_____

IF YOU ANSWER "YES" TO QUESTION 7 OR BOTH QUESTIONS 8 AND 9 IN SECTION E, OR ARE OTHERWISE IN AN OPEN ENROLLMENT PERIOD, SKIP SECTIONS F & G AND GO TO SECTION H.

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

[(Please see the enclosed material for explanation of the open enrollment and guaranteed issue periods.)]

Note: The applicant does not have to disclose an HIV (AIDS virus) test which was administered: (1) to a criminal offender or crime victim as a result of a crime that was reported to the police; (2) to a patient who received the services of emergency medical service personnel at a hospital or medical care facility, corrections employee, or employee of a secure treatment facility; (3) to emergency medical personnel who were tested as a result of performing emergency medical services; or (4) to a person who has been the victim of an assault or any other crime which involves bodily contact with the offender.

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F. Health Information

For all plans, answer questions 10-20.
(If "YES" is answered to any of the following questions 10-19, that person is not eligible for coverage.)

To the Best of Your Knowledge and Belief:	
10. Are you currently confined to a wheelchair or any motorized mobility device?	☐ Y ☐ N
11. Are you currently hospitalized, confined to a bed, in a nursing home or assisted living facility?	☐ Y ☐ N
12. Are you currently receiving any occupational, speech or physical therapy?	☐ Y ☐ N
13. Have you been advised by a medical professional to have treatment, further diagnostic evaluation, diagnostic testing, follow up visits or any surgery that has not been performed?	☐ Y ☐ N
14. 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?	☐ Y ☐ N
B. Emphysema, Chronic Obstructive Pulmonary Disease (COPD), any other chronic pulmonary disorder or any cardio-pulmonary disorder requiring oxygen?	☐ Y ☐ N
C. Alzheimer's Disease, dementia or any other cognitive disorder?	☐ Y ☐ N
D. Parkinson's Disease, multiple sclerosis or amyotrophic lateral sclerosis (Lou Gehrig's Disease)?	☐ Y ☐ N
E. Systemic Lupus, scleroderma or myasthenia gravis?	☐ Y ☐ N
F. Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	☐ Y ☐ N
G. An organ transplant or been advised to have an organ transplant (excluding cornea transplants)?	☐ Y ☐ N
H. Chronic hepatitis or cirrhosis?	☐ Y ☐ N
I. Osteoporosis with fractures?	☐ Y ☐ N
15. Do you have diabetes?	☐ Y ☐ N
16. Do you have an implanted cardiac defibrillator?	☐ Y ☐ N
17. 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?	☐ Y ☐ N
B. Cardiomyopathy, congestive heart failure, aortic or cardiac aneurysm, peripheral artery disease, peripheral venous thrombotic disease, vascular angioplasty, endarterectomy, carotid artery disease, any heart or heart valve disorder, atrial fibrillation, other heart rhythm disorder, or implantation of a pacemaker?	☐ Y ☐ N
C. Alcoholism or drug abuse?	☐ Y ☐ N
D. Any mental or nervous disorder requiring treatment (including hospital confinement) by a psychiatrist, psychologist, counselor or therapist?	☐ Y ☐ N
E. Internal cancer, lymphoma or melanoma?	☐ Y ☐ N
F. A stroke or transient ischemic attack (TIA)?	☐ Y ☐ 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?	☐ Y ☐ N
18. Have you been advised by a medical professional that surgery may be required within the next 12 months for cataracts?	☐ Y ☐ N
19. Have you been hospital confined three or more times in the past two years for a same or similar condition?	☐ Y ☐ N
20. Have you taken any over-the-counter or prescription drugs in the past 24 months? **(If YES, please complete the Medication Information sheet on the next page)**	☐ Y ☐ N

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G. 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.

Medication Name (copy off pharmacy label)	Dosage	Frequency	Have you taken this medication for more than 2 years?	Prescribed by Primary Physician?	Diagnosis/Condition
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	
			☐ Y ☐ N	☐ Y ☐ N	

H. 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 reinstituted if requested within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- 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 the suspension.
- Counseling services may be available in Minnesota to provide advice concerning medical assistance through the state Medicaid program, Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

H. Agreement and Authorization (Cont.)

AUTHORIZATION TO DISCLOSE PERSONAL INFORMATION TO OMAHA 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 Omaha Insurance Company, 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 Omaha Insurance Company. This authorization excludes the release of information about an HIV (AIDS Virus) test or a test to determine a bloodborne pathogen which was administered to: a criminal offender or crime victim as a result of a crime that was reported to the police; a patient who received the services of emergency medical service personnel at a hospital or medical care facility, corrections employee, or employee of a secure treatment facility; emergency medical personnel who were tested as a result of performing emergency medical services; or a person who has been the victim of an assault or any other crime which involves bodily contact with the offender. This Authorization shall be valid for 24 months after it is signed, or until any contract of insurance issued as a result of this application ends, whichever comes first. I understand that I may revoke this authorization at any time, by written notice to: ATTN: Individual Underwriting, Omaha 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 Omaha Insurance Company has taken action in reliance on the authorization or the law allows Omaha Insurance Company 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, 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 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 Omaha Insurance Company.

I acknowledge receipt of **A Guide to Health Insurance for People with Medicare** (not applicable for Direct-to-Consumer business) and an Outline of Coverage.

✍ Dated at _____, on ___/___/_____ _____

City State Month Day Year Applicant's Signature

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I. Producer Comments (please attach a separate sheet if needed)

J. To be Completed by Producer

21. Producers shall list any other health insurance policies/certificates they have sold to the applicant.
(a) List policies/certificates sold to the applicant(s) which are still in force.

(b) List policies/certificates sold to the applicant in the past five (5) years which are no longer in force.

I/We certify as follows:

I/We have accurately recorded in the application the information supplied by the applicant..... ☐ Y ☐ N

I/We certify that we have interviewed the proposed applicant..... ☐ Y ☐ N

If you answered "NO" to any of the above statements, please explain why. _____

_____

I acknowledge that if the applicant(s) is replacing coverage, I/We have provided a copy of the replacement notice.

✍ _____
Signature of Licensed Producer Date

_____
Printed Name

Agent Writing Number

✍ _____
Signature of Licensed Producer Date

_____
Printed Name

Agent Writing Number

NA6008-21 Rev

METHOD OF PAYMENT FORM

REQUIRED FORM – PLEASE RETURN PAGES 1 & 2

Part I . Select Premium Payment Option

Initial Premium Payment (Select option #1 or #2)

✍ **Initial premium amount** (based on age at application date) ..... $ |_|_|_|_|_|_|.|_|_|

1. Paper Check (submit signed check with application) ..... ☐

(California collect only one month's premium at time of application)

2. Automatic Bank Account Withdrawal ..... ☐

Ongoing Premium Payments (Select option #1a, #1b, or #2)

1. I want my payments automatically withdrawn from my bank
   a. Choose the day payments will be deducted every month from your bank account ..... 1st through the 28th or the last day of every month

   OR

   b. Choose the week and weekday that payments will be deducted every month from your bank account..... (For Example: 3rd Wednesday of every month)

   _____ **Week (1st, 2nd, 3rd, 4th, last)**

   _____ **Weekday (Mon, Tue, Wed, Thu, Fri)** _____

2. I will mail my premium to the company every 3, 6, or 12 months. (Monthly billing is not allowed. Select frequency of billing ..... **every_____months** Insert 3, 6, or 12

When choosing automatic bank account withdrawal, MONEY WILL BE WITHDRAWN FROM YOUR ACCOUNT IMMEDIATELY UPON POLICY APPROVAL AND ISSUE. The first withdrawal date may be different from the monthly date selected for ongoing premiums. Depending on the amount of time elapsed between the policy date and the date the policy is placed inforce, the amount of the first ongoing withdrawal may exceed one modal premium and may occur on a date other than the policy date. The Proposed Insured(s) will not receive premium billing notices while on this premium payment option. We CANNOT establish electronic payments from foreign banks.

Each month, payments will be automatically deducted from the account below on the day selected above. If no date is selected, premiums will be deducted on the policy date (which is determined at the time the policy is issued and can be found within the policy). Ongoing deductions will begin once the policy is issued. If the scheduled deduction date begins on a weekend or holiday, the payment will process on the following business day.

Part II. Payor Information

1. **Account Owner Name**, if different than applicant's ..... _____
2. If premium is **NOT** paid by Proposed Insured/Insured (**includes spouse or joint-married account**), indicate the bank account owner's relationship to Proposed Insured/Insured by selecting one of the following.
   - Employer (3 app minimum/applicant must be retired. Refer to List-Bill guidelines. N/A for Direct-to-Consumer business)..... ☐
   - Living Trust..... ☐
   - Power of Attorney or legal guardian (documentation required) ..... ☐
   - Business owned by applicant or applicant's spouse ..... ☐

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Part III. Account Information

Complete the Following ONLY if Automated Bank Account Withdrawal is Chosen:
This section is intended as authorization to debit your bank account.
Complete bank account information below **OR** attach a copy of a voided check (Do NOT use a deposit slip)

Can attach voided check here

Applicant A

Account Type (check one): ☐ Checking ☐ Savings

Name of Financial Institution

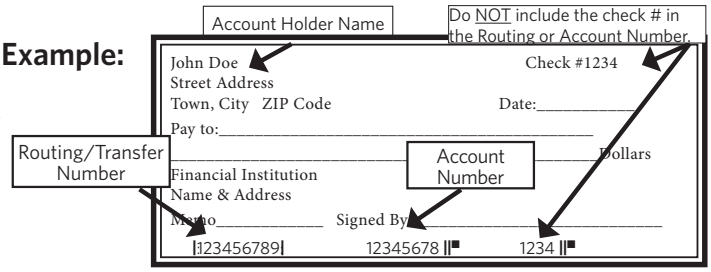
Routing Number (9 digits on lower left side of check)

Account Number (Do NOT use Debit/Credit Card numbers)

Name as Shown on Account

- Payments cannot be postponed until a later date.
- Payment from a third party, including any foundation, will not be accepted, except in certain pre-approved situations.
- All refunds will be made to the applicant in the event of rejection, incomplete submission, overpayment, cancellation, etc.

Example:



I authorize Omaha Insurance Company to withdraw funds from my account for the initial and/or monthly renewal premiums and understand that the amounts may differ. This authorization shall apply to any future payments unless specifically revoked by me. Premium shortages may result from a variety of causes, including underwriting adjustments. I authorize my financial institution to pay from my account to Omaha Insurance Company any preauthorized bank account withdrawals. I agree that my financial institution shall be fully protected in honoring any such payment and that its rights and responsibilities regarding the payment shall be the same as if the payment were signed personally by me. I agree to notify the business in writing of any changes in my account information. This authorization will be effective until I give you at least three business days' notice to cancel. If notice is given verbally, Omaha Insurance Company may require written confirmation from me within 14 days after my verbal notice.

✍ _____

Authorized Signature as Shown on Account

_____

Date

N41_1219_MN

Omaha 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 Omaha 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):

Applicant

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

_____

_____

_____

Applicant B

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

Omaha Insurance Company, Mutual of Omaha Plaza, Omaha, NE 68175

Applicant	**Applicant B**
Signature	Signature
Date	Date

*Signature not required for direct response sales.

N17

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

Provide applicant with completed and signed copy of application before submitting original application for processing.

Omaha 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 Omaha 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):

Applicant

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

_____

_____

_____

Applicant B

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

Omaha Insurance Company, Mutual of Omaha Plaza, Omaha, NE 68175

Applicant	**Applicant B**
Signature	Signature
Date	Date

*Signature not required for direct response sales.

N17

Omaha Insurance Company

A Mutual *of* Omaha Company

Agent Information Form

Omaha Insurance Company
P.O. Box 3608
Omaha, NE 68103

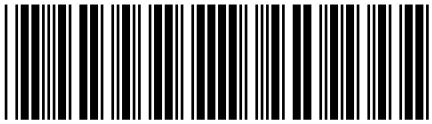
Agent Name _____

State Insurance Agent License Number _____

Company _____

Insurance Sales Representative

Neither Omaha Insurance Company nor its agents are connected with any government agency.



N177_MN

N177_MN

Underwritten by
Omaha Insurance Company
A Mutual of Omaha Company

3300 Mutual of Omaha Plaza
Omaha, Nebraska 68175

Premium Receipt

All premiums must be made payable to Omaha Insurance Company.

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

Received from _____this _____ day of _____ , _____

an application for Form_____Policy and/or Riders _____and

Check for _____Dollars.

✍ 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, Omaha 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

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: OMAHA INSURANCE COMPANY, DIRECTOR OF INDIVIDUAL UNDERWRITING, 3300 MUTUAL OF OMAHA PLAZA, OMAHA, NE 68175.

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

N40_0619_MN

Underwritten by
Mutual of Omaha Insurance Company

3300 Mutual of Omaha Plaza
Omaha, Nebraska 68175

APPLICATION for

INDIVIDUAL DENTAL INSURANCE WITH OPTIONAL VISION RIDER

MINNESOTA

MAP642_MN
10/04/2023

Mutual of Omaha | Underwritten by Mutual of Omaha Insurance Company | 3300 Mutual of Omaha Plaza Omaha, Nebraska 68175

Monthly Rates (Issue Age 19-99)

MINNESOTA							
ZIP Codes	**Mutual Dental Preferred DNT2**			**Mutual Dental Protection DNT5**			**Vision Rider 0PD1M**
	$1,500	$3,000	$5,000	$1,500	$3,000	$5,000	
557-566	$52.98	$60.67	$63.32	$29.04	$29.86	$30.41	$8.28
550-556, 567	$63.58	$72.80	$75.98	$34.85	$35.83	$36.49	$8.28

Rates Subject to Change.

As of 10/05/2023

The applicant will receive the following benefits under the Optional Vision Rider. The applicant must be enrolled in the Mutual of Omaha dental plan to apply.

Up to $50 every calendar year for one eye exam (no waiting period)
Up to $150 every two calendar years for eyeglasses or contact lenses (after a six-month waiting period)

Internal Tracking Code _____
Group # (if applicable) _____

Underwritten by
Mutual of Omaha Insurance Company

3300 Mutual of Omaha Plaza
Omaha, Nebraska 68175

Application for Individual Dental Insurance with Optional Vision Rider

A. Applicant Information

Name (First, Middle Initial, Last)		Phone Number Home Cell
Residence Address (Street, City, State, ZIP)		E-mail
Mailing Address (Street, City, State, ZIP) (if different from residence address)		Deliver Policy to ☐ Applicant ☐ Producer
Gender ☐ Male ☐ Female	Date of Birth	Social Security Number*

*Your Social Security Number is requested to support accurate and timely claim processing on your plan. It does not have any impact on your application or enrollment.

B. Plan Information

Select Dental Benefit Plan	Select Annual Maximum	
☐ Mutual Dental Preferred ☐ Mutual Dental Protection	☐ $1,500 ☐ $3,000 ☐ $5,000	**Requested Effective Date** _____ **Monthly Premium Rate for Dental $** _____
☐ Optional Vision Rider (only available with Dental)		**Monthly Premium Rate for Vision $** _____
		Total Monthly Premium $ _____

C. Existing Coverage Information

Are you covered by any other dental or vision insurance? . . . . . ☐ Y ☐ N

If Yes, answer the following about this existing coverage:

Name of dental carrier(s) _____

Name of vision carrier(s) _____

Is the coverage you are applying for replacing existing dental insurance? . . . . . ☐ Y ☐ N

Is the coverage you are applying for replacing existing vision insurance? . . . . . ☐ Y ☐ N

D. Agreements

I represent the information above is true and complete to the best of my knowledge and belief. Any incorrect or misleading answers may void this application and any issued policy. I understand that no insurance shall take effect until a policy is issued and the first premium is received by Mutual of Omaha during my lifetime.

✍ _____ _____
Applicant Signature Date Signed at City State

I/We acknowledge that if the applicant is replacing coverage, I/We have provided a copy of the replacement notice, if applicable.

✍ _____
Signature of Licensed Insurance Producer Date

_____ _____ _____%
Printed Name Agent Writing Number Comm. % Share

✍ _____
Signature of Licensed Insurance Producer Date

_____ _____ _____%
Printed Name Agent Writing Number Comm. % Share

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METHOD OF PAYMENT FORM

REQUIRED FORM – PLEASE RETURN 1 & 2

Part I . Select Premium Payment Option

Initial Premium Payment (Select option #1 or #2)

✍ **Initial premium amount** (based on age at application date)..... $ _____.__

1. Paper Check (submit signed check with application)..... ☐
2. Automatic Bank Account Withdrawal..... ☐

Ongoing Premium Payments (Select option #1a, #1b, or #2)

1. I want my payments automatically withdrawn from my bank
   a. Choose the day payments will be deducted every month from your bank account..... 1st through the 28th or the last day of every month _____

   OR

   b. Choose the week and weekday that payments will be deducted every month from your bank account..... (For Example: 3rd Wednesday of every month)
   Week (1st, 2nd, 3rd, 4th, last) _____
   Weekday (Mon, Tue, Wed, Thu, Fri) _____

2. I will mail my premium to the company every 3, 6, or 12 months. (Monthly billing is not allowed. **Select** frequency of billing)..... **every**_____**months** Insert 3, 6, or 12

When choosing automatic bank account withdrawal, MONEY WILL BE WITHDRAWN FROM YOUR ACCOUNT IMMEDIATELY UPON POLICY APPROVAL AND ISSUE. The first withdrawal date may be different from the monthly date selected for ongoing premiums. Depending on the amount of time elapsed between the policy date and the date the policy is placed inforce, the amount of the first ongoing withdrawal may exceed one modal premium and may occur on a date other than the policy date. The Proposed Insured(s) will not receive premium billing notices while on this premium payment option. We **CANNOT** establish electronic payments from foreign banks.

Each month, payments will be automatically deducted from the account below on the day selected above. If no date is selected, premiums will be deducted on the policy date (which is determined at the time the policy is issued and can be found within the policy). **Ongoing deductions will begin once the policy is issued. If the scheduled deduction date begins on a weekend or holiday, the payment will process on the following business day.**

Part II. Payor Information

1. **Account Owner Name,** if different than applicant's..... _____
2. If premium is **NOT** paid by Proposed Insured/Insured **(includes spouse or joint-married account)**, indicate the bank account owner's relationship to Proposed Insured/Insured by selecting one of the following.

   Employer (3 app minimum/applicant must be retired. Refer to List-Bill guidelines. N/A for Direct-to-Consumer business) ☐
   Living Trust ☐
   Power of Attorney or legal guardian (documentation required) ☐
   Business owned by applicant or applicant's spouse ☐

Part III. Muti-Policy Discount

You may be eligible for a lower premium rate based on your answer to the statement in this section

Are you applying for or have you applied for a Medicare supplement policy with Mutual of Omaha Insurance Company or its affiliates within the last 30 days? ..... ☐ Y ☐ N

Do you have a Medicare supplement policy with Mutual of Omaha Insurance Company or one of its affiliates that has been issued within the last 30 days?..... ☐ Y ☐ N

M469133

Part IV. Account Information

Complete the Following ONLY if Automated Bank Account Withdrawal is Chosen:
This section is intended as authorization to debit your bank account.
Complete bank account information below **OR** attach a copy of a voided check (Do NOT use a deposit slip)

Can attach voided check here

Applicant A

Account Type (check one): ☐ Checking ☐ Savings

Name of Financial Institution

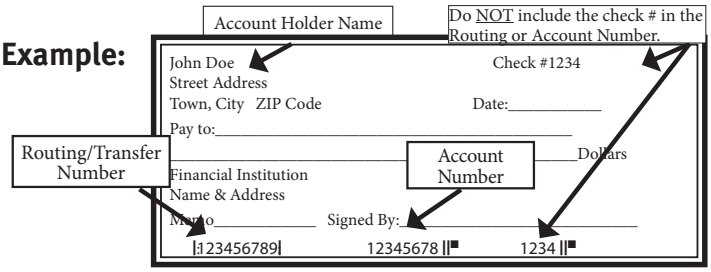
Routing Number (9 digits on lower left side of check)

Account Number (Do NOT use Debit/Credit Card numbers)

Name as Shown on Account

- Payments cannot be postponed until a later date.
- Payment from a third party, including any foundation, will not be accepted, except in certain pre-approved situations.
- All refunds will be made to the applicant in the event of rejection, incomplete submission, overpayment, cancellation, etc.

Example:



I authorize Mutual of Omaha Insurance Company ("Mutual of Omaha") to withdraw funds from my account for the initial and/or monthly renewal premiums and understand that the amounts may differ. Premium shortages may result from a variety of causes, including underwriting adjustments. I authorize my financial institution to pay from my account to Mutual of Omaha any preauthorized bank account withdrawals. I agree that my financial institution shall be fully protected in honoring any such payment and that its rights and responsibilities regarding the payment shall be the same as if the payment were signed personally by me. I agree to notify the business in writing of any changes in my account information. This authorization will be effective until I give you at least three business days' notice to cancel. If notice is given verbally, Mutual of Omaha may require written confirmation from me within 14 days after my verbal notice.

Applicant A

✍

Authorized Signature as Shown on Account

Date

M469133

Mutual of Omaha Insurance Company – Notice of Information Practices

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: MUTUAL OF OMAHA INSURANCE COMPANY, DIRECTOR OF INDIVIDUAL UNDERWRITING, MUTUAL OF OMAHA PLAZA, OMAHA, NE 68175.

M26977

GIVE THIS NOTICE TO THE APPLICANT

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MUTUAL OF OMAHA INSURANCE COMPANY
3300 MUTUAL OF OMAHA PLAZA
OMAHA, NEBRASKA 68175
(402) 342-7600

OUTLINE OF COVERAGE FOR POLICY SERIES DNT2

INDIVIDUAL DENTAL PREFERRED PROVIDER ORGANIZATION (PPO) INSURANCE

THE POLICY PROVIDES LIMITED BENEFIT DENTAL COVERAGE ONLY.
BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES.

THIS IS NOT A MEDICARE SUPPLEMENT POLICY.
If you are eligible for Medicare, review the "Guide to Health Insurance for People with Medicare" available from us.

Read Your Policy Carefully – This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

Limited Benefit Dental-Only Insurance Coverage – This policy is designed to provide you ONLY with limited benefit dental insurance coverage. Coverage is NOT provided for any other diseases or accidents.

Benefits – This is a Preferred Provider Organization (PPO) dental insurance policy that pays benefits for covered dental services provided by in-network and out-of-network dentists. It pays benefits for Diagnostic and Preventive Services, Basic Services, and Major Services. If you incur expense for a covered dental service, we will pay the coinsurance percentage of the allowed amount after you have satisfied the deductible and any applicable waiting period. Benefits payable are limited to any annual maximum benefit and lifetime maximum benefit.

Shown below is a brief summary of the dental benefits we will pay under this policy. For a full list of covered dental services and procedures, please visit our website at www.mutualofomaha.com/individual-dental.

DENTAL BENEFITS SUMMARY

DEDUCTIBLE	AMOUNT
Class I -- Diagnostic & Preventive Services	None
Class II – Basic Services and Class III - Major Services Combined	$50.00
COINSURANCE	**PERCENTAGE PAYABLE**
Class I – Diagnostic & Preventive Services	100%
Class II – Basic Services	80%
Class III – Major Services	20% Day One, 50% After Year One
WAITING PERIOD	**TIME FRAME**
Class I– Diagnostic & Preventive Services	None
Class II– Basic Services	None
Class III– Major Services	None
MAXIMUM BENEFIT	**AMOUNT**
Annual Maximum Benefit per Calendar Year	$1,500, $3,000 or $5,000
Implant Lifetime Maximum Benefit	$3,000

You may obtain dental care for covered dental services from any licensed dentist. No matter which dentist you choose, you will be eligible for some level of benefits for covered dental services. However, when you use an in-network dentist who participates in the PPO network, that dentist has agreed to provide dental care at negotiated fees. For in-network dentists, you will not be responsible for

the difference between your dentist's submitted amount and the scheduled fee amount that the dentist has contractually agreed to accept as payment in full. The PPO network used by this policy is DenteMax Plus.

If you select a dentist who does not participate in the PPO network, your out-of-pocket expenses may be greater. For out-of-network dentists, you will be responsible for the difference between your dentist's submitted amount and our payment. The amount we use to calculate our payment will be the lesser of the dentist's submitted amount or the 80th percentile amount for covered dental services as identified by the Dental Charges Database.

Waiting Period – Covered dental services are subject to the waiting period shown in the above Dental Benefits Summary chart. You must satisfy the waiting period before benefits are paid for these services. The waiting period begins on the policy effective date and is applied once during the lifetime of your policy.

Exclusions -- Your policy pays benefits only for covered dental services. We will not pay benefits for:

(a) first installation of a denture or fixed bridge, and any inlay and crown that serves as an abutment to replace congenitally missing teeth or to replace teeth all of which were lost while the person was not covered;
(b) services or treatment not prescribed by or under the direct supervision of a dentist;
(c) services or treatment which is experimental or investigational;
(d) services or treatment which is for any illness or bodily injury which occurs in the course of employment if a benefit or compensation is available, in whole or in part, under the provision of any law or regulation or any government unit. This exclusion applies whether or not you claim the benefits or compensation;
(e) services or treatment received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, Veterans Administration hospital or similar person or group;
(f) services or treatment performed prior to the policy effective date;
(g) services or treatment incurred after the termination date of your coverage unless otherwise indicated;
(h) services or treatment which is not dentally necessary or which does not meet generally accepted standards of dental practice;
(i) services or treatment resulting from your failure to comply with professionally prescribed treatment;
(j) telephone consultations;
(k) any charges for failure to keep a scheduled appointment;
(l) any services that are considered strictly cosmetic in nature including, but not limited to, charges for personalization or characterization of prosthetic appliances;
(m) fluoride treatments;
(n) services or treatment provided as a result of intentionally self-inflicted injury or illness;
(o) services or treatment provided as a result of injuries suffered while committing or attempting to commit a felony, engaging in an illegal occupation, or participating in a riot, rebellion or insurrection;
(p) office infection control charges;
(q) charges for copies of your records, charts or x-rays, or any costs associated with forwarding/mailing copies of your records, charts or x-rays;
(r) state, federal, or territorial taxes on dental services performed;
(s) those charges submitted by a dentist, which are for the same services performed on the same date by another dentist;
(t) those dental services provided free of charge by any governmental unit, except where this exclusion is prohibited by law;
(u) those dental services for which you would have no obligation to pay in the absence of this or any similar insurance;
(v) those dental services which are for specialized procedures and techniques;
(w) those dental services performed by a dentist who is compensated by a facility for similar covered services performed for you on the same date;
(x) duplicate, provisional and temporary devices, appliances, and services;
(y) plaque control programs, oral hygiene instruction, and dietary instructions;
(z) services to alter vertical dimension and/or restore or maintain the occlusion. Such procedures include, but are not limited to:
    1. equilibration;
    2. periodontal splinting;
    3. full mouth rehabilitation and;
    4. restoration for misalignment of teeth;
(aa) gold foil restorations;
(bb) services or treatment for injuries resulting from war or act of war, whether declared or undeclared, or from police or military service for any country or organization;
(cc) hospital costs or any additional fees that the dentist or hospital charges for treatment at the hospital (inpatient or outpatient);
(dd) charges by the provider for completing dental forms;

(ee) adjustment of a denture or bridgework which is made within 6 months after installation by the same dentist who installed it;
(ff) use of material or home health aids to prevent decay, such as:
  1. toothpaste;
  2. fluoride gels;
  3. dental floss and;
  4. teeth whiteners;
(gg) sealants;
(hh) precision attachments, personalization, precious metal bases and other specialized techniques;
(ii) replacement of dentures that have been:
  1. lost;
  2. stolen or;
  3. misplaced;
(jj) repair of damaged orthodontic appliances;
(kk) replacement of lost or missing appliances;
(ll) fabrication of athletic mouth guard;
(mm) internal bleaching;
(nn) nitrous oxide;
(oo) oral sedation;
(pp) topical medicament carrier;
(qq) orthodontic services, treatment or supplies, including braces and retainers;
(rr) bone grafts when done in connection with:
  1. extractions;
  2. apicoectomies or;
  3. non-covered/non-eligible implants;
(ss) tooth whitening;
(tt) occlusal guards;
(uu) space maintainers;
(vv) services or treatment provided by a member of your immediate family;
(ww) services or treatment received outside of the United States, its possessions or territories, Canada, or Mexico; or

Multiple Procedure Limitations – When two or more dental services are submitted and the dental services are considered part of the same service to one another, this policy will pay the most comprehensive service (the service that includes the other non-benefited service) as determined by us. When two or more dental services are submitted on the same day and the dental services are considered mutually exclusive (when one service contradicts the need for the other service), this policy will pay for the service that represents the final treatment as determined by us.

Guaranteed Renewable For Life – The policy is guaranteed renewable for life. We cannot cancel your policy as long as you pay the required premium before the end of each grace period.

Premiums Can Change – We will not increase your policy's premium due to any change in your health. However, we can change premiums if we make the same change to all policies of this form issued to persons of the same class. We will give you the advance notice required by your state prior to any such premium change.

Loss Ratio – The anticipated loss ratio is 65% for the dental policy and 70% for the vision rider. This ratio is the portion of future premiums, which the company expects to return as benefits, when averaged over all people with this policy.

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MUTUAL OF OMAHA INSURANCE COMPANY
3300 MUTUAL OF OMAHA PLAZA
OMAHA, NEBRASKA 68175
(402) 342-7600

OUTLINE OF COVERAGE FOR POLICY SERIES DNT5

INDIVIDUAL DENTAL PREFERRED PROVIDER ORGANIZATION (PPO) INSURANCE

THE POLICY PROVIDES LIMITED BENEFIT DENTAL COVERAGE ONLY.
BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES.

THIS IS NOT A MEDICARE SUPPLEMENT POLICY.

If you are eligible for Medicare, review the

"Guide to Health Insurance for People with Medicare" available from us.

Read Your Policy Carefully – This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

Limited Benefit Dental-Only Insurance Coverage – This policy is designed to provide you ONLY with limited benefit dental insurance coverage. Coverage is NOT provided for any other diseases or accidents.

Benefits – This is a Preferred Provider Organization (PPO) dental insurance policy that pays benefits for covered dental services provided by in-network and out-of-network dentists. It pays benefits for Diagnostic and Preventive Services, Basic Services, and Major Services. If you incur expense for a covered dental service, we will pay the coinsurance percentage of the allowed amount after you have satisfied the deductible and any applicable waiting period. Benefits payable are limited to any annual maximum benefit and lifetime maximum benefit.

Shown below is a brief summary of the dental benefits we will pay under this policy. For a full list of covered dental services and procedures, please visit our website at www.mutualofomaha.com/individual-dental.

DENTAL BENEFITS SUMMARY

DEDUCTIBLE	AMOUNT
Class I -- Diagnostic & Preventive Services, Class II – Basic Services and Class III – Major Services Combined	$100.00
COINSURANCE	**PERCENTAGE PAYABLE**
Class I – Diagnostic & Preventive Services	100%
Class II – Basic Services	50%
Class III – Major Services	20% Day One, 50% After Year One
WAITING PERIOD	**TIME FRAME**
Class I– Diagnostic & Preventive Services	None
Class II– Basic Services	None
Class III– Major Services	None
MAXIMUM BENEFIT	**AMOUNT**
Annual Maximum Benefit per Calendar Year	$1,500, $3,000 or $5,000
Implant Lifetime Maximum Benefit	$2,000

You may obtain dental care for covered dental services from any licensed dentist. No matter which dentist you choose, you will be eligible for some level of benefits for covered dental services. However, when you use an in-network dentist who participates in the

PPO network, that dentist has agreed to provide dental care at negotiated fees. For in-network dentists, you will not be responsible for the difference between your dentist's submitted amount and the scheduled fee amount that the dentist has contractually agreed to accept as payment in full. The PPO network used by this policy is DenteMax Plus.

If you select a dentist who does not participate in the PPO network, your out-of-pocket expenses may be greater. For out-of-network dentists, you will be responsible for the difference between your dentist's submitted amount and our payment. The amount we use to calculate our payment will be the lesser of the dentist's submitted amount or an amount equal to the lowest prevailing scheduled fee used for in-network dentists in the geographic area.

Waiting Period – Covered dental services are subject to the waiting period shown in the above Dental Benefits Summary chart. You must satisfy the waiting period before benefits are paid for these services. The waiting period begins on the policy effective date and is applied once during the lifetime of your policy.

Exclusions -- Your policy pays benefits only for covered dental services. We will not pay benefits for:

(a) first installation of a denture or fixed bridge, and any inlay and crown that serves as an abutment to replace congenitally missing teeth or to replace teeth all of which were lost while the person was not covered;
(b) services or treatment not prescribed by or under the direct supervision of a dentist;
(c) services or treatment which is experimental or investigational;
(d) services or treatment which is for any illness or bodily injury which occurs in the course of employment if a benefit or compensation is available, in whole or in part, under the provision of any law or regulation or any government unit. This exclusion applies whether or not you claim the benefits or compensation;
(e) services or treatment received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, Veterans Administration hospital or similar person or group;
(f) services or treatment performed prior to the policy effective date;
(g) services or treatment incurred after the termination date of your coverage unless otherwise indicated;
(h) services or treatment which is not dentally necessary or which does not meet generally accepted standards of dental practice;
(i) services or treatment resulting from your failure to comply with professionally prescribed treatment;
(j) telephone consultations;
(k) any charges for failure to keep a scheduled appointment;
(l) any services that are considered strictly cosmetic in nature including, but not limited to, charges for personalization or characterization of prosthetic appliances;
(m) fluoride treatments;
(n) services or treatment provided as a result of intentionally self-inflicted injury or illness;
(o) services or treatment provided as a result of injuries suffered while committing or attempting to commit a felony, engaging in an illegal occupation, or participating in a riot, rebellion or insurrection;
(p) office infection control charges;
(q) charges for copies of your records, charts or x-rays, or any costs associated with forwarding/mailing copies of your records, charts or x-rays;
(r) state, federal, or territorial taxes on dental services performed;
(s) those charges submitted by a dentist, which are for the same services performed on the same date by another dentist;
(t) those dental services provided free of charge by any governmental unit, except where this exclusion is prohibited by law;
(u) those dental services for which you would have no obligation to pay in the absence of this or any similar insurance;
(v) those dental services which are for specialized procedures and techniques;
(w) those dental services performed by a dentist who is compensated by a facility for similar covered services performed for you on the same date;
(x) duplicate, provisional and temporary devices, appliances, and services;
(y) plaque control programs, oral hygiene instruction, and dietary instructions;
(z) services to alter vertical dimension and/or restore or maintain the occlusion. Such procedures include, but are not limited to:
    1. equilibration;
    2. periodontal splinting;
    3. full mouth rehabilitation and;
    4. restoration for misalignment of teeth;
(aa) gold foil restorations;
(bb) services or treatment for injuries resulting from war or act of war, whether declared or undeclared, or from police or military service for any country or organization;
(cc) hospital costs or any additional fees that the dentist or hospital charges for treatment at the hospital (inpatient or outpatient);
(dd) charges by the provider for completing dental forms;

(ee) adjustment of a denture or bridgework which is made within 6 months after installation by the same dentist who installed it;
(ff) use of material or home health aids to prevent decay, such as:
  1. toothpaste;
  2. fluoride gels;
  3. dental floss and;
  4. teeth whiteners;
(gg) sealants;
(hh) precision attachments, personalization, precious metal bases and other specialized techniques;
(ii) replacement of dentures that have been:
  1. lost;
  2. stolen or;
  3. misplaced;
(jj) repair of damaged orthodontic appliances;
(kk) replacement of lost or missing appliances;
(ll) fabrication of athletic mouth guard;
(mm) internal bleaching;
(nn) nitrous oxide;
(oo) oral sedation;
(pp) topical medicament carrier;
(qq) orthodontic services, treatment or supplies, including braces and retainers;
(rr) bone grafts when done in connection with:
  1. extractions;
  2. apicoectomies or;
  3. non-covered/non-eligible implants;
(ss) tooth whitening;
(tt) occlusal guards;
(uu) space maintainers;
(vv) services or treatment provided by a member of your immediate family; or
(ww) services or treatment received outside of the United States, its possessions or territories, Canada, or Mexico.

Multiple Procedure Limitations – When two or more dental services are submitted and the dental services are considered part of the same service to one another, this policy will pay the most comprehensive service (the service that includes the other non-benefited service) as determined by us. When two or more dental services are submitted on the same day and the dental services are considered mutually exclusive (when one service contradicts the need for the other service), this policy will pay for the service that represents the final treatment as determined by us.

Guaranteed Renewable For Life – The policy is guaranteed renewable for life. We cannot cancel your policy as long as you pay the required premium before the end of each grace period.

Premiums Can Change – We will not increase your policy's premium due to any change in your health. However, we can change premiums if we make the same change to all policies of this form issued to persons of the same class. We will give you the advance notice required by your state prior to any such premium change.

Loss Ratio – The anticipated loss ratio is 65% for the dental policy and 70% for the vision rider. This ratio is the portion of future premiums, which the company expects to return as benefits, when averaged over all people with this policy.