

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

NORTH CAROLINA

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OMAHA INSURANCE COMPANY

OUTLINE OF MEDICARE SUPPLEMENT COVERAGE – COVER PAGE BENEFIT PLANS A, F, G, HIGH DEDUCTIBLE G AND N A Mutual of Omaha Company

This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plan A available. Some plans may not be available in your state. Only applicants first eligible for Medicare before 2020 may purchase Plans C, F and High Deductible F.

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

Medicare first eligible	before 2020 only	PLAN C PLAN F F1	>	>	>	>	>	>	>	>	>	
		PLAN N	>	copays apply ³	>	>	>	>			>	
ı		PLAN M	>	>	>	>	>	20%			>	
ı	ants	PLANL	>	75%	75%	75%	75%	75%				$$3,530^{2}$
ı	All Applica	PLAN K	>	%09	%09	%09	20%	20%				\$7,0602
	Plans Available to All Applicants	PLAN G G1	>	>	>	>	>	>		>	>	
ı	귭	PLAN D	>	>	>	>	>	>			>	
ı		PLAN B	>	>	>	>		>				
		PLAN A PLAN B	>	>	>	>						
		Benefits	Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	Medicare Part B coinsurance or Copayment	Blood (first three pints each year)	Part A hospice care coinsurance or copayment	Skilled nursing facility coinsurance	Medicare Part A deductible	Medicare Part B deductible	Medicare Part B excess charges	Foreign travel emergency (up to plan limits)	Out-of-pocket limit in 2024 ²

plan pays 100% of covered services for the rest of the calendar year. High deductible plan G does not cover the Medicare part B deductible. However, high deductible plans Plans F and G also have a high deductible option which require first paying a plan deductible \$2,800 before the plan begins to pay. Once the plan deductible is met, the F and G count your payment of the Medicare Part B deductible toward meeting the plan deductible.

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

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

MONTHLY NON-TOBACCO PREMIUMS* ZIP CODES: 270 - 289

Plan A Plan B Plan B Attained Plan A Plan B Plan			FEMALE						MALE		
NNIX2	Plan A	Plan F	Plan G		Plan N	Attained	Plan A	Plan F	Plan G	Plan High G	Plan N
1,008.20 1,008.20 1,009. 1,009. 1,099.	//Z0	NM23	NM24	NM36	NM35	Age	NM20	NM23	NM24	NM36	NM35
12,61).72	1,068.20	861.63			Thru 64	874.84	1,228.43	990.88	!	
152 61 123 09 55 80 90 09 66 124 88 175 50 141 55 40 47 155 68 125 02 33 00 66 127.75 179 04 141 55 40 47 155 68 132 09 33 00 66 127.75 179 04 144 70 41 18 164 39 131 29 36 69 70 133 30 186 13 147 34 44 178 164 39 134 20 40 74 105 28 71 138 69 167 27 44 16 164 39 142 09 100 38 71 138 69 167 27 47 16 164 39 142 09 100 38 71 144 20 167 27 47 16 165 36 142 09 113 00 74 142 00 144 00 44 44 182 36 142 00 113 00 113 00 144 00 144 00 144 00 182 37 144 00 144 00 144 00 144 00 144 00 144 00 144 00 144 00 144 00 1	3.67	152.61	123.09	35.80	90.09	65	124.98	175.50	141.55	40.47	103.61
152.61 123.89 37.00 35.80 90.00 67 174.98 175.60 144.70 40.47 158.77 128.66 38.19 96.69 69 130.53 182.58 147.84 43.18 161.85 13.12 38.40 96.69 69 130.53 182.58 147.84 43.18 168.01 136.76 42.09 106.58 72 138.65 157.27 47.58 168.01 136.76 42.09 106.58 73 148.25 147.33 49.10 182.73 147.81 117.20 74 148.57 74 148.50 148.54 169.54 44.56 169.54 169.64 169.	3.67	152.61	123.09	35.80	60.06	99	124.98	175.50	141.55	40.47	103.61
156.67 125.82 37.00 98.40 68 127.75 179.04 41.83 41.83 161.86 131.25 182.66 182.66 182.66 14.47 41.83 161.86 131.20 39.40 99.99 70 133.50 186.61 14.47 41.90 164.93 134.02 39.40 99.99 70 133.50 186.61 44.51 45.09 168.77 14.20 43.44 110.12 73 138.86 189.66 189.66 44.54 44.50 168.77 14.20 43.44 110.12 73 138.86 189.66 189.66 44.54 44.54 175.87 147.57 17.77 147.57 17.73 44.50 44.54 56.63 44.54 190.09 152.89 17.74 17.20 17.20 17.20 44.54 45.66 44.54 45.67 44.54 45.67 44.54 45.67 44.54 45.67 46.88 44.54 47.52	3.67	152.61	123.09	35.80	60.06	29	124.98	175.50	141.55	40.47	103.61
168.77 128.66 86.9 130.53 182.58 14784 44.19 161.65 131.29 39.40 99.99 70 130.53 182.58 147.84 44.54 164.95 132.0 40.74 10.58 72 138.65 150.98 44.54 164.95 147.31 44.78 10.65 72 133.21 157.27 46.90 162.73 147.31 44.78 113.66 74 149.57 210.14 169.41 50.63 182.73 147.31 44.78 113.66 74 149.57 210.14 169.41 50.63 182.73 147.31 44.78 113.66 74 149.57 210.14 152.74 44.54 190.09 152.59 26.18 163.41 46.75 165.62 225.55 174.74 47.87 190.09 170.30 50.30 124.29 77 165.64 225.55 187.54 66.83 218.89 170.30 23.34 <td>1.10</td> <td>155.68</td> <td>125.82</td> <td>37.00</td> <td>93.40</td> <td>89</td> <td>127.75</td> <td>179.04</td> <td>144.70</td> <td>41.83</td> <td>107.40</td>	1.10	155.68	125.82	37.00	93.40	89	127.75	179.04	144.70	41.83	107.40
161 85 131 29 39 40 99 99 70 133 30 166 13 150 98 44 54 164 35 134 02 105 28 72 138 85 182 66 154.13 46.07 168 01 136.76 42.09 106 58 72 138 85 193.21 157.27 47.58 175 38 147.31 44.78 110.12 73 144.20 201 68 165.33 49.10 176 31 44.78 117.20 75 164.93 210.14 169.41 50.63 190.09 125.93 46.17 76 160.29 27.07 181.55 52.72 204.81 167.87 77 162.49 26.29 77 16.29 53.77 211.89 177.44 48.91 172.40 76 160.29 271.07 181.55 53.72 211.89 177.44 48.91 124.22 77 181.55 53.72 52.28 52.28 52.28 52.28 52.28 52.28	3.50	158.77	128.56	38.19	69.96	69	130.53	182.58	147.84	43.19	111.19
164 93 134 02 40.74 103.28 71 136 08 188 66 154.13 44 07 15.38 142.03 142.03 106.58 72 138.65 193.21 157.27 47.58 175.38 142.03 140.03 13.66 74 149.57 201.68 163.33 49.10 182.73 147.31 44.78 113.66 74 149.57 201.44 169.41 50.63 197.45 15.28 46.13 17.20 27.07 181.55 53.72 204.81 163.14 48.91 124.28 77 165.64 27.07 181.55 53.72 204.81 163.14 48.91 124.28 77 181.55 53.72 204.81 163.14 48.91 124.28 77 181.55 53.72 204.81 163.14 160.29 227.07 181.55 53.72 53.00 52.15 53.00 52.15 53.00 52.15 53.00 52.15 53.00 <td>5.92</td> <td>161.85</td> <td>131.29</td> <td>39.40</td> <td>66.66</td> <td>20</td> <td>133.30</td> <td>186.13</td> <td>150.98</td> <td>44.54</td> <td>114.98</td>	5.92	161.85	131.29	39.40	66.66	20	133.30	186.13	150.98	44.54	114.98
168 01 136 76 42 09 106 58 72 138 85 193 21 157 27 47 58 17.38 14.20 4.34 110.12 73 144.20 201 68 163.33 49.10 182.73 147.31 4.47.8 117.20 75 164.93 201.68 163.33 49.10 190.09 152.59 46.13 117.20 75 166.29 227.07 181.55 52.15 204.81 163.44 48.91 142.20 78 172.90 243.68 195.84 56.86 211.89 170.30 50.30 129.50 78 172.90 243.68 195.84 56.86 218.99 177.44 51.68 180.16 180.16 58.43 56.86 233.15 191.72 54.67 145.15 81 180.16 243.68 56.86 56.87 240.24 198.88 56.27 145.15 84 219.62 297.94 248.77 67.87 259.08 <td>3.33</td> <td>164.93</td> <td>134.02</td> <td>40.74</td> <td>103.28</td> <td>71</td> <td>136.08</td> <td>189.66</td> <td>154.13</td> <td>46.07</td> <td>118.77</td>	3.33	164.93	134.02	40.74	103.28	71	136.08	189.66	154.13	46.07	118.77
175.38 142.03 43.44 110.12 73 144.20 201.68 163.33 49.10 182.73 147.31 44.78 110.12 74 149.57 201.44 163.41 50.63 190.45 157.87 44.78 113.66 74 149.57 201.44 165.41 50.63 197.45 157.87 47.52 120.74 76 160.29 227.07 181.56 55.29 204.81 163.14 48.91 124.28 77 165.64 255.33 181.65 55.29 218.89 177.44 51.68 194.67 256.98 272.27 60.00 233.15 191.89 80 187.41 256.98 272.27 60.00 249.67 162.04 84 291.67 228.13 67.22 280.38 26.29 17.74 67.22 66.42 66.42 280.38 26.20 82.13.7 228.74 67.22 67.22 280.48 26.21	0.74	168.01	136.76	42.09	106.58	72	138.85	193.21	157.27	47.58	122.57
182.73 147.31 44.78 113.66 74 149.57 210.14 169.41 50.63 190.09 152.59 46.13 117.20 75 144.93 218.61 175.47 52.15 197.87 167.87 46.13 177.20 76 162.83 218.61 175.47 52.15 204.81 163.44 48.91 124.28 77 165.64 235.63 187.62 55.25 211.89 177.30 50.30 129.50 78 172.90 243.68 165.84 56.86 226.02 187.74 51.68 174.72 79 180.16 251.88 56.84 56.27 167.88 56.43 5	5.40	175.38	142.03	43.44	110.12	73	144.20	201.68	163.33	49.10	126.64
190.09 152.59 46.13 117.20 75 164.93 218.61 175.47 52.16 197.45 167.87 47.52 120.74 76 160.29 227.07 181.55 53.72 204.11 163.44 48.91 120.74 76 160.29 243.68 195.84 56.29 211.89 177.44 51.68 134.72 79 180.16 255.83 204.06 58.43 226.07 184.59 55.07 139.94 80 187.41 259.98 212.27 60.00 2233.16 191.77 44.61.5 81 201.92 276.27 220.49 61.00 2233.16 191.22 162.29 165.21 82 201.77 287.10 238.72 65.42 226.08 266.09 167.88 85 228.45 20.49 61.07 66.42 227.71 288.74 67.22 66.42 66.42 66.42 66.42 66.42 66.42 66.42 66.42 <td< td=""><td>90.0</td><td>182.73</td><td>147.31</td><td>44.78</td><td>113.66</td><td>74</td><td>149.57</td><td>210.14</td><td>169.41</td><td>50.63</td><td>130.71</td></td<>	90.0	182.73	147.31	44.78	113.66	74	149.57	210.14	169.41	50.63	130.71
197.45 157.87 47.52 120.74 76 160.29 227.07 181.55 53.72 204.81 163.44 48.91 124.28 77 165.64 225.53 187.62 56.29 218.89 177.44 56.88 134.72 79 172.90 245.63 187.62 56.29 28.18 177.44 56.88 134.72 79 180.16 251.83 204.06 58.46 56.86 23.3.15 191.72 54.67 146.15 80 187.41 259.98 212.27 60.00 249.67 207.59 57.86 166.21 82 201.77 288.13 220.49 61.81 249.67 207.59 57.46 162.04 84 219.62 297.94 248.74 67.22 287.32 226.02 61.07 167.88 85 228.45 308.77 228.76 65.46 287.32 242.43 63.54 162.04 86 237.30 319.59 288.7	4.72	190.09	152.59	46.13	117.20	75	154.93	218.61	175.47	52.15	134.78
204.81 163.14 48.91 124.28 77 165.64 235.53 187.62 55.29 211.89 177.44 56.30 129.50 78 172.90 243.68 195.84 56.86 226.07 184.59 53.07 139.94 80 187.41 269.98 212.27 60.00 226.07 184.59 53.07 145.15 81 194.67 268.13 204.06 58.43 240.24 180.88 56.27 145.15 81 194.67 268.13 220.49 61.81 240.24 191.72 54.67 145.15 81 204.97 207.27 63.61 240.24 198.28 501.92 276.27 220.49 61.81 63.61 259.08 216.30 59.46 162.04 84 219.62 297.94 248.74 67.22 258.49 225.02 61.07 167.88 85 227.30 319.56 78.76 293.07 242.43 63.64<	9.38	197.45	157.87	47.52	120.74	92	160.29	227.07	181.55	53.72	138.85
211.89 170.30 50.30 129.50 78 172.90 243.68 195.84 56.86 226.07 184.59 51.68 134.72 79 180.16 251.83 204.06 58.43 226.07 184.59 51.07 139.44 80 187.41 259.98 210.27 60.00 233.15 191.72 54.67 145.15 81 194.67 269.98 210.27 60.00 240.24 198.88 56.27 145.15 81 194.67 268.13 220.49 61.81 240.24 198.88 56.27 145.14 84 219.62 297.94 248.74 67.22 269.08 225.08 173.71 86 237.30 319.59 268.77 70.41 277.91 233.73 62.29 173.71 86 237.30 319.59 268.77 70.41 287.32 247.28 64.81 183.14 88 251.07 337.03 278.74 76.23 <t< td=""><td>4.04</td><td>204.81</td><td>163.14</td><td>48.91</td><td>124.28</td><td>77</td><td>165.64</td><td>235.53</td><td>187.62</td><td>55.29</td><td>142.92</td></t<>	4.04	204.81	163.14	48.91	124.28	77	165.64	235.53	187.62	55.29	142.92
218.99 177.44 51.68 134.72 79 180.16 251.83 204.06 58.43 226.07 184.59 53.07 139.94 80 187.41 229.98 212.27 60.00 236.15 191.72 56.27 150.38 82 201.77 288.13 220.49 61.81 240.24 198.88 56.27 150.38 83 210.77 288.17 65.42 249.67 207.59 57.86 162.04 84 219.62 297.94 248.74 67.22 259.08 216.30 59.46 162.04 84 219.62 297.94 248.74 67.22 268.49 225.02 61.07 167.88 85 227.30 319.59 268.77 70.41 277.91 233.73 62.29 173.71 86 221.07 280.06 70.41 298.34 252.22 66.11 186.80 89 256.09 343.77 290.06 70.41 298.34 <td>0.35</td> <td>211.89</td> <td>170.30</td> <td>50.30</td> <td>129.50</td> <td>78</td> <td>172.90</td> <td>243.68</td> <td>195.84</td> <td>56.86</td> <td>148.92</td>	0.35	211.89	170.30	50.30	129.50	78	172.90	243.68	195.84	56.86	148.92
226.07 184.59 53.07 139.94 80 187.41 259.98 212.27 60.00 233.15 191.72 54.67 145.15 81 194.67 268.13 220.49 61.81 240.24 198.88 56.27 145.15 81 194.67 268.13 220.49 61.81 240.24 207.39 57.62 156.21 83 201.72 287.10 228.71 63.61 259.08 226.02 61.07 167.88 85 228.45 297.34 248.74 67.22 277.91 225.02 61.07 167.88 85 228.45 308.77 258.76 69.03 287.32 242.43 62.29 173.71 86 228.74 67.29 70.41 287.32 246.44 183.14 86 228.45 308.77 258.76 69.03 287.32 242.43 62.29 173.44 87.65 297.94 248.74 67.29 287.24 66.14 </td <td>99.6</td> <td>218.99</td> <td>177.44</td> <td>51.68</td> <td>134.72</td> <td>79</td> <td>180.16</td> <td>251.83</td> <td>204.06</td> <td>58.43</td> <td>154.92</td>	99.6	218.99	177.44	51.68	134.72	79	180.16	251.83	204.06	58.43	154.92
233.15 191.72 54.67 145.15 81 194.67 268.13 220.49 61.81 240.24 198.88 56.27 150.38 82 201.92 276.27 228.71 63.61 249.67 207.59 57.86 156.21 83 210.77 287.10 238.72 65.42 259.08 216.30 59.46 156.24 84 219.52 287.74 67.22 269.08 225.02 61.07 167.88 85 228.45 297.34 248.74 65.42 277.91 233.73 319.59 268.77 70.41 71.83 287.32 242.43 62.29 173.71 86 256.09 343.77 258.77 70.41 298.34 257.26 66.14 188.80 89 256.09 343.77 290.06 74.74 298.34 256.24 91.44 330.43 277.6 30.06 77.76 317.23 267.66 77.74 198.23 97 <td>2.96</td> <td>226.07</td> <td>184.59</td> <td>53.07</td> <td>139.94</td> <td>80</td> <td>187.41</td> <td>259.98</td> <td>212.27</td> <td>00.09</td> <td>160.92</td>	2.96	226.07	184.59	53.07	139.94	80	187.41	259.98	212.27	00.09	160.92
240.24 198.88 56.27 150.38 82 201.92 276.27 228.71 63.61 249.67 207.59 57.86 156.21 83 210.77 287.10 238.72 65.42 259.08 216.30 59.46 162.04 84 219.62 297.94 248.74 66.72 268.49 225.02 61.07 167.88 85 228.45 308.77 258.76 69.03 277.91 237.73 62.29 17.34 86 227.30 319.59 268.77 70.41 287.32 242.43 63.54 179.54 87 246.14 330.43 278.79 71.83 288.94 252.22 66.11 186.80 89 256.09 343.77 230.06 74.74 298.94 257.26 66.11 196.34 91 266.43 357.66 295.86 76.23 311.01 262.42 68.79 194.35 94 266.43 372.11 313.96 80.91	9.27	233.15	191.72	54.67	145.15	84	194.67	268.13	220.49	61.81	166.93
249.67 207.59 57.86 156.21 83 210.77 287.10 238.72 65.42 259.08 216.30 59.46 162.04 84 219.62 297.94 248.74 67.22 268.49 225.02 61.07 167.88 85 228.45 30.43 228.76 69.03 277.91 233.73 62.29 173.71 86 237.30 319.59 268.77 70.41 283.72 242.43 66.29 173.74 86 246.14 330.43 278.77 77.83 288.07 247.28 64.81 183.44 89 256.07 343.77 290.06 74.74 298.94 252.22 66.14 190.54 90 261.21 350.65 295.86 76.23 311.01 262.42 68.79 194.35 91 266.43 350.65 295.86 77.76 317.23 267.66 70.17 198.23 92 277.70 372.14 37.95	5.58	240.24	198.88	56.27	150.38	82	201.92	276.27	228.71	63.61	172.93
259.08 216.30 59.46 162.04 84 219.62 297.94 248.74 67.22 268.49 225.02 61.07 167.88 85 228.45 308.77 258.76 69.03 268.49 225.02 61.07 167.88 85 228.45 308.77 258.76 69.03 277.91 233.73 62.29 173.71 86 237.30 319.59 268.77 70.41 287.32 242.43 63.54 179.54 87 246.14 330.43 278.79 71.83 293.07 247.28 64.81 183.14 88 256.09 343.77 290.06 74.74 304.92 257.26 67.44 190.54 90 261.21 350.65 295.86 77.76 317.23 267.66 70.17 198.23 92 271.76 301.78 77.76 330.04 278.48 73.02 206.24 94 287.74 379.55 320.25 82.34 <tr< td=""><td>3.28</td><td>249.67</td><td>207.59</td><td>57.86</td><td>156.21</td><td>83</td><td>210.77</td><td>287.10</td><td>238.72</td><td>65.42</td><td>179.64</td></tr<>	3.28	249.67	207.59	57.86	156.21	83	210.77	287.10	238.72	65.42	179.64
268.49 225.02 61.07 167.88 85 228.45 308.77 258.76 69.03 277.91 233.73 62.29 173.71 86 237.30 319.59 268.77 70.41 287.32 242.43 63.54 179.54 87 246.14 330.43 278.79 71.83 287.32 242.43 63.54 179.54 87 246.14 330.43 278.79 71.83 293.07 247.28 64.81 183.14 88 251.07 337.03 284.37 73.26 298.94 252.22 66.11 186.80 89 256.09 343.77 290.06 74.74 304.92 256.24 390.65 291.26 301.78 77.76 77.76 317.23 262.42 68.79 194.35 91 266.43 357.66 301.78 77.76 323.58 273.04 71.76 92 277.20 372.11 313.96 82.53 330.04 27.26<	0.97	259.08	216.30	59.46	162.04	84	219.62	297.94	248.74	67.22	186.35
277.91 233.73 62.29 173.71 86 237.30 319.59 268.77 70.41 287.32 242.43 63.54 179.54 87 246.14 330.43 278.79 71.83 293.07 247.28 64.81 183.14 88 251.07 337.03 284.37 73.26 298.94 252.22 66.11 186.80 89 256.09 343.77 290.06 74.74 304.92 257.26 67.44 190.54 90 261.21 350.65 295.86 76.23 311.01 262.42 68.79 194.35 91 266.43 357.66 301.78 77.76 317.23 267.66 70.17 198.23 92 277.20 372.11 313.96 80.91 330.04 278.48 73.02 206.24 94 282.74 379.55 320.25 84.19 343.39 284.05 74.48 210.37 95 288.40 387.15 346.65 89.3	99.8	268.49	225.02	61.07	167.88	82	228.45	308.77	258.76	69.03	193.06
287.32 242.43 63.54 179.54 87 246.14 330.43 278.79 71.83 293.07 247.28 64.81 183.14 88 251.07 337.03 284.37 73.26 298.94 252.22 66.11 186.80 89 256.09 343.77 290.06 74.74 304.92 257.26 67.44 190.54 90 261.21 350.65 295.86 76.23 311.01 262.42 68.79 194.35 91 266.43 357.66 301.78 77.76 317.23 267.66 70.17 198.23 92 271.76 364.81 307.81 79.32 330.04 278.48 73.02 206.24 94 282.74 379.55 320.25 82.53 336.65 284.05 74.48 210.37 95 288.40 387.15 326.65 84.19 343.39 289.72 75.97 214.57 96 294.17 394.89 333.19 87.6	6.35	277.91	233.73	62.29	173.71	98	237.30	319.59	268.77	70.41	199.77
293.07 247.28 64.81 183.14 88 251.07 337.03 284.37 73.26 298.94 252.22 66.11 186.80 89 256.09 343.77 290.06 74.74 304.92 257.26 67.44 190.54 90 261.21 350.65 295.86 76.23 311.01 262.42 68.79 194.35 91 266.43 357.66 301.78 77.76 317.23 267.66 70.17 198.23 92 271.76 364.81 307.81 79.32 323.58 273.01 71.58 202.20 93 277.20 372.11 313.96 80.91 330.04 278.48 73.02 206.24 94 282.74 379.55 320.25 82.53 343.39 289.72 74.48 210.37 96 294.17 394.89 333.19 85.88 350.25 395.52 77.50 218.87 97 300.05 402.79 339.84 87.6	1.04	287.32	242.43	63.54	179.54	87	246.14	330.43	278.79	71.83	206.48
298.94 252.22 66.11 186.80 89 256.09 343.77 290.06 74.74 304.92 257.26 67.44 190.54 90 261.21 350.65 295.86 76.23 311.01 262.42 68.79 194.35 91 266.43 357.66 301.78 77.76 317.23 267.66 70.17 198.23 92 271.76 364.81 307.81 79.32 323.58 273.01 71.58 202.20 93 277.20 372.11 313.96 80.91 330.04 278.48 73.02 206.24 94 282.74 379.55 320.25 82.53 336.65 284.05 74.48 210.37 96 294.17 394.89 333.19 85.88 350.25 295.52 77.50 27.87 96 294.17 394.89 339.84 87.60 357.25 301.43 79.05 223.25 98 306.05 410.84 346.65 89.35	3.31	293.07	247.28	64.81	183.14	88	251.07	337.03	284.37	73.26	210.61
304.92 257.26 67.44 190.54 90 261.21 350.65 295.86 76.23 311.01 262.42 68.79 194.35 91 266.43 357.66 301.78 77.76 317.23 267.66 70.17 198.23 92 271.76 364.81 307.81 79.32 323.58 273.04 71.58 202.20 93 277.20 372.11 313.96 80.91 330.04 278.48 73.02 206.24 94 282.74 379.55 320.25 82.53 336.65 284.05 74.48 210.37 96 294.17 394.89 333.19 85.88 343.39 289.72 75.97 214.57 96 294.17 394.89 333.19 85.88 350.25 295.52 77.50 218.87 97 300.05 410.84 346.65 89.35 357.25 301.44 307.46 80.63 227.71 99+ 312.17 419.06 353	5.69	298.94	252.22	66.11	186.80	88	256.09	343.77	290.06	74.74	214.82
311.01 262.42 68.79 194.35 91 266.43 357.66 301.78 77.76 317.23 267.66 70.17 198.23 92 271.76 364.81 307.81 79.32 323.58 273.04 71.58 202.20 93 277.20 372.11 313.96 80.91 330.04 278.48 73.02 206.24 94 282.74 379.55 320.25 82.53 336.65 284.05 74.48 210.37 95 228.74 387.15 326.65 84.19 343.39 289.72 75.97 214.57 96 294.17 394.89 333.19 85.88 350.25 295.52 77.50 218.87 97 300.05 402.79 339.84 87.60 357.25 301.43 79.05 223.25 98 306.05 410.84 346.65 89.35 364.41 307.46 80.63 227.71 99+ 312.17 419.06 353.58 91.	7.14	304.92	257.26	67.44	190.54	06	261.21	350.65	295.86	76.23	219.12
317.23 267.66 70.17 198.23 92 271.76 364.81 307.81 79.32 323.58 273.01 71.58 202.20 93 277.20 372.11 313.96 80.91 330.04 278.48 73.02 206.24 94 282.74 379.55 320.25 82.53 336.65 284.05 74.48 210.37 95 288.40 387.15 326.65 84.19 343.39 289.72 75.97 214.57 96 294.17 394.89 333.19 85.88 350.25 295.52 77.50 218.87 97 300.05 402.79 339.84 87.60 357.25 301.43 79.05 223.25 98 306.05 410.84 346.65 89.35 364.41 307.46 80.63 227.71 99+ 312.17 419.06 353.58 91.14	1.68	311.01	262.42	68.79	194.35	91	266.43	357.66	301.78	77.76	223.50
323.58 273.01 71.58 202.20 93 277.20 372.11 313.96 80.91 330.04 278.48 73.02 206.24 94 282.74 379.55 320.25 82.53 336.65 284.05 74.48 210.37 95 288.40 387.15 326.65 84.19 343.39 289.72 75.97 214.57 96 294.17 394.89 333.19 85.88 350.25 295.52 77.50 218.87 97 300.05 402.79 339.84 87.60 357.25 301.43 79.05 223.25 98 306.05 410.84 346.65 89.35 364.41 307.46 80.63 227.71 99+ 312.17 419.06 353.58 91.14	6.32	317.23	267.66	70.17	198.23	92	271.76	364.81	307.81	79.32	227.96
330.04 278.48 73.02 206.24 94 282.74 379.55 320.25 82.53 336.65 284.05 74.48 210.37 95 288.40 387.15 326.65 84.19 343.39 289.72 75.97 214.57 96 294.17 394.89 333.19 85.88 350.25 295.52 77.50 218.87 97 300.05 402.79 339.84 87.60 357.25 301.43 79.05 223.25 98 306.05 410.84 346.65 89.35 364.41 307.46 80.63 227.71 99+ 312.17 419.06 353.58 91.14	1.04	323.58	273.01	71.58	202.20	93	277.20	372.11	313.96	80.91	232.53
336.65 284.05 74.48 210.37 95 288.40 387.15 326.65 84.19 343.39 289.72 75.97 214.57 96 294.17 394.89 333.19 85.88 350.25 295.52 77.50 218.87 97 300.05 402.79 339.84 87.60 357.25 301.43 79.05 223.25 98 306.05 410.84 346.65 89.35 364.41 307.46 80.63 227.71 99+ 312.17 419.06 353.58 91.14	5.86	330.04	278.48	73.02	206.24	94	282.74	379.55	320.25	82.53	237.18
343.39 289.72 75.97 214.57 96 294.17 394.89 333.19 85.88 350.25 295.52 77.50 218.87 97 300.05 402.79 339.84 87.60 357.25 301.43 79.05 223.25 98 306.05 410.84 346.65 89.35 364.41 307.46 80.63 227.71 99+ 312.17 419.06 353.58 91.14	0.78	336.65	284.05	74.48	210.37	92	288.40	387.15	326.65	84.19	241.92
350.25 295.52 77.50 218.87 97 300.05 402.79 339.84 87.60 357.25 301.43 79.05 223.25 98 306.05 410.84 346.65 89.35 364.41 307.46 80.63 227.71 99+ 312.17 419.06 353.58 91.14	5.79	343.39	289.72	75.97	214.57	96	294.17	394.89	333.19	85.88	246.76
357.25 301.43 79.05 223.25 98 306.05 410.84 346.65 89.35 89.35 364.41 307.46 80.63 227.71 99+ 312.17 419.06 353.58 91.14	0.91	350.25	295.52	77.50	218.87	97	300.05	402.79	339.84	87.60	251.70
364.41	5.13	357.25	301.43	79.05	223.25	86	306.05	410.84	346.65	89.35	256.73
	1.45	364.41	307.46	80.63	227.71	+66	312.17	419.06	353.58	91.14	261.86

*See PREMIUM INFORMATION regarding Risk Class and Household Premium Discount rating.

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

Omaha Insurance Company
North Carolina Plans A, F, G, High G & N
Life Expectancy* at Issuance and Increase**
In Monthly Premium after 10 Policy Years

Female Non-Tobacco

Male Non-Tobacco

Plan N	~ 1		<u>~</u>	~	_	.	.	_	_	~	<u>~</u> ;		<u> </u>	_	_	_	~	<u> </u>	~	.	<u> </u>	۰.	٥.	_	_	
<u>Pa</u>	31.17	39.37	41.52	43.73	45.97	48.16	50.36	53.00	55.6	58.28	60.92	63.56	61.69	29.90	58.20	56.57	55.03	52.86	50.83	48.86	46.99	45.22	46.12	47.0	42.74	
Plan High G	11.68	14.82	15.03	15.24	15.46	15.74	16.03	16.32	16.59	16.88	16.69	16.54	16.40	16.31	16.23	15.95	15.71	15.49	15.31	15.16	15.47	15.77	16.09	16.40	14.91	
Plan G	33.92	46.07	51.14	56.22	61.29	96.39	71.44	75.39	79.33	83.29	87.22	91.17	88.53	86.00	83.59	81.29	79.10	75.24	71.51	68.79	64.42	61.05	62.28	63.52	57.72	
Plan F	43.11	60.03	64.64	69.25	73.85	78.47	83.06	85.42	87.80	90.16	92.52	94.90	93.35	91.94	20.67	89.53	88.54	85.01	81.61	78.38	75.30	72.36	73.81	75.29	68.41	
<u>Plan A</u>	29.95	40.66	45.15	49.63	54.11	58.59	63.07	29.99	70.05	73.52	77.01	80.50	78.17	75.93	73.80	71.76	69.84	66.43	63.12	59.95	26.87	53.91	54.98	26.08	96.09	
<u>Life</u> Expectancy	17.39	15.79	15.02	14.27	13.96	13.21	12.49	11.78	11.10	10.45	9.78	9.51	8.88	8.28	7.70	7.13	6.91	6.38	5.88	5.70	5.21	4.76	4.33	3.93	3.56	
Age at Issue	65 66	29	89	69	20	71	72	73	74	75	9/	77	78	79	80	81	82	83	84	85	86	87	88	89	+06	
Plan N	27.11	34.19	36.10	38.03	39.95	41.87	43.80	46.09	48.38	50.68	52.97	55.26	53.64	52.08	20.60	49.20	47.85	45.99	44.20	42.49	40.86	39.33	40.11	40.91	37.17	
<u>Plan</u> High G	10.33	13.11	13.30	13.49	13.67	13.93	14.18	14.42	14.68	14.94	14.77	14.63	14.51	14.43	14.37	14.12	13.90	13.72	13.56	13.41	13.68	13.96	14.24	14.52	13.19	
Plan G	29.50	40.05	44.48	48.88	53.30	57.70	62.12	65.56	68.99	72.43	75.86	79.29	76.98	74.78	72.67	70.70	68.78	65.42	62.18	59.03	55.99	53.09	54.15	55.24	50.20	ortolity
Plan F	37.48	52.20	56.21	60.22	64.22	68.22	72.23	74.29	76.35	78.40	80.46	82.51	81.18	79.95	78.85	27.86	76.99	73.91	96.02	68.16	65.48	62.93	64.18	65.47	59.49	doc only n
Plan A	26.05	35.37	39.25	43.16	47.04	50.94	54.84	57.88	60.91	63.94	26.99	70.00	96'.29	66.03	64.18	62.41	60.74	97.79	54.89	52.12	49.44	46.87	47.82	48.76	44.31	uloui voue
<u>Life</u> Expectanc <u>y</u>	20.55																								5.01	*I if avacant
Age at <u>Issue</u>	65	29	89	69	20	71	72	73	74	75	9/	77	78	79	80	8	82	83	84	82	98	87	88	88	+06	

*Life expectancy includes only mortality
**Increase in premium is based on rates at the time of Issue. Increase is subject to premium change provisions.

MONTHLY TOBACCO PREMIUMS* ZIP CODES: 270 - 289

	Plan N	NM35		119.09	119.09	119.09	123.45	127.81	132.17	136.52	140.89	145.56	150.24	154.92	159.59	164.27	171.17	178.07	184.97	191.87	198.77	206.48	214.19	221.90	229.62	237.33	242.08	246.92	251.86	256.90	262.03	267.27	272.63	278.07	283.64	289.31	295.10	300.99
	Plan High G	NM36		46.52	46.52	46.52	48.08	49.64	51.20	52.96	54.69	56.44	58.19	59.94	61.75	63.55	65.36	67.16	68.97	71.04	73.12	75.20	77.27	79.34	80.93	82.56	84.21	85.91	87.62	86.38	91.18	93.00	94.86	96.77	98.71	100.69	102.70	104.76
MALE	Plan G	NM24	1,138.94	162.71	162.71	162.71	166.32	169.94	173.54	177.16	180.77	187.74	194.72	201.69	208.68	215.66	225.11	234.55	243.99	253.44	262.89	274.40	285.91	297.42	308.93	320.45	326.86	333.40	340.07	346.87	353.81	360.88	368.10	375.47	382.97	390.62	398.45	406.41
	Plan F	NM23	1,411.99	201.72	201.72	201.72	205.79	209.87	213.94	218.00	222.08	231.82	241.55	251.27	261.00	270.72	280.09	289.46	298.82	308.20	317.55	330.00	342.46	354.91	367.35	379.80	387.39	395.14	403.05	411.11	419.33	427.72	436.27	445.00	453.90	462.98	472.23	481.68
	Plan A	NM20	1,005.56	143.66	143.66	143.66	146.84	150.04	153.22	156.41	159.59	165.75	171.92	178.08	184.24	190.40	198.74	207.08	215.42	223.76	232.10	242.27	252.44	262.59	272.76	282.92	288.59	294.35	300.24	306.24	312.37	318.62	324.99	331.49	338.12	344.89	351.78	358.82
	Attained	Age	Thru 64	65	99	29	89	69	20	71	72	73	74	75	9/	77	78	79	80	81	82	83	84	82	98	87	88	88	06	91	92	93	94	95	96	97	86	+66
i	Plan N	NM35		103.55	103.55	103.55	107.36	111.14	114.93	118.72	122.51	126.58	130.64	134.71	138.78	142.85	148.85	154.85	160.85	166.84	172.85	179.55	186.26	192.97	199.67	206.37	210.50	214.71	219.01	223.39	227.85	232.41	237.06	241.80	246.63	251.57	256.61	261.74
	Plan High G	NM36		41.15	41.15	41.15	42.53	43.90	45.29	46.83	48.38	49.93	51.47	53.02	54.62	56.21	57.82	59.41	61.01	62.84	64.68	66.51	68.35	70.19	71.60	73.04	74.49	75.99	77.52	79.07	99.08	82.28	83.93	85.61	87.32	80.08	90.86	92.68
FEMALE	Plan G	NM24	990.38	141.49	141.49	141.49	144.62	147.77	150.91	154.05	157.19	163.25	169.32	175.40	181.46	187.52	195.74	203.96	212.17	220.37	228.60	238.61	248.62	258.64	268.65	278.66	284.23	289.91	295.70	301.63	307.66	313.81	320.09	326.49	333.02	339.68	346.47	353.40
	Plan F	NM23	1,227.82	175.41	175.41	175.41	178.94	182.49	186.03	189.58	193.12	201.59	210.03	218.49	226.95	235.41	243.56	251.71	259.85	267.99	276.14	286.97	297.79	308.61	319.43	330.26	336.86	343.61	350.48	357.48	364.63	371.93	379.36	386.96	394.70	402.59	410.63	418.86
	Plan A	NM20	874.40	124.91	124.91	124.91	127.70	130.46	133.24	136.01	138.78	144.14	149.49	154.85	160.21	165.56	172.82	180.07	187.31	194.57	201.82	210.67	219.50	228.35	237.19	246.02	250.94	255.96	261.08	266.30	271.63	277.06	282.60	288.26	294.02	299.90	305.90	312.02

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

NC OIC AGY 001

Omaha Insurance Company
North Carolina Plans A, F, G, High G & N
Life Expectancy* at Issuance and Increase**
In Monthly Premium after 10 Policy Years

Male Tobacco

Female Tobacco

7																											
Plan N	35.83	40.50	45.18	47.72	50.26	52.80	55.35	57.88	60.92	63.95	86.99	70.03	73.06	70.91	68.85	68.99	65.03	63.26	60.79	58.44	56.17	54.02	51.98	53.02	54.07	49.13	
<u>Plan</u> High G	13.42	15.23	17.03	17.28	17.52	17.77	18.08	18.43	18.76	19.08	19.40	19.18	19.01	18.85	18.75	18.65	18.34	18.06	17.80	17.59	17.43	17.78	18.13	18.49	18.85	17.14	
Plan G	38.98	45.97	52.95	58.79	64.61	70.45	76.28	82.12	99.98	91.19	95.73	100.25	104.79	101.75	98.85	90.96	93.43	90.92	86.48	82.19	78.05	74.04	70.17	71.59	73.01	66.34	
Plan F	49.55	59.28	00.69	74.30	79.59	84.88	90.20	95.47	98.18	100.91	103.64	106.35	109.08	107.30	105.68	104.23	102.91	101.78	97.72	93.81	60.06	86.55	83.18	84.84	86.54	78.63	
Plan A	34.42	40.58	46.74	51.90	57.04	62.20	67.35	72.51	76.52	80.52	84.51	88.52	92.52	89.85	87.27	84.82	82.48	80.27	76.35	72.55	06.89	65.36	61.97	63.19	64.47	58.58	
<u>Life</u> Expectancy	15.36	14.59	13.84	13.12	12.43	12.11	11.42	10.76	10.12	9.50	8.91	8.32	8.04	7.49	96.9	6.47	5.98	5.76	5.31	4.89	4.70	4.30	3.93	3.58	3.26	2.97	
Age at Issue	65	99	29	89	69	20	71	72	73	74	75	9/	77	78	6/	80	81	82	83	84	85	98	87	88	83	+06	
Plan N	31.16	35.23	39.30	41.49	43.71	45.92	48.12	50.34	52.97	55.62	58.26	68.09	63.52	61.65	59.86	58.16	56.55	55.00	52.86	50.80	48.83	46.96	45.20	46.11	47.03	42.73	
<u>Plan</u> High G	11.87	13.47	15.06	15.29	15.51	15.72	16.01	16.30	16.58	16.88	17.17	16.98	16.83	16.67	16.58	16.51	16.23	15.98	15.77	15.58	15.42	15.72	16.04	16.37	16.69	15.16	
Plan G	33.91	39.97	46.03	51.12	56.19	61.26	66.32	71.41	75.36	79.30	83.24	87.19	91.14	88.49	85.95	83.53	81.26	90.62	75.20	71.47	67.85	64.37	61.02	62.24	63.49	57.70	ortality
Plan F					69.22																						n vlno sek
Plan A	29.94	35.30	40.65	45.12	49.61	54.07	58.56	63.04	66.53	70.01	73.50	76.98	80.46	78.12	75.89	73.77	71.73	69.81	66.39	63.10	59.91	56.83	53.88	54.96	90.99	50.94	uloui voue
<u>Life</u> Expectancy	18.04	17.22	16.43	15.65	14.90	14.56	13.79	13.04	12.32	11.63	10.96	10.27	9.95	9.31	8.70	8.11	7.54	7.28	6.75	6.25	6.02	5.54	5.09	4.67	4.28	3.91	"I ife expectancy incl
<u>Age at</u> <u>Issue</u>	65	99	29	89	69	20	71	72	73	74	75	9/	77	28	26	80	81	82	83	84	82	98	87	88	83	÷06	

^{*}Life expectancy includes only mortality **Increase in premium is based on rates at the time of Issue. Increase is subject to premium change provisions.

Disclosures

Use this outline to compare benefits and premiums among policies.

Premium Information

The premium for your policy will change. Because the premium rate is based on your attained age, the premium will increase each year as you age. This annual premium change will occur on the first policy renewal date which coincides with or follows the policy anniversary date.

A premium change for any other reason can occur on any policy renewal date. However, we cannot make such a change unless we make the same change to all policies of this form issued in the same state to persons of the same classification. In no event will the premium rate increase more often than once during any 12-month period. We will give you advance written notice as required by your state before we change your premium.

Risk Class Rating

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

Household Premium Discount

You are eligible for a household premium discount if: (a) you reside with your spouse (including civil union/domestic partner) of any age or (b) for the past year you have resided with at least one, but not more than three, other adults who are age 60 or older. The discounted premium will be priced 12% lower than the rates illustrated. The policy's household premium discount will be removed if the other adult or spouse no longer resides with you (other than in the case of his or her death).

Read Your Policy Very Carefully

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

Right to Return Policy

If you find that you are not satisfied with your policy, you may return it to 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.

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.

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

Complete Answers Are Very Important

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

Exclusions

Exclusions apply to your coverage. Please be sure to review the exclusions in your policy. This policy does not cover Part A benefits periods that begin while this policy is not in force, and other exclusions apply.

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

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

III any other radiily for on days in a row.			
SERVICES	MEDICARE PAYS	PLAN A PAYS	YOU PAY
HOSPITALIZATION*			
Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$1,632	0\$	\$1,632 (Part A deductible)
61st 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\$
Once lifetime reserve days are used: Additional 365 days	0\$	100% of Medicare-eligible expenses	**0\$
Beyond the additional 365 days	\$0	0\$	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including			
having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days			
after leaving the hospital First 20 days	All approved amounts	0\$	0\$
21st through 100th day	All but \$204 a day	0\$	Up to \$204 a day
101st day and after	\$0	0\$	All costs
BLOOD			
First 3 pints	\$0	3 pints	\$0
Additional amounts	100%	\$0	\$0
HOSPICE CARE	All but very limited	Medicare copayment/coinsurance	0\$
You must meet Medicare's requirements, including a doctor's certification of terminal illness	copayment/coinsurance for outpatient drugs and inpatient respite care		

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

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

*Once you have been billed \$240 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN A PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's			
services, inpatient and outpatient medical and surgical services			
durable medical equipment			
First \$240 of Medicare-approved amounts*	\$0	0\$	\$240 (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	0\$
Part B Excess Charges (above Medicare-approved amounts)	\$0	0\$	All costs
BLOOD			
First 3 pints	\$0	All costs	\$0
Next \$240 of Medicare-approved amounts*	\$0	0\$	\$240 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	\$0
CLINICAL LABORATORY SERVICES – TESTS FOR			
DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A AND B

SERVICES	MEDICARE PAYS	PLAN A PAYS	YOU PAY
HOME HEALTH CARE – MEDICARE-APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	80	\$0
DURABLE MEDICAL EQUIPMENT			
First \$240 of Medicare-approved amounts*	\$0	\$0	\$240 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	\$0

PLAN F

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

Medicare first eligible before 2020 only

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

SERVICES	MEDICARE PAYS	PLAN F PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies	All but \$1 632	\$1632 (Dart A deductible)	G
61st through 90th day	All but \$408 a day	\$408 a day	08
91⁵ day and after: While using 60 lifetime reserve days	All but \$816 a day	\$816 a day	0\$
Once lifetime reserve days are used: Additional 365 days	0\$	100% of Medicare-eligible expenses	**0\$
Beyond the additional 365 days	\$0	0\$	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicareapproved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	80	80
21st through 100th day	All but \$204 a day	Up to \$204 a day	0\$
101⁵t day and after	0\$	0\$	All costs
BLOOD First 3 pints	0\$	3 pints	0\$
Additional amounts	100%	98	\$0
HOSPICE CARE	All but very limited	Medicare copayment/coinsurance	0\$
You must meet Medicare's requirements, including a doctor's certification of terminal illness	copayment/coinsurance for outpatient drugs and inpatient respite care		
12 1 - v · C v · L (-+(-14+7)			

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

PLAN F MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR Medicare first eligible before 2020 only

SERVICES	MEDICARE PAYS	PLAN F PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First \$240 of Medicare-approved amounts*	0\$	\$240 (Part B deductible)	0\$
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	0\$
Part B Excess Charges (above Medicare-approved amounts)	0\$	100%	0\$
BLOOD			
First 3 pints	\$0	All costs	0\$
Next \$240 of Medicare-approved amounts*	0\$	\$240 (Part B deductible)	0\$
Remainder of Medicare-approved amounts	%08	20%	0\$
CLINICAL LABORATORY SERVICES – TESTS FOR		÷	
DIAGNOSTIC SERVICES	100%	\$0	\$0

	YOU PAY		\$0		\$0	\$0
	PLAN F PAYS		0\$		\$240 (Part B deductible)	20%
PARTS A AND B	MEDICARE PAYS		100%		\$0	%08
	SERVICES	HOME HEALTH CARE – MEDICARE-APPROVED SERVICES	Medically necessary skilled care services and medical supplies	DURABLE MEDICAL EQUIPMENT	First \$240 of Medicare-approved amounts*	Remainder of Medicare-approved amounts

PLAN F MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR Medicare first eligible before 2020 only

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN F PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning			
during the first 60 days of each trip outside the USA			
First \$250 each calendar year	90	0\$	\$250
Remainder of charges	0\$	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

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

SERVICES	MEDICARE PAYS	PLAN G PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies	, , , , , , , , , , , , , , , , , , ,		Ç
First 60 days	All but \$1,632	\$1,632 (Part A deductible)	04
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\$
Once lifetime reserve days are used: Additional 365 days	0\$	100% of Medicare-eligible expenses	**0\$
Beyond the additional 365 days	0\$	0\$	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0
21st 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	08
Additional amounts	100%	\$0	\$0
HOSPICE CARE	All but very limited	Medicare copayment/coinsurance	\$0
You must meet Medicare's requirements, including a doctor's certification of terminal illness	copayment/coinsurance for outpatient drugs and inpatient respite care		

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

PLAN G
*Once you have been billed \$240 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN G PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT Such as physician's			
services, inpatient and outpatient medical and surgical services			
and supplies, physical and speech therapy, diagnostic tests,			
durable medical equipment			
First \$240 of Medicare-approved amounts*	\$0	\$0	\$240 (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	0\$
Part B Excess Charges (above Medicare-approved amounts)	\$0	100%	0\$
BLOOD			
First 3 pints	\$0	All costs	80
Next \$240 of Medicare-approved amounts*	\$0	0\$	\$240 (Part B deductible)
Remainder of Medicare-approved amounts	%08	20%	. 0\$
CLINICAL LABORATORY SERVICES – TESTS FOR			
DIAGNOSTIC SERVICES	100%	\$0	80

	PARTS A AND B		
SERVICES	MEDICARE PAYS	PLAN G PAYS	YOU PAY
HOME HEALTH CARE – MEDICARE-APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	0\$	\$0
DURABLE MEDICAL EQUIPMENT			
First \$240 of Medicare-approved amounts*	\$0	0\$	\$240 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	\$0

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

OTHER BENEFITS – NOT COVERED BY MEDICARE

OINER	OTHER BENEFITS - NOT COVERED BY MEDICANE	O DI MEDICARE	
SERVICES	MEDICARE PAYS	PLAN G PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during			
the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	80	\$250
Remainder of charges	\$0	80% to a lifetime maximum benefit	20% and amounts over the
		of \$50,000	\$50,000 lifetime maximum
			benefit

HIGH DEDUCTIBLE PLAN G MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

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

***This high deductible plan pays the same benefits as Plan G after you have paid a calendar year \$2,800 deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are \$2,800. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$2,800 DEDUCTIBLE*** PLAN PAYS	IN ADDITION TO \$2,800 DEDUCTIBLE*** YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$1,632	\$1,632 (Part A deductible)	0\$
61st 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\$
Once lifetime reserve days are used: Additional 365 days	0\$	100% of Medicare-eligible expenses	**0\$
Beyond the additional 365 days	\$0	0\$	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicareapproved 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\$

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

HIGH DEDUCTIBLE PLAN G MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed \$240 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year. ***This high deductible plan pays the same benefits as Plan G after you have paid a calendar year \$2,800 deductible plan pays the same benefits as Plan G after you have paid a calendar year \$2,800 deductible, and expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign fravel emergency deductible

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		AFTER YOU PAY \$2,800 DEDUCTIBLE***	IN ADDITION TO \$2,800 DEDUCTIBLE***
SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services			
and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First \$240 of Medicare-approved amounts*	\$0	0\$	\$240 (Unless Part B deductible has been met)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (above Medicare-approved amounts)	0\$	100%	\$0
BLOOD			
First 3 pints	\$0	All costs	0\$
Next \$240 of Medicare-approved amounts*	0\$	\$0	\$240 (Unless Part B
			deductible has been met)
Remainder of Medicare-approved amounts	%08	20%	0\$
CLINICAL LABORATORY SERVICES – TESTS FOR			
DIAGNOSTIC SERVICES	100%	2 0	80

PARTS A AND B

		AFTER YOU PAY \$2,800 DEDUCTIBLE***	IN ADDITION TO \$2,800 DEDUCTIBLE***
SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE – MEDICARE-APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	0\$	\$0
DURABLE MEDICAL EQUIPMENT			
First \$240 of Medicare-approved amounts*	\$0	0\$	\$240 (Unless Part B
			deductible has been met)
Remainder of Medicare-approved amounts	80%	20%	\$0

HIGH DEDUCTIBLE PLAN G MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

***This high deductible plan pays the same benefits as Plan G after you have paid a calendar year \$2,800 deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are \$2,800. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.

OTHER BENEFITS - NOT COVERED BY MEDICARE

		AFTER YOU PAY \$2,800 DEDUCTIBLE***	IN ADDITION TO \$2,800 DEDUCTIBLE***
SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL – NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during			
the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of charges	\$0	80% to a lifetime maximum benefit	20% and amounts over the
		of \$50,000	\$50,000 lifetime maximum
			benefit

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD
*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN N PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but \$1,632	\$1,632 (Part A deductible)	\$0
61st through 90th day	All but \$408 a day	\$408 a day	\$0
91⁵ day and after: While using 60 lifetime reserve days	All but \$816 a day	\$816 a day	0\$
Once lifetime reserve days are used: Additional 365 days	0\$	100% of Medicare-eligible expenses	**0\$
Beyond the additional 365 days	\$0	0\$	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	\$0	\$0
21st 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\$

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

PLAN N
*Once you have been billed \$240 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN N PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient			
and outpatient medical and surgical services and			
supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First \$240 of Medicare-approved amounts*	80	\$0	\$240 (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Balance, other than up to \$20 per	Up to \$20 per office visit and up
		office visit and up to \$50 per	to \$50 per emergency room
		emergency room VISIT. The	VISIT. The copayment of up to
		if the insured is admitted to any	add is walved if the filsuled is
		here insured is admitted to any	admitted to any mospital and the
		nospital and the emergency visit	emergency visit is covered as a
		is covered as a Medicare Part A expense	Medicare Part A expense
Part B Excess Charges (above Medicare-approved	0\$	-20\$	All costs
amounts)			
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	%08	20%	0\$
CLINICAL LABORATORY SERVICES – TESTS FOR			
DIAGNOSTIC SERVICES	100%	\$0	\$0

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

PARTS A AND B

SERVICES	MEDICARE PAYS	PLAN N PAYS	YOU PAY
HOME HEALTH CARE – MEDICARE-APPROVED			
SERVICES			
Medically necessary skilled care services and medical	100%	\$0	\$0
supplies			
DÜRABLE MEDICAL EQUIPMENT			
First \$240 of Medicare-approved amounts*	80	\$0	\$240 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	0\$

	OTHER BENEFITS - NOT COVERED BY MEDICARE	D BY MEDICARE	
SERVICES	MEDICARE PAYS	PLAN N PAYS	YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE			
Aedically necessary emergency care services beginning			
furing the first 60 days of each trip outside the USA			
First \$250 each calendar year	80	\$0	\$250
Remainder of charges	0\$	80% to a lifetime maximum	20% and amounts over the
		benefit of \$50,000	\$50,000 lifetime maximum
			benefit

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 (S Phone Fax Email Conta Note: Producers must be under the same of information at http://www.mutualof	ct info:commission code to share or split comm	issions. Please update your contact
Application Submission Check	<u>klist – Omaha Insurance Co. I</u>	Medicare Supplement Coverage
 Provide Applicant with the Out Calculate the premium bas 	sed on age at application date during open enrollment or guara remium form to determine rate	
 Select plan Enter Requested Effective Indicate where the policy i Section C: Medicare Informati Include applicant's Medica claim processing. If this nu provide this number by call Medicare, indicate "eligibil 	Date s to be mailed on re number on the application. This mber is not available at time of ap ling 1-877-617-5587 once it is recitive and "enrollment" dates.	nlication the applicant/agent must
 Section D: Household Premium Indicate if eligible for a Household Section E: Previous or Existin Please complete ALL quest 	usehold Premium Discount g Coverage Information	
For Sections F and G – Refer to the Ope		sheet to help identify eligibility.
 Section F: Please answer all of the either Applicant A or B and F, they can skip to Section Sections G & H: Health/Medic 	of the following questions nswered "YES" to <u>BOTH</u> questions I	57(a) or 7(b) or question 8 in Section
Section I: Agreement and Aut		,
 Section K: To be Completed b Make sure producer(s) sign 	y Producer	
 Úse premium determined l 	ent form and return with the com by the Calculate Your Premium for collected at the time of application	m
	and leave a copy with the application in Receipt signed by agent (if apportions)	
Note: An interviewer may call to ve		rided on the application. ssions.



Mutual of Omaha is excited to introduce our new comprehensive wellness program called Mutually Well. Please visit www.mutuallywell.com for more information and to enroll.

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

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 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 statespecific 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 (ONLY 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



Calculate Your Premium

PLEASE COMPLETE

Medicare Supplement Insurance Plan	Applicant A
	Applicant B

Before you begin: Please go to the Height and Weight Chart on the next page to determine your eligibility for coverage, unless you are in an open enrollment or guaranteed issue period.

	Steps	Example Rate displayed is used for calculation purposes only.	Applicant A	Applicant B
#1	Age Write in your age at the time of signing the application. ZIP Code Indicate your ZIP Code used to determine your rate.	65 51502		
#2	Premium Write in your Med supp plan's premium from the Outline of Coverage provided, based on your age and ZIP Code listed in Step #1.	\$128.52		
#3	Household Premium Discount Please refer to the application for state specific household discount premium rules. If the rules apply, multiply the amount from Step #2 by .88. If the rules do not apply, enter the amount from Step #2.	\$128.52 x .88 = \$113.10 In this example, the person qualifies for the household premium discount.		
#4	Rate Adjustment If you're in your open enrollment or guaranteed issue period, skip to Step #5. Locate your height, then weight on the next page. If your weight is in the Standard column, enter the amount from Step #3 If your weight is in the Class I or II column, multiply the amount from Step #3 by: 1.10 if in Class I column 1.20 if in Class II column	\$113.10 x 1.20 = \$135.70 Person's weight is in the Class II column.		
#5	Payment Options Your monthly payment is your last premium entered (Step #3 or #4). To determine other payment schedules, multiply your monthly premium by: 3 to pay 4 times a year (quarterly) 6 to pay twice a year (semiannually) 12 to pay once a year (annually)	\$135.70 monthly payment \$407.10 quarterly payment \$814.20 semiannual payment \$1,628.40 annual payment		



Eligibility

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

Rate Adjustment

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

	Decline	Class I (10%)	Standard	Class I (10%)	Class II (20%)	Decline
Height	Weight	Weight	Weight	Weight	Weight	Weight
4' 2''	< 54	54 - 60	61 - 110	111 - 128	129 - 145	146 +
4' 3''	< 56	56 - 62	63 - 114	115 - 133	134 - 151	152 +
4' 4''	< 58	58 - 65	66 - 119	120 - 138	139 - 157	158 +
4' 5''	< 60	60 - 67	68 - 123	124 - 143	144 - 163	164 +
4' 6''	< 63	63 - 70	71 - 128	129 - 149	150 - 170	171 +
4' 7''	< 65	65 - 73	74 - 133	134 - 154	155 - 176	177 +
4' 8''	< 67	67 - 75	76 - 138	139 - 160	161 - 182	183 +
4' 9''	< 70	70 - 78	79 - 143	144 - 166	167 - 189	190 +
4' 10''	< 72	72 - 81	82 - 148	149 - 172	173 - 196	197 +
4' 11''	< 75	75 - 84	85 - 153	154 - 178	179 - 202	203 +
5' 0''	< 77	77 - 87	88 - 158	159 - 184	185 - 209	210 +
5' 1''	< 80	80 - 89	90 - 164	165 - 190	191 - 216	217 +
5' 2''	< 83	83 - 92	93 - 169	170 - 196	197 - 224	225 +
5' 3''	< 85	85 - 95	96 - 175	176 - 203	204 - 231	232 +
5' 4''	< 88	88 - 99	100 - 180	181 - 209	210 - 238	239 +
5' 5''	< 91	91 - 102	103 - 186	187 - 216	217 - 246	247 +
5' 6''	< 93	93 - 105	106 - 192	193 - 223	224 - 254	255 +
5' 7''	< 96	96 - 108	109 - 197	198 - 229	230 - 261	262 +
5' 8''	< 99	99 - 111	112 - 203	204 - 236	237 - 269	270 +
5' 9''	< 102	102 - 115	116 - 209	210 - 243	244 - 277	278 +
5' 10''	< 105	105 - 118	119 - 216	217 - 250	251 - 285	286 +
5' 11''	< 108	108 - 121	122 - 222	223 - 258	259 - 293	294 +
6' 0''	< 111	111 - 125	126 - 228	229 - 265	266 - 302	303 +
6' 1''	< 114	114 - 128	129 - 234	235 - 272	273 - 310	311 +
6' 2''	< 117	117 - 132	133 - 241	242 - 280	281 - 319	320 +
6' 3''	< 121	121 - 136	137 - 248	249 - 288	289 - 328	329 +
6' 4''	< 124	124 - 139	140 - 254	255 - 295	296 - 336	337 +
6' 5''	< 127	127 - 143	144 - 261	262 - 303	304 - 345	346 +
6' 6''	< 130	130 - 147	148 - 268	269 - 311	312 - 354	355 +
6' 7''	< 134	134 - 150	151 - 275	276 - 319	320 - 363	364 +
6' 8''	< 137	137 - 154	155 - 282	283 - 327	328 - 373	374 +
6' 9''	< 140	140 - 158	159 - 289	290 - 335	336 - 382	383 +
6' 10''	< 144	144 - 162	163 - 296	297 - 344	345 - 392	393 +
6' 11''	< 147	147 - 166	167 - 303	304 - 352	353 - 401	402 +
7' 0''	< 151	151 - 170	171 - 311	312 - 361	362 - 411	412 +
7' 1''	< 155	155 - 174	175 - 318	319 - 369	370 - 421	422 +
7' 2''	< 158	158 - 178	179 - 326	327 - 378	379 - 431	432 +
7' 3''	< 162	162 - 183	184 - 333	334 - 387	388 - 441	442 +
7' 4''	< 166	166 - 187	188 - 341	342 - 396	397 - 451	452 +



	DNIS Auth #
Agent Writing # Group # (f applicable) Keyline
Mutual of Omaha Insurance Compa A Mutual of Omaha Compa A Mutual of Omaha Compa	any
Applicant acknowledges and agrees that if there is more than on viewed or shared with the other applicant.	
How Did You Hear About Us?	
Please select all that apply. Thank you for providing this helpful info	rmation.
Agent/Broker/Producer Family Member/Friend	Physician Referral Social Media
Direct Mail Internet Search	Radio
A. Plan Information (to be completed by	Producer)
Applicant A	Applicant B
Plan (select one): Plan A Plan G	Plan (select one): Plan A Plan G
High Deductible Plan G Plan N	High Deductible Plan G Plan N
OR If your Medicare Part A eligibility date is before 01/01/2020, this additional plan is an available option:	OR If your Medicare Part A eligibility date is before 01/01/2020, this additional plan is an available option:
Plan F	☐ Plan F
Requested Effective Date / / / /	Requested Effective Date / / / / / / / / / / / / / / / / / / /
Deliver Policy to:	Deliver Policy to:
Deliver Policy to: Applicant A Producer	Deliver Policy to: Applicant B Producer
Applicant A Producer	
Applicant A Producer B. Applicant Information	Applicant B Producer
Applicant A Producer B. Applicant Information Applicant A	Applicant B Producer Applicant B
Applicant A Producer B. Applicant Information Applicant A Name (First/Middle Initial/Last)	Applicant B Producer Applicant B Name (First/Middle Initial/Last)
Applicant A Producer B. Applicant Information Applicant A Name (First/Middle Initial/Last) Residence Address	Applicant B Producer Applicant B Applicant B Name (First/Middle Initial/Last) Residence Address
Applicant A Producer B. Applicant Information Applicant A Name (First/Middle Initial/Last) Residence Address City	Applicant B Applicant B Name (First/Middle Initial/Last) Residence Address City
B. Applicant Information Applicant A Name (First/Middle Initial/Last) Residence Address City State ZIP	Applicant B Producer Applicant B Name (First/Middle Initial/Last) Residence Address City State ZIP
Applicant A Producer B. Applicant Information Applicant A Name (First/Middle Initial/Last) Residence Address City State ZIP Mailing Address (if different from residence address)	Applicant B Applicant B Name (First/Middle Initial/Last) Residence Address City State ZIP Mailing Address (if different from residence address)
Applicant Information Applicant A Applicant A Name (First/Middle Initial/Last) Residence Address City State ZIP Mailing Address (if different from residence address) City State ZIP Home Phone	Applicant B Applicant B Name (First/Middle Initial/Last) Residence Address City State ZIP Mailing Address (if different from residence address) City State ZIP Home Phone
Applicant Information Applicant A Name (First/Middle Initial/Last) Residence Address City State ZIP Mailing Address (if different from residence address) City State ZIP	Applicant B Applicant B Name (First/Middle Initial/Last) Residence Address City State ZIP Mailing Address (if different from residence address) City State ZIP

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Applicant A	Applicant B				
☐ Male ☐ Female	☐ Male ☐ Female				
Social Security #	Social Security #				
Height Weight Ft In Lbs	Height Weight Lbs				
Go paperless! To receive your Explanation of Benefits (EOBs) onli in Section B. If you subscribe, you will <u>not</u> receive paper EOBs, but become available with a link to access each specific EOB. We will reimbursement from Omaha Insurance Company.	t instead, will receive an e-mail notification when new EOBs				
Receive statement online? Y N	Receive statement online? Y N				
C. Medicare Information					
Please reference your Medicare card to complete this section	MEDICARE HEALTH INSURANCE Name/Nombre JOHN L SMITH Medicare Number/Número de Medicare 1EG4-TE5-MK72 Entitled tot/con derecho a HOSPITAL (PART A) MEDICAL (PART B) 03-01-2016 03-01-2016				
Applicant A	Applicant B				
Medicare Number	Medicare Number				
Medicare Part A Effective Date//////	Medicare Part A Effective Date////				
Medicare Part B Effective Date/////	Medicare Part B Effective Date///////				
D. Household Premium Discount In	formation				
You may be eligible for a policy with a lower premium rate base statements in this section. 1. Do you currently have a household resident (at least one, no real with whom you have continuously resided for the last 12 months (b) with whom you reside and to whom you are either married or the last 12 months (b) with whom you reside and to whom you are either married or the last 12 months (b) with whom you reside and to whom you are either married or the last 12 months (b) with whom you reside and to whom you are either married or the last 12 months (a) with whom you reside and to whom you are either married or the last 12 months (b) with whom you reside and to whom you are either married or the last 12 months (b) with whom you reside and to whom you are either married or the last 12 months (b) with whom you reside and to whom you are either married or the last 12 months (b) with whom you reside and to whom you are either married or the last 12 months (b) with whom you reside and to whom you are either married or the last 12 months (b) with whom you reside and to whom you are either married or the last 12 months (b) with whom you reside and to whom you are either married or the last 12 months (b) whom you reside and to whom you are either married or the last 12 months (b) whom you reside and the last 12 months (b) whom you reside and the last 12 months (b) whom you reside and the last 12 months (b) whom you reside and the last 12 months (b) whom you reside and the last 12 months (b) whom you reside and the last 12 months (b) whom you reside and the last 12 months (b) whom you reside and the last 12 months (b) whom you reside and the last 12 months (b) whom you reside and the last 12 months (b) whom you reside and the last 12 months (b) whom you reside and the last 12 months (b) whom you reside and the last 12 months (b) whom you reside and the last 12 months (b) whom you reside and the last 12 months (b) whom you reside and the last 12 months (b) whom you reside and the last 12 months (b) whom you reside and the l	more than three): and who is age 60 or older; or				

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Name (First/Middle/Last)

Date of Birth
Street Address
City/State/ZIP

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E. Previous or Existing Coverage Information

for guaranteed issue of a Medicare supplement insurance policy or certificate, or that you had certain rights to buy such a policy or certificate, you may be guaranteed acceptance in one or more of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with your application. PLEASE ANSWER ALL QUESTIONS. Please mark "YES" or "NO" with an "X" to the questions below. To the Best of Your Knowledge and Belief: Applicant A Applicant B $\prod_{Y}\prod_{N}$ 3. Are you covered for medical assistance through the state Medicaid program?..... (NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer "NO" to this question.) If "YES," answer the following about this existing coverage: $\square_{\mathsf{Y}} \square_{\mathsf{N}}$ (a) Will Medicaid pay your premiums for this Medicare supplement policy?..... (b) Do you receive any benefits from Medicaid OTHER THAN payments toward your \square Y \square N \square Y \square N Medicare Part B premium?.... Please answer questions regarding another Medicare supplement or Select plan: 4. Do you have another Medicare supplement or Medicare Select insurance policy or $\prod_{Y}\prod_{N}$ $\prod_{Y}\prod_{N}$ certificate in force?..... If "YES," answer the following about this existing coverage: (a) Do you intend to replace your current Medicare supplement policy/certificate with this policy?..... (b) Indicate planned termination or disenrollment date...... Applicant A Applicant B (c) With what company, and what plan do you have? Applicant A **Applicant B** Name of Company Name of Company Plan Plan Please answer questions regarding Medicare plan coverage (other than Medicare supplement): **Applicant B** Applicant A 5. Have you had coverage from any Medicare plan other than Medicare Part A or B within \square Y \square N $\prod_{Y}\prod_{N}$ the past 63 days? (for example, a Medicare Advantage plan, or a Medicare HMO or PPO)... 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...... Applicant A START Applicant B START (b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy?..... (c) Planned date of termination/disenrollment?..... Applicant A Applicant B (d) Was this your first time in this type of Medicare plan?..... (e) Did you drop a Medicare supplement or Medicare Select policy/certificate to enroll in $\exists \mathsf{Y} \square \mathsf{N}$ this Medicare plan?.... (f) Is your former Medicare supplement or Medicare Select policy/certificate still available? $\prod_{Y}\prod_{N}$ $\prod_{Y}\prod_{N}$

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible

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 (g) Please indicate reason for termination/disenrollment: Your Medicare Advantage plan is leaving the Medicare Your Medicare Advantage organization stopped offering Your Medicare Advantage organization stopped offering in which you live You moved out of the geographic service area of your N You had a Medicare Advantage plan with Medicare Part in a stand-alone Medicare Part D plan Other: Applicant A Applicant B 	g Medicare Advantage plans g coverage in the area Medicare Advantage plan t D benefits and are enrolling	Check box(s) below if applicable Applicant A
Please answer questions regarding other health insurance	:	
 6. Have you had coverage under any other health insurance wit (For example, an employer group health plan, union plan, or i supplement plan.) If "YES," answer the following about this previous or existing (a) What are your dates of coverage under the other policy/cert If you are still covered under this plan, leave "END" blank (b) Planned date of termination/disenrollment? (c) Have you disenrolled from your current coverage volunta (d) Please state the reason for your disenrollment: Applicant A Applicant B (e) With what company and what kind of policy/certificate? 	ndividual non-Medicare coverage: tificate?	Applicant A Applicant B Y N I N I N I N I N I N I N I N
Applicant A	Applicant B	
Name of Company	Name of Company	
Policy/Certificate type	Policy/Certificate type	
F. Please answer all of the following To the Best of Your Knowledge and Belief: 7. Are you applying during an open enrollment period? (a) Did you turn age 65 in the last six months? (b) Did you enroll in Medicare Part B in the last six months? If either question 7a or 7b is "YES", indicate your Medicare Part 8. Are you applying during a guaranteed issue period?	B effective date Applicant A Applicant B	Applicant A Applicant B Y N Y N N N N N N N N N N N N N N N N
if you are eligible. If the answer above is "YES," attach proof of the state of the	AND 7B OR QUESTION 8 II	

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

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

G. Health Information

For all plans, answer questions 9-20. Note: An interviewer may call to confirm and verify the information you have provided on this application.

Part A: Medical Questions: (If "YES" is answered to any of the following questions 9-15, that person is not eligible for coverage.)

1		Best of Your Knowledge and Belief:	Applicant A	Applicant B
		e you currently confined to a wheelchair or any motorized mobility device?	\square Y \square N	\square \vee \square \bowtie
	fac	e you currently hospitalized, confined to a bed, in a nursing home or assisted living cility?	\square Y \square N	\square Y \square N
11.		ave you been medically diagnosed with, treated for, or had surgery for any of the following:		
		Chronic kidney disease (Stages 3, 4, or 5), kidney failure, or kidney disease requiring dialysis?	\square Y \square N	\square Y \square N
		Emphysema, chronic obstructive pulmonary disease (COPD), any other chronic pulmonary disorder or any cardio-pulmonary disorder requiring oxygen?	□y□n	\square Y \square N
	C.	Alzheimer's disease, dementia or any other cognitive disorder?	\square Y \square N	\square Y \square N
	D.	Parkinson's disease, multiple sclerosis or amyotrophic lateral sclerosis (Lou Gehrig's Disease), Huntington's disease, or cerebral palsy?	□y□n	\square Y \square N
	E.	Systemic lupus, scleroderma or myasthenia gravis?	\square Y \square N	\square Y \square N
	F.	Chronic hepatitis or cirrhosis?	\square Y \square N	\square Y \square N
	G.	Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) or tested positive for Human Immunodeficiency Virus (HIV)?	$\square_{Y} \square_{N}$	ПуПл
12.	. Hav	ve you had an organ or stem cell transplant or been advised to have an organ or stem cell		
		insplant (excluding cornea implants)?	LYLN	\square \vee \square \bowtie
		you have Osteoporosis, and as a result, experienced a fracture?	\square Y \square N	\square Y \square N
14	. Do dise	you have diabetes with complications including retinopathy, neuropathy, peripheral artery sease, peripheral venous thrombotic disease, stroke, transient ischemic attack (TIA), any heart sorder or any kidney disease?	$\square_{Y} \square_{N}$	$\square_{\vee}\square_{N}$
15.		you have an implanted cardiac defibrillator?	$\square_{Y} \square_{N}$	
		you have an implanted cardiac denominator imminimum.		
	- L D -			
and	d is s	: Medical Questions: (If "YES" is answered to any of the following questions 16-19 that person M subject to an underwriting review.) If you would like consideration to be given to an application that on in Part B, attach an explanation stating how long the condition has existed and how it is being co	contains a "Yes	
and que	d is s estio	subject to an underwriting review.) If you would like consideration to be given to an application that	contains a "Yes ntrolled.	answer to any
and que To	d is sestion the the	subject to an underwriting review.) If you would like consideration to be given to an application that on in Part B, attach an explanation stating how long the condition has existed and how it is being con	contains a "Yes	
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To 16 A B C C E F.	d is s sestion the tree tree. Coopla per disciple. Alco. And a si. De	subject to an underwriting review.) If you would like consideration to be given to an application that on in Part B, attach an explanation stating how long the condition has existed and how it is being concepts of Your Knowledge and Belief: ithin the past two years, have you been treated for, or been advised by a physician to have eatment for: oronary artery disease, angina, heart attack, cardiac angioplasty, bypass surgery or stent accement? ordiomyopathy, congestive heart failure, aortic or cardiac aneurysm, peripheral artery disease, ripheral venous thrombotic disease, vascular angioplasty, endarterectomy, carotid artery sease, any heart or heart valve disorder, atrial fibrillation, other heart rhythm disorder, or plantation of a pacemaker? ordiomyopathy or drug abuse? ordiomyopathy ordiomyopath	contains a "Yes ntrolled. Applicant A Y N Y N Y N Y N Y N Y N Y N Y	Applicant B Y N Y N Y N
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G. Health Informa	ation (con	t.)				
To the Best of Your Knowledge	and Belief:				Applicant A	Applicant B
20. Have you used any form of						
the past 12 months?					Шү Ш и	
H. Medication In	nformatio	on				•
If you are applying for ANY the question. If "yes" list all prescribed in the last 2 year	l over-the-cou	E of an open on the or prescription	enrollment or guara ription medications	nteed issue pe you are curre	eriod, please an	iswer ave been
To the Best of Your Knowledg					Applicant A	Applicant B
21. Are you currently taking, or prescription drugs or over	or have you been r-the-counter m	n prescribed du edications?	ring the previous 2 ye	ars any		□y□N
Applicant A						
Medication Name (copy off pharmacy label)	Dosage	Frequency	Have you taken this medication for more than 2 years?	Prescribed by Primary Physician?	Diagnosis/Cond	dition
			□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		
Applicant B	1					
Medication Name (copy off pharmacy label)	Dosage	Frequency	Have you taken this medication for more than 2 years?	Prescribed by Primary Physician?	Diagnosis/Cond	dition
			□Y □N	□У□И		
			□Y □N	□Y □N		
			□Y □N	□Y □N		
			□Y □N	□Y □N		
			□Y □N	□Y □N		
			□Y □N	□Y □N		
			□Y □N	□Y □N		



I. Agreement and Authorization

IMPORTANT STATEMENTS



- You do not need more than one Medicare supplement policy.
- If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
- If you are age 65 or older, 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 your state to provide advice concerning your purchase of Medicare supplement
 insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare
 Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

AUTHORIZATION TO DISCLOSE PERSONAL INFORMATION TO 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 Mutual of Omaha Insurance Company, United World Life Insurance Company, United of Omaha 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. Unless revoked earlier, this authorization will remain in effect for 30 months from the date I sign this application. I understand that I may revoke this authorization at any time, by written notice to: ATTN: Individual Underwriting, 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, including the presence of HIV infection, AIDS or ARC, prescription drug records, drug and alcohol use and other information such as finances, occupation, general reputation and insurance claims information about me. Personal Information does not include Psychotherapy Notes, which are notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a counseling session, which notes are separated from the rest of the person's medical record. Certain information, such as that relating to prescriptions, diagnosis and functional status, is not included in the term Psychotherapy Notes.
- The Personal Information will be used to determine my eligibility for insurance and to resolve or contest any issues of incomplete, incorrect or misrepresented information on my application which may arise during the processing of my application or in connection with claims for insurance benefits. This authorization will not be used if the applicant is in an open enrollment or guaranteed issue period.
- If the person or entity to whom Personal Information is disclosed is not a health care provider or health plan subject to federal privacy regulations, the Personal Information may then be subject to further disclosure by that person or entity without the protections of the federal privacy regulations.
- I understand that I may refuse to sign this application. I realize that if I refuse to sign, the insurance for which I am applying will not be issued.
- I understand that I have a right to receive a copy of the signed application. A copy of this application is as effective as the original. I acknowledge and agree that if there is more than one applicant on this application, all information provided may be reviewed or shared with the other applicant. I understand that, upon acceptance of the completed application, each applicant will receive a separate policy and a completed and signed application will become part of each applicant's policy. I represent that my answers and statements on this application are true and complete to the best of my knowledge and belief. I understand that my policy benefits can start no earlier than my Medicare effective date, my first month's premium has been

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.

received and/or processed and my application has been approved by Omaha Insurance Company.

Dated at	, (on Month Day	/		Applicant A's Signature
	State		I I I I	1 1	Applicant No Signature
Dated at	, (on/ Month Day	/		Applicant B's Signature (if applying)

J. Producer Comments (please attach a separate sheet if needed)	
K. To be Completed by Producer	
22. Producers shall list any other health insurance policies/certificates they have sold to the applicant(s). (a) List policies/certificates sold to the applicant(s) which are still in force.	
Applicant A	
Applicant B	
(b) List policies/certificates sold to the applicant(s) in the past five (5) years which are no longer in force.	
Applicant A	
Applicant B	
I/We certify as follows: I/We have truly and accurately recorded in the application the information supplied by the applicant(] n
I/We certify that we have interviewed the proposed applicant(s) \square Y	
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 Signature of Licensed Producer Date	
Signature of Elcensed Froducer Date Signature of Elcensed Froducer Date	
Printed Name Printed Name	
Agent Writing Number Agent Writing Number	

NA6012-3

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)	Applicant A	Applicant B		
Initial Premium Payment (Select option #1 or #2) Initial premium amount (based on age at application date)	1st through the 28 th or the last day of every month Week (1 st , 2 nd , 3 rd , 4 th , last)	\$		
deducted every month from your bank account				
 Account Owner Name, if different than applicant's	Applicant A	Applicant B		

Page 1



Part III. Account Information

rait III. Account information			
Complete the Following ONLY if <u>Automated Bank Account Withdrawal</u> 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)			
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) 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.	Applicant B		
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.			
Applicant A	Applicant B		
L o	∠ n		
Authorized Signature as Shown on Account	Authorized Signature as Shown on Account		
Date	Date		



Page 2 N41_1219



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, the replacement of insurance involved in this transaction does not duplicate coverage. The replacement policy is being purchased for the following reason(s) (check one):

	Applicant A		Applicant B
	Additional benefits		Additional benefits
	No change in benefits, but lower premiums		No change in benefits, but lower premiums
	Fewer benefits and lower premiums		Fewer benefits and lower premiums
	My plan has outpatient prescription drug coverage and I am enrolling in Part D		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)		Disenrollment from a Medicare Advantage Plan (Please explain reason for disenrollment)
	Other (please specify)		Other (please specify)
if y 2. If, co me	ealth conditions which may now have (preexisting condition you have had your present policy for less than six months. It is you still wish to terminate your present policy or certificate mpletely answer all questions on the application concernited information on an application may provide a basis for the provide a basis for the provide and the provide a basis for the provide and the provided and the	e and r ng you or the (er the a	eplace it with new coverage, be certain to truthfully and medical and health history. Failure to include all material company to deny any future claims and to refund your pplication has been completed and before you sign it,
	view it carefully to be certain that all information has been cancel your present policy or certificate until you have red		•
Ø			
<i>p</i>	gnature of Agent, Broker or Other Representative*		Date
Or	maha Insurance Company, 3300 Mutual of Omaha Plaza,	Omaha	, NE 68175
Appli	cant A	Appl	icant B
Signat	ture	Signa	ture
Date		Date	

*Signature not required for direct response sales.



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 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, the replacement of insurance involved in this transaction does not duplicate coverage. The replacement policy is being purchased for the following reason(s) (check one):

	Applicant A		Applicant B
	Additional benefits		Additional benefits
	No change in benefits, but lower premiums		No change in benefits, but lower premiums
	Fewer benefits and lower premiums		Fewer benefits and lower premiums
	My plan has outpatient prescription drug coverage and I am enrolling in Part D		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)		Disenrollment from a Medicare Advantage Plan (Please explain reason for disenrollment)
	Other (please specify)		Other (please specify)
if y 2. If, co me	ealth conditions which may now have (preexisting condition you have had your present policy for less than six months. It is you still wish to terminate your present policy or certificate mpletely answer all questions on the application concernited information on an application may provide a basis for the provide a basis for the provide and the provide a basis for the provide and the provided and the	e and r ng you or the (er the a	eplace it with new coverage, be certain to truthfully and medical and health history. Failure to include all material company to deny any future claims and to refund your pplication has been completed and before you sign it,
	view it carefully to be certain that all information has been cancel your present policy or certificate until you have red		•
Ø			
<i>p</i>	gnature of Agent, Broker or Other Representative*		Date
Or	maha Insurance Company, 3300 Mutual of Omaha Plaza,	Omaha	, NE 68175
Appli	cant A	Appl	icant B
Signat	ture	Signa	ture
Date		Date	

*Signature not required for direct response sales.





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.

Applicant A	Applicant B
Received from	Received from
this , ,	this , , ,
an application for FormPolicy	an application for FormPolicy
and/or Ridersand	and/or Ridersand
Check forDollars.	Check forDollars.
Agent	Agent

No insurance of any kind shall take effect until a policy is issued and delivered to the applicant, and the initial premium is paid, all during the life of the applicant. If no policy is issued, 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.



APPLICATION for INDIVIDUAL DENTAL INSURANCE WITH OPTIONAL VISION RIDER

NORTH CAROLINA



Monthly Rates (Issue Age 19-99)

NORTH CAROLINA							
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	
270, 278, 279,							
284-289	\$53.51	\$61.28	\$63.95	\$26.40	\$27.15	\$27.64	\$8.28
271-274, 280-283	\$57.75	\$66.13	\$69.02	\$28.49	\$29.30	\$29.83	\$8.28
275-277	\$62.52	\$71.59	\$74.72	\$30.85	\$31.72	\$32.30	\$8.28

Rates Subject to Change.

As of 07/14/2023

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)



Underwritten by
Mutual of Omaha Insurance Company

3300 Mutual of Omaha Plaza Omaha, Nebraska 68175

Internal Tracking Code Group # (if applicable)

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, St	ate, ZIP) (if different from reside	nce address)	Deliver Polic	· —
Gender Male Female			ecurity Number	r
B. Plan Information]			
Select Dental Benefit Plan Mutual Dental Preferred Mutual Dental Protection	Select Annual Maximum ☐ \$1,500 ☐ \$3,000 ☐ \$5,000		ective Date	Dental \$
Optional Vision Rider (only	available with Dental)	Monthly Pro	emium Rate for	Vision \$
		To	otal Monthly Pr	emium \$
C. Existing Coverag	e Information			
Is the coverage you are applying Is the coverage you are applying D. Agreements I represent the information above answers may void this application the first premium is received by N	for replacing existing vision insuring is true and complete to the best and any issued policy. I underst	of my knowledge and and that no insurance	belief. Any inco	orrect or misleading
Applicant Signature		Date	Sign	ned at City State
I/We certify that I/we have truly acknowledge that if the applicant		· · ·		
L 1				
Signature of Licensed Insura	nce Producer	Date		0/-
Printed Name		Agent Writi	ng Number	Comm. % Share
Signature of Licensed Insura	nce Producer	Date		
Printed Name		Agent Writi	ng Number	Comm % Share

MA6025_NC REV



METHOD OF PAYMENT FORM

REQUIRED FORM – PLEASE RETURN 1 & 2

Part I. Select Premium Payment Option

Initial Premium Payment (Select option #1 <u>or</u> #2)	
Initial premium amount (based on age at application date)	\$
Paper Check (submit signed check with application)	
2. Automatic Bank Account Withdrawal	
Ongoing Premium Payments (Select option #1a, #1b, or #2)	1 St through the 28 th or
1. I want my payments automatically withdrawn from my bank	the last day of every month
a. Choose the day payments will be deducted every month from your bank account	
OR	Week (1 st , 2 nd , 3 rd , 4 th , last)
b. Choose the week and weekday that payments will be	Weekday (Mon, Tue, Wed,
deducted every month from your bank account	Thu, Fri)
(For Example: 3rd Wednesday of every month)	, ,
2. I will mail my premium to the company every 3, 6, or 12 months.	every months
(Monthly billing is not allowed. Select frequency of billing)	Insert 3, 6, or 12
APPROVAL AND ISSUE. The first withdrawal date may be different from the monthly date selected for ongo the amount of time elapsed between the policy date and the date the policy is placed inforce, the amount may exceed one modal premium and may occur on a date other than the policy date. The Proposed Insure billing notices while on this premium payment option. We CANNOT establish electronic payments from for Each month, payments will be automatically deducted from the account below on the day selected above. premiums will be deducted on the policy date (which is determined at the time the policy is issued and ca Ongoing deductions will begin once the policy is issued. If the scheduled deduction date begins on a we will process on the following business day. Part II. Payor Information	of the first ongoing withdrawal ed(s) will not receive premium eign banks. If no date is selected, no be found within the policy).
 Account Owner Name, if different than applicant's 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 □ Y □ N



Part IV. Account Information

i dit iv. Account information
Complete the Following ONLY if <u>Automated Bank Account Withdrawal</u> 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)
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. Routing/Transfer Number Name & Address Name & Address Signed By: 123456789 12345678 1234
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



Page 2 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



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.

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!

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

<u>Benefits</u> – 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 COMPARISON SUMMARY	IN-NETWORK	OUT-OF-NETWORK
	DEDUCTIBLE AMOUNT	DEDUCTIBLE AMOUNT
Class I Diagnostic & Preventive Services	None	None
Class II – Basic Services and Class III - Major Services Combined	\$50.00	\$50.00
	COINSURANCE	COINSURANCE
	PERCENTAGE PAYABLE	PERCENTAGE PAYABLE
Class I – Diagnostic & Preventive Services	100%	100%
Class II – Basic Services	80%	80%
Class III – Major Services	20% Day One, 50% After Year One	20% Day One, 50% After Year One
	WAITING PERIOD TIME FRAME	WAITING PERIOD TIME FRAME
Class I- Diagnostic & Preventive Services	None	None
Class II- Basic Services	None	None
Class III- Major Services	None	None
	MAXIMUM BENEFIT AMOUNT	MAXIMUM BENEFIT AMOUNT
Annual Maximum Benefit per Calendar Year	\$1,500, \$3,000 or \$5,000	\$1,500, \$3,000 or \$5,000
Implant Lifetime Maximum Benefit	\$3,000	\$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.

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.

<u>Waiting Period</u> – 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 supplies for the treatment of an Occupational Injury or Sickness which are paid under the North Carolina Workers' Compensation Act only to the extent such services or supplies are the liability of the employee, employer or workers' compensation insurance carrier according to a final adjudication under the North Carolina Workers' Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers' Compensation Act;
- (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;
- (i) 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 active participation 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, not including acts of terrorism, 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
- (xx) services related to the diagnosis and treatment of Temporomandibular Joint Dysfunction (TMD, TMJD) and related disorders.

<u>Multiple Procedure Limitations</u> — 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.

<u>Guaranteed Renewable For Life</u> – 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.

<u>Premiums Can Change</u> — 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 not change premiums during the first 12 months your policy is in force and we will give you the 45 days advance written notice required by your state prior to any such premium change.



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.

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!

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

<u>Benefits</u> – 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	IN-NETWORK	OUT-OF-NETWORK
	IN-NETWORK	OUI-OF-NEI WORK
COMPARISON SUMMARY		
	DEDUCTIBLE AMOUNT	DEDUCTIBLE AMOUNT
Class I Diagnostic & Preventive Services,	\$100.00	\$100.00
Class II – Basic Services and Class III –		
Major Services Combined		
	COINSURANCE	COINSURANCE
	PERCENTAGE PAYABLE	PERCENTAGE PAYABLE
Class I – Diagnostic & Preventive Services	100%	100%
Class II – Basic Services	50%	50%
Class III – Major Services	20% Day One, 50% After	20% Day One, 50% After
	Year One	Year One
	WAITING PERIOD	WAITING PERIOD
	TIME FRAME	TIME FRAME
Class I- Diagnostic & Preventive Services	None	None
Class II- Basic Services	None	None
Class III – Major Services	None	None
	MAXIMUM BENEFIT	MAXIMUM BENEFIT
	AMOUNT	AMOUNT
Annual Maximum Benefit per Calendar	\$1,500, \$3,000 or \$5,000	\$1,500, \$3,000 or \$5,000
Year		
Implant Lifetime Maximum Benefit	\$2,000	\$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 DNT5OC NC 1 (05-2023)

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.

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.

<u>Waiting Period</u> – 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 supplies for the treatment of an Occupational Injury or Sickness which are paid under the North Carolina Workers' Compensation Act only to the extent such services or supplies are the liability of the employee, employer or workers' compensation insurance carrier according to a final adjudication under the North Carolina Workers' Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers' Compensation Act;
- (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;
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 - 1. lost:
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 - 3. misplaced;
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- (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;
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