Underwritten by
United of Omaha Life Insurance Company
A Mutual of Omaha Company

3300 Mutual of Omaha Plaza
Omaha, Nebraska 68175

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

## MAINE



UAP1132_ME
12/13/2023

# UNITED OF OMAHA LIFE INSURANCE COMPANY

**A Mutual of Omaha Company**

**OUTLINE OF MEDICARE SUPPLEMENT COVERAGE – COVER PAGE**

**BENEFIT PLANS A, F, G, HIGH DEDUCTIBLE G AND M**

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

This chart shows the benefits included in each of the standard Medicare supplement plans. Some plans may not be available. Only applicants **first** eligible for Medicare before 2020 may purchase Plans C, F and High Deductible F.

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

| Benefits | Plans Available to All Applicants | | | | | | | | Medicare first eligible before 2020 only | |
|---|---|---|---|---|---|---|---|---|---|---|
| | **PLAN A** | PLAN B | PLAN D | **PLAN G**[1] | PLAN K | PLAN L | **PLAN M** | PLAN N | PLAN C | **PLAN F**[1] |
| Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up) | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| Medicare Part B coinsurance or Copayment | ✓ | ✓ | ✓ | ✓ | 50% | 75% | ✓ | ✓ copays apply[3] | ✓ | ✓ |
| Blood (first three pints each year) | ✓ | ✓ | ✓ | ✓ | 50% | 75% | ✓ | ✓ | ✓ | ✓ |
| Part A hospice care coinsurance or copayment | ✓ | ✓ | ✓ | ✓ | 50% | 75% | ✓ | ✓ | ✓ | ✓ |
| Skilled nursing facility coinsurance | | | ✓ | ✓ | 50% | 75% | ✓ | ✓ | ✓ | ✓ |
| Medicare Part A deductible | | ✓ | ✓ | ✓ | 50% | 75% | **50%** | ✓ | ✓ | ✓ |
| Medicare Part B deductible | | | | | | | | | ✓ | ✓ |
| Medicare Part B excess charges | | | | ✓ | | | | | | ✓ |
| Foreign travel emergency (up to plan limits) | | | ✓ | ✓ | | | ✓ | ✓ | ✓ | ✓ |
| Out-of-pocket limit in 2024[2] | | | | | $7,060[2] | $3,530[2] | | | | |

[1]Plans F and G also have a high deductible option which require first paying a plan deductible $2,800 before the plan begins to pay. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High deductible plan G does not cover the Medicare part B deductible. However, high deductible plans F and G count your payment of the Medicare Part B deductible toward meeting the plan deductible. If, in the rare circumstance the Plan G High Deductible is met with all Part A expenses, any Part B Deductible expense incurred will not count towards meeting the High Deductible nor will they be covered expenses until you meet the Medicare Part B deductible.

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

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

**MONTHLY PREMIUMS***

| | Non-Tobacco | | | | |
|---|---|---|---|---|---|
| | **Plan A** | **Plan F †** | **Plan G †** | **Plan High G†** | **Plan M†** |
| | **UM20** | **UM23** | **UM24** | **UM36** | **UM30** |
| **All Ages** | 224.67 | 301.59 | 218.78 | 54.27 | 186.48 |

**MONTHLY PREMIUMS***

| | Tobacco | | | | |
|---|---|---|---|---|---|
| | **Plan A** | **Plan F †** | **Plan G †** | **Plan High G†** | **Plan M†** |
| | **UM20** | **UM23** | **UM24** | **UM36** | **UM30** |
| **All Ages** | 258.24 | 346.66 | 251.47 | 62.38 | 214.35 |

*See PREMIUM INFORMATION regarding Household Premium Discount rating.
†The annual premium difference between Plan F and Plan G exceeds the difference in the additional benefit of $240 for the Part B deductible.

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

**Premium Information**
We, United of Omaha, can only raise your premium if we raise the premium for all the policies like yours in the same geographic area of the state where you live.

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

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

**Right to Return Policy**
If you find that you are not satisfied with your policy, you may return it to United of Omaha Life Insurance Company, 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 your payments.

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

**Notice**
The policy may not fully cover all of your medical costs. Neither United of Omaha Life Insurance Company nor its agents are connected with Medicare. This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security office or consult "Medicare & You" for more details.

**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.

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

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

| SERVICES | MEDICARE PAYS | PLAN A PAYS | YOU PAY |
|---|---|---|---|
| **HOSPITALIZATION*** | | | |
| Semiprivate room and board, general nursing, and miscellaneous services and supplies | | | |
| First 60 days | All but $1,632 | $0 | $1,632 (Part A deductible) |
| 61st 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 copayment/ coinsurance for outpatient drugs and inpatient respite care | Medicare copayment/coinsurance | $0 |
| You must meet Medicare's requirements, including a doctor's certification of terminal illness | | | |

**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 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 | $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

| | | | |
|---|---|---|---|
| **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 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 | | | |
| 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 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 F

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

**Medicare first eligible before 2020 only**

*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 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 | 80% | 20% | $0 |
| **CLINICAL LABORATORY SERVICES** – TESTS FOR DIAGNOSTIC SERVICES | 100% | $0 | $0 |

**PARTS A AND B**

| | | | |
|---|---|---|---|
| **HOME HEALTH CARE** – MEDICARE-APPROVED SERVICES<br>Medically necessary skilled care services and medical supplies | 100% | $0 | $0 |
| **DURABLE MEDICAL EQUIPMENT** | | | |
| First $240 of Medicare-approved amounts* | $0 | $240 (Part B deductible) | $0 |
| Remainder of Medicare-approved amounts | 80% | 20% | $0 |

# 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<br>Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA | | | |
| First $250 each calendar year | $0 | $0 | $250 |
| Remainder of charges | $0 | 80% to a lifetime maximum benefit of $50,000 | 20% and amounts over the $50,000 lifetime maximum benefit |

# PLAN G

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

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

| SERVICES | MEDICARE PAYS | PLAN G PAYS | YOU PAY |
|---|---|---|---|
| **HOSPITALIZATION*** | | | |
| Semiprivate room and board, general nursing and miscellaneous services and supplies | | | |
| First 60 days | All but $1,632 | $1,632 (Part A deductible) | $0 |
| 61st 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 | $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 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.

| 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 | $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

| | | | |
|---|---|---|---|
| **HOME HEALTH CARE** – MEDICARE-APPROVED SERVICES<br>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

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

# 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 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.

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

## PARTS A AND B

| | | | |
|---|---|---|---|
| **HOME HEALTH CARE** – MEDICARE-APPROVED SERVICES<br>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

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

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

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

| SERVICES | MEDICARE PAYS | PLAN M PAYS | YOU PAY |
|---|---|---|---|
| **HOSPITALIZATION*** | | | |
| Semiprivate room and board, general nursing, and miscellaneous services and supplies | | | |
| First 60 days | All but $1,632 | $816 (50% Part A deductible) | $816 (50% 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 | 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 M
## 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 M 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 | $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 |

# PLAN M

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

### PARTS A AND B

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

### OTHER BENEFITS – NOT COVERED BY MEDICARE

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

## Maine

## Producer Information – Please Complete

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

**Preferred Method of Communication (Select one)**

☐ Phone ☐ Fax ☐ Email Contact info: _____

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

## Application Submission Checklist – United of Omaha Medicare Supplement Coverage

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

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

☐ **Complete the Calculate Your Premium form to determine rate**

☐ **Application (complete in full)**

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

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

**Section D: Household Premium Discount Information**
- Indicate if eligible for a Household Premium Discount

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

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

**Section F: Please answer all of the following questions**
- If either Applicant A or B answered "YES" to question 7 OR BOTH questions 8 and 9 in Section F, they can skip to Section I

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

**Section I: Agreement and Authorization**
- Make sure applicant(s) sign and date the application

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

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

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

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

**Note: An interviewer may call to verify/confirm the information provided on the application.**
**This form is required if splitting commissions.**



UAP1143_ME_0120

# Open Enrollment and Guaranteed Issue Worksheet

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

**ELIGIBILITY FOR OPEN ENROLLMENT**

**Applicant is:**

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

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

**ELIGIBILITY FOR GUARANTEED ISSUE**

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

**Applicant:**

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

*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 state-specific variation of a Medicaid plan

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

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

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

M27788_0819

Mutual of Omaha

Underwritten by
United of Omaha Life Insurance Company
A Mutual of Omaha Company

3300 Mutual of Omaha Plaza
Omaha, Nebraska 68175

# 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<br>Rate displayed is used for calculation purposes only. | Applicant A | Applicant B |
|---|---|---|---|---|
| #1 | **Age**<br>Write in your age at the time of signing the application.<br>**ZIP Code**<br>Indicate your ZIP Code used to determine your rate. | 65<br><br>51502 | | |
| #2 | **Premium**<br>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**<br>Please refer to the application for state specific household discount premium rules.<br><br>**If the rules apply**, multiply the amount from Step #2 by .93.<br>**If the rules do not apply**, enter the amount from Step #2. | $128.52 x .93 = $119.52<br><br>In this example, the person qualifies for the household premium discount. | | |
| #4 | **Rate Adjustment**<br>If you're in your open enrollment or guaranteed issue period, skip to Step #5.<br>Locate your height, then weight on the next page.<br>• If your weight is in the Standard column, enter the amount from Step #3<br>• If your weight is in the Class I or II column, multiply the amount from Step #3 by:<br>1.10 if in Class I column<br>1.20 if in Class II column | $119.52 x 1.20 = $143.42<br><br>Person's weight is in the Class II column. | | |
| #5 | **Payment Options**<br>Your monthly payment is your last premium entered (Step #3 or #4).<br>To determine other payment schedules, multiply your monthly premium by:<br>3 to pay 4 times a year (quarterly)<br>6 to pay twice a year (semiannually)<br>12 to pay once a year (annually) | $143.42 monthly payment<br>$430.26 quarterly payment<br>$860.52 semiannual payment<br>$1,721.04 annual payment | | |



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# Height and Weight Chart

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

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

| | Decline | Standard | Decline |
|---|---|---|---|
| Height | Weight | Weight | Weight |
| 4' 2'' | ‹ 54 | 55 – 145 | 146 + |
| 4' 3'' | ‹ 56 | 57 – 151 | 152 + |
| 4' 4'' | ‹ 58 | 59 – 157 | 158 + |
| 4' 5'' | ‹ 60 | 61 – 163 | 164 + |
| 4' 6'' | ‹ 63 | 64 – 170 | 171 + |
| 4' 7'' | ‹ 65 | 66 – 176 | 177 + |
| 4' 8'' | ‹ 67 | 68 – 182 | 183 + |
| 4' 9'' | ‹ 70 | 71 – 189 | 190 + |
| 4' 10'' | ‹ 72 | 73 – 196 | 197 + |
| 4' 11'' | ‹ 75 | 76 – 202 | 203 + |
| 5' 0'' | ‹ 77 | 78 – 209 | 210 + |
| 5' 1'' | ‹ 80 | 81 – 216 | 217 + |
| 5' 2'' | ‹ 83 | 84 – 224 | 225 + |
| 5' 3'' | ‹ 85 | 86 – 231 | 232 + |
| 5' 4'' | ‹ 88 | 89 – 238 | 239 + |
| 5' 5'' | ‹ 91 | 92 – 246 | 247 + |
| 5' 6'' | ‹ 93 | 94 – 254 | 255 + |
| 5' 7'' | ‹ 96 | 97 – 261 | 262 + |
| 5' 8'' | ‹ 99 | 100 – 269 | 270 + |
| 5' 9'' | ‹ 102 | 103 – 277 | 278 + |
| 5' 10'' | ‹ 105 | 106 – 285 | 286 + |
| 5' 11'' | ‹ 108 | 109 – 293 | 294 + |
| 6' 0'' | ‹ 111 | 112 – 302 | 303 + |
| 6' 1'' | ‹ 114 | 115 – 310 | 311 + |
| 6' 2'' | ‹ 117 | 118 – 319 | 320 + |
| 6' 3'' | ‹ 121 | 122 – 328 | 329 + |
| 6' 4'' | ‹ 124 | 125 – 336 | 337 + |
| 6' 5'' | ‹ 127 | 128 – 345 | 346 + |
| 6' 6'' | ‹ 130 | 131 – 354 | 355 + |
| 6' 7'' | ‹ 134 | 135 – 363 | 364 + |
| 6' 8'' | ‹ 137 | 138 – 373 | 374 + |
| 6' 9'' | ‹ 140 | 141 – 382 | 383 + |
| 6' 10'' | ‹ 144 | 145 – 392 | 393 + |
| 6' 11'' | ‹ 147 | 148 – 401 | 402 + |
| 7' 0'' | ‹ 151 | 152 – 411 | 412 + |
| 7' 1'' | ‹ 155 | 156 – 421 | 422 + |
| 7' 2'' | ‹ 158 | 159 – 431 | 432 + |
| 7' 3'' | ‹ 162 | 163 – 441 | 442 + |
| 7' 4'' | ‹ 166 | 167 – 451 | 452 + |



U8422_0619

Agent Writing # _____ DNIS _____ Auth # _____

Group # (if applicable) _____ Keyline _____

MUTUAL of OMAHA

Underwritten by
United of Omaha Life Insurance Company
A Mutual of Omaha Company

3300 Mutual of Omaha Plaza
Omaha, Nebraska 68175

# Application for Medicare Supplement Coverage

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

## A. Plan Information (to be completed by Producer)

| Applicant A | Applicant B |
|---|---|
| **Plan (select one):** ☐ Plan A ☐ Plan G ☐ Plan G - High Deductible ☐ Plan M<br>**OR**<br>If your Medicare Part A eligibility date is before 01/01/2020, these **additional** plans are available options:<br>☐ Plan F | **Plan (select one):** ☐ Plan A ☐ Plan G ☐ Plan G - High Deductible ☐ Plan M<br>**OR**<br>If your Medicare Part A eligibility date is before 01/01/2020, these **additional** plans are available options:<br>☐ Plan F |
| **Requested Effective Date** ___ / ___ / _____ | **Requested Effective Date** ___ / ___ / _____ |
| **Deliver Policy to**<br>Applicant A ☐ Producer ☐ | **Deliver Policy to**<br>Applicant B ☐ Producer ☐ |

## B. Applicant Information

| Applicant A | Applicant B |
|---|---|
| Name (First/Middle Initial/Last) | Name (First/Middle Initial/Last) |
| Residence Address | Residence Address (if different from Applicant A's) |
| City | City |
| State ZIP | State ZIP |
| Mailing Address (if different from residence address) | Mailing Address (if different from residence address) |
| City | City |
| State ZIP _____ | State ZIP _____ |
| Home Phone ___ – ___ – _____ (area code) | Home Phone ___ – ___ – _____ (area code) |
| E-mail Address | E-mail Address |
| Current Age _____<br>Date of Birth ___ / ___ / _____ mo day yr | Current Age _____<br>Date of Birth ___ / ___ / _____ mo day yr |
| ☐ Male ☐ Female | ☐ Male ☐ Female |
| Social Security # ___ – ___ – _____ | Social Security # ___ – ___ – _____ |

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# B. Applicant Information

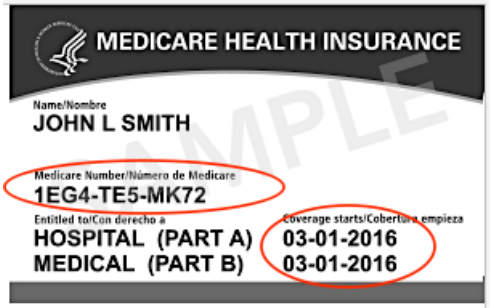
| Applicant A | Applicant B |
|---|---|
| Height Ft ___ In ___ Weight Lbs ___ | Height Ft ___ In ___ Weight Lbs ___ |
| Have you used tobacco in any form in the past 12 months? ☐ Y ☐ N | Have you used tobacco in any form in the past 12 months? ☐ Y ☐ N |

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

| | |
|---|---|
| Receive statement online? ☐ Y ☐ N | Receive statement online? ☐ Y ☐ N |

# C. Medicare Information

**Please reference your Medicare card to complete this section.**




| Applicant A | Applicant B |
|---|---|
| Medicare Number | Medicare Number |
| Medicare Part A Effective Date ___/___/_____ If you are not covered under Medicare Part A, what is your eligibility date ___/___/_____ | Medicare Part A Effective Date ___/___/_____ If you are not covered under Medicare Part A, what is your eligibility date ___/___/_____ |
| Medicare Part B Effective Date ___/___/_____ If you are not covered under Medicare Part B, indicate the date you plan to enroll ___/___/_____ | Medicare Part B Effective Date ___/___/_____ If you are not covered under Medicare Part B, indicate the date you plan to enroll ___/___/_____ |

# D. Household Premium Discount Information

| **You may be eligible for a policy with a lower premium rate based on your answers to the statements in this section.** | **Applicant A** | **Applicant B** |
|---|---|---|
| 1. Does a member of your household:<br>(a) with whom you have continuously resided for the last 12 months; or<br>(b) with whom you reside and to whom you are either married or in a civil union partnership;<br>either have an existing Medicare supplement plan with, or are applying for coverage with Omaha Insurance Company, United of Omaha Life Insurance Company, United World Life Insurance Company or Mutual of Omaha Insurance Company?..... | ☐ Y ☐ N | ☐ Y ☐ N |

2. If you answered "YES" to Question 1 above, please fill out the following information, except if both applicants are both applying for coverage on this application.

| |
|---|
| Name (First/Middle/Last) |
| Policy Number |
| Street Address |
| City/State/ZIP |

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# E. Previous or Existing Coverage Information

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy or certificate, or that you had certain rights to buy such a policy or certificate, you may be guaranteed acceptance in one or more of our Medicare supplement plans. **Please include a copy of the notice from your prior insurer with your application.** PLEASE ANSWER ALL QUESTIONS. Please mark "YES" or "NO" with an "X" to the questions below.

| To the Best of Your Knowledge and Belief: | Applicant A | Applicant B |
|---|---|---|
| 3. Are you covered for medical assistance through the state Medicaid program?..... (NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer "NO" to this question.) | ☐ Y ☐ N | ☐ Y ☐ N |
| **If "YES," answer the following about this existing coverage:** | | |
| (a) Will Medicaid pay your premiums for this Medicare supplement policy?..... | ☐ Y ☐ N | ☐ Y ☐ N |
| (b) Do you receive any medical benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium? If yes, please describe..... | ☐ Y ☐ N | ☐ Y ☐ N |

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

| | | |
|---|---|---|
| 4. Do you have another Medicare supplement or Medicare Select insurance policy or certificate in force?..... | ☐ Y ☐ N | ☐ Y ☐ N |
| **If "YES," answer the following about this existing coverage:** | | |
| (a) Do you intend to replace your current Medicare supplement policy/certificate with this policy?..... | ☐ Y ☐ N | ☐ Y ☐ N |

(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 |
| Effective Date | Effective Date |

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

| | Applicant A | Applicant B |
|---|---|---|
| 5. Have you had coverage from any Medicare plan other than Medicare Part A or B within the past 90 days? (for example, a Medicare Advantage plan, or a Medicare HMO or PPO)..... | ☐ Y ☐ N | ☐ Y ☐ N |
| **If "YES," answer the following about this previous or existing coverage:** | | |

(a) Fill in your start and end dates below. If you are still covered under this plan, leave "END" blank..... Applicant A START ☐☐/☐☐/☐☐☐☐

END ☐☐/☐☐/☐☐☐☐

Applicant B START ☐☐/☐☐/☐☐☐☐

END ☐☐/☐☐/☐☐☐☐

| | | |
|---|---|---|
| (b) If you have been covered by more than one Medicare plan of this type, have you been covered continuously by these plans, with no break in coverage and no period of original Medicare (Part A or B) between the first plan and your current plan? ..... | ☐ Y ☐ N | ☐ Y ☐ N |
| (c) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy?..... | ☐ Y ☐ N | ☐ Y ☐ N |

(d) Planned date of termination/disenrollment?..... Applicant A ☐☐/☐☐/☐☐☐☐

Applicant B ☐☐/☐☐/☐☐☐☐

| | | |
|---|---|---|
| (e) Was this your first time in this type of Medicare plan?..... | ☐ Y ☐ N | ☐ Y ☐ N |
| (f) Did you drop a Medicare supplement or Medicare Select policy/certificate to enroll in this Medicare plan?..... | ☐ Y ☐ N | ☐ Y ☐ N |
| (g) Did you drop a union group or employer health plan to enroll in this Medicare plan? .... | ☐ Y ☐ N | ☐ Y ☐ N |

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(h) Please indicate reason for termination/disenrollment:

| | Check box(s) below if applicable | |
|---|---|---|
| | **Applicant A** | **Applicant B** |
| ■ Your Medicare Advantage plan is leaving the Medicare program..... | ☐ | ☐ |
| ■ Your Medicare Advantage organization stopped offering Medicare Advantage plans..... | ☐ | ☐ |
| ■ Your Medicare Advantage organization stopped offering coverage in the area in which you live..... | ☐ | ☐ |
| ■ You moved out of the geographic service area of your Medicare Advantage plan..... | ☐ | ☐ |
| ■ You had a Medicare Advantage plan with Medicare Part D benefits and are enrolling in a stand-alone Medicare Part D plan..... | ☐ | ☐ |

■ Other: _____
Applicant A

_____
Applicant B

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

| | **Applicant A** | **Applicant B** |
|---|---|---|
| 6. Have you had coverage under any other health insurance within the past 90 days?..... (For example, an employer group health plan, union plan, or individual non-Medicare supplement plan.) | ☐ Y ☐ N | ☐ Y ☐ N |

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

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

END ☐☐/☐☐/☐☐☐☐

Applicant B START ☐☐/☐☐/☐☐☐☐

END ☐☐/☐☐/☐☐☐☐

(b) Planned date of termination/disenrollment?..... Applicant A ☐☐/☐☐/☐☐☐☐

Applicant B ☐☐/☐☐/☐☐☐☐

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

(d) Please state the reason for your disenrollment:

_____
Applicant A

_____
Applicant B

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

| **Applicant A** | **Applicant B** |
|---|---|
| Name of Company | Name of Company |
| Policy/Certificate type | Policy/Certificate type |

# F. Please answer all of the following questions:

To the Best of Your Knowledge and Belief:

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

**If "YES," indicate your Medicare Part B effective date.....** Applicant A ☐☐/☐☐/☐☐☐☐

Applicant B ☐☐/☐☐/☐☐☐☐


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

## 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 10-21.**

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

| To the Best of Your Knowledge and Belief: | Applicant A | Applicant B |
|---|---|---|
| 10. Are you currently confined to a wheelchair or any motorized mobility device? | ☐ Y ☐ N | ☐ Y ☐ N |
| 11. Are you currently hospitalized, confined to a bed, in a nursing home or assisted living facility? | ☐ Y ☐ N | ☐ Y ☐ N |
| 12. Are you currently receiving any occupational, speech or physical therapy? | ☐ Y ☐ N | ☐ Y ☐ N |
| 13. Have you been advised by a medical professional to have treatment **(except for HIV)**, further diagnostic evaluation, diagnostic testing, follow up visits or any surgery that has not been performed? | ☐ Y ☐ N | ☐ Y ☐ N |
| 14. At any time have you been medically diagnosed with, treated for, or had surgery for any of the following: | | |
| A. Chronic kidney disease, kidney failure, or kidney disease requiring dialysis? | ☐ Y ☐ N | ☐ Y ☐ N |
| B. Emphysema, Chronic Obstructive Pulmonary Disease (COPD), any other chronic pulmonary disorder or any cardio-pulmonary disorder requiring oxygen? | ☐ Y ☐ N | ☐ Y ☐ N |
| C. Alzheimer's Disease, dementia or any other cognitive disorder? | ☐ Y ☐ N | ☐ Y ☐ N |
| D. Parkinson's Disease, multiple sclerosis or amyotrophic lateral sclerosis (Lou Gehrig's Disease)? | ☐ Y ☐ N | ☐ Y ☐ N |
| E. Systemic Lupus, scleroderma or myasthenia gravis? | ☐ Y ☐ N | ☐ Y ☐ N |
| F. An organ transplant or been advised to have an organ transplant (excluding cornea transplants)? | ☐ Y ☐ N | ☐ Y ☐ N |
| G. Chronic hepatitis or cirrhosis? | ☐ Y ☐ N | ☐ Y ☐ N |
| H. Osteoporosis with fractures? | ☐ Y ☐ N | ☐ Y ☐ N |
| 15. Have you been diagnosed with or treated for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) withing the past two years? (Answer this question "N" if you are HIV positive and have not developed symptoms of the disease AIDS) | ☐ Y ☐ N | ☐ Y ☐ N |
| 16. Do you have diabetes in addition to any of the following: retinopathy, neuropathy, peripheral artery disease, peripheral venous thrombotic disease, any heart disorder (including hypertension/high blood pressure), stroke, transient ischemic attach (TIA) or kidney disease? | ☐ Y ☐ N | ☐ Y ☐ N |
| 17. Do you have an implanted cardiac defibrillator? | ☐ Y ☐ N | ☐ Y ☐ N |
| 18. Within the past two years, have you been treated for, or been advised by a physician to have treatment for: | | |
| A. Coronary artery disease, angina, heart attack, cardiac angioplasty, bypass surgery or stent placement? | ☐ Y ☐ N | ☐ Y ☐ N |
| B. Cardiomyopathy, congestive heart failure, aortic or cardiac aneurysm, peripheral artery disease, peripheral venous thrombotic disease, vascular angioplasty, endarterectomy, carotid artery disease, any heart or heart valve disorder, atrial fibrillation, other heart rhythm disorder, or implantation of a pacemaker? | ☐ Y ☐ N | ☐ Y ☐ N |
| C. Alcoholism or drug abuse? | ☐ Y ☐ N | ☐ Y ☐ N |
| D. Any mental or nervous disorder requiring treatment (including hospital confinement) by a psychiatrist, psychologist, counselor or therapist? | ☐ Y ☐ N | ☐ Y ☐ N |
| E. Internal cancer, lymphoma or melanoma? | ☐ Y ☐ N | ☐ Y ☐ N |
| F. A stroke or transient ischemic attack (TIA)? | ☐ Y ☐ N | ☐ Y ☐ N |
| G. Degenerative bone disease, spinal stenosis, rheumatoid arthritis, psoriatic arthritis, arthritis that restricts mobility or have you been advised to have a joint replacement? | ☐ Y ☐ N | ☐ Y ☐ N |
| 19. Have you been advised by a medical professional that surgery may be required within the next 12 months for cataracts? | ☐ Y ☐ N | ☐ Y ☐ N |
| 20. Have you been hospital confined three or more times in the past two years for a same or similar condition? | ☐ Y ☐ N | ☐ Y ☐ N |
| 21. Have you taken any over-the-counter or prescription drugs in the past 24 months? | ☐ Y ☐ N | ☐ Y ☐ N |

# H. Medication Information

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

## Applicant A

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

## Applicant B

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

UA5978-17REV

# I. Agreement and Authorization

**IMPORTANT STATEMENTS**

- You do not need more than one Medicare supplement policy.
- If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverage.
- You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.
- If, after purchasing the policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be 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).

UA5978-17REV

# I. Agreement and Authorization (cont.)

**AUTHORIZATION TO DISCLOSE PERSONAL INFORMATION TO United of Omaha Life INSURANCE COMPANY**

- I authorize any physician, medical or dental practitioners, hospitals, clinics, pharmacies, pharmacy benefit managers, other medical care facilities, health maintenance organizations and all other providers of medical or dental services, the group of companies which presently includes Mutual of Omaha Insurance Company, United of Omaha Life Insurance Company, United World Life Insurance Company, Companion Life Insurance Company, and any additional companies which may become part of this group of companies and their successors, along with other persons and entities which act on behalf of those companies to provide services to them, employers, consumer reporting agencies, and other insurance companies to disclose Personal Information about me to United of Omaha. This authorization excludes the disclosure of the result of a test for HIV if the applicant has tested HIV positive but has not developed symptoms of the disease AIDS. Such test results shall not be discovered or published. Nothing in this caveat will prohibit this authorization from including the fact that the applicant has AIDS. Unless revoked earlier, this authorization will remain in effect for 24 months from the date I sign this application. I understand that I may revoke this authorization at any time, by written notice to: ATTN: Individual Underwriting, United of Omaha Life Insurance Company, P.O. Box 3608, Omaha, NE 68103-3608. I realize that my right to revoke this authorization is limited to the extent that United of Omaha has taken action in reliance on the authorization. You may revoke this authorization at any time. Revocation may be a basis for denying insurance benefits.
- "Personal Information" means all health information, such as medical history, mental and physical condition, prescription drug records, drug and alcohol use and other information such as finances, occupation, general reputation and insurance claims information about me. Personal Information does not include Psychotherapy Notes, which are notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a counseling session, which notes are separated from the rest of the person's medical record. Certain information, such as that relating to prescriptions, diagnosis and functional status, is not included in the term Psychotherapy Notes.
- The Personal Information will be used to determine my eligibility for insurance and to resolve or contest any issues of incomplete, incorrect or misrepresented information on my application which may arise during the processing of my application or in connection with claims for insurance benefits. This authorization will not be used if the applicant is in an open enrollment or guaranteed issue period.
- If the person or entity to whom Personal Information is disclosed is not a health care provider or health plan subject to federal privacy regulations, the Personal Information may then be subject to further disclosure by that person or entity without the protections of the federal privacy regulations.
- I understand that I may refuse to sign this application. I realize that if I refuse to sign, the insurance for which I am applying will not be issued. Failure to sign this application may impair the ability of United of Omaha to evaluate or process the application or claim and may be a basis for denying the application or claims for benefits.
- I understand that I will receive a copy of the signed application. A copy of this application is as effective as the original. I acknowledge and agree that if there is more than one applicant on this application, all information provided may be reviewed or shared with the other applicant. I understand that, upon acceptance of the completed application, each applicant will receive a separate policy and a completed and signed application will become part of each applicant's policy.

  I represent that my answers and statements on this application are true and complete and that all statements and descriptions are deemed to be representations and not warranties.I understand that my policy benefits can start no earlier than my Medicare effective date, my first month's premium has been received and/or processed and my application has been approved by United of Omaha Life Insurance Company.

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

**Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits a false or deceptive statement is guilty of insurance fraud.**

✍ Dated at _____, on ___/___/_____ _____
City State Month Day Year Applicant A's Signature

✍ Dated at _____, on ___/___/_____ _____
City State Month Day Year Applicant B's Signature (if applying)

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## 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 provided a copy of the replacement notice if the applicant is replacing coverage..... ☐ Y ☐ N

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

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

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

_____

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

✍ _____ _____
Signature of Licensed Producer Date

_____
Printed Name

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | | | | |

Agent Writing Number

✍ _____ _____
Signature of Licensed Producer Date

_____
Printed Name

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | | | | |

Agent Writing Number

UA5978-17REV

# METHOD OF PAYMENT FORM

**REQUIRED FORM – PLEASE RETURN PAGES 1 & 2**

## Part I . Select Premium Payment Option

| | Applicant A | Applicant B |
|---|---|---|
| **Initial Premium Payment (Select option #1 or #2)** | | |
| ✍ **Initial premium amount** (based on age at application date)..... | $ _____.__ | $ _____.__ |
| 1. Paper Check (submit signed check with application)..... | ☐ | ☐ |
| (California collect only one month's premium at time of application) | | |
| 2. Automatic Bank Account Withdrawal..... | ☐ | ☐ |
| **Ongoing Premium Payments (Select option #1a, #1b, or #2)** | | |
| 1. I want my payments automatically withdrawn from my bank | | |
| a. Choose the day payments will be deducted every month from your bank account..... | 1st through the 28th or the last day of every month | 1st through the 28th or the last day of every month |
| OR | | |
| b. Choose the week and weekday that payments will be deducted every month from your bank account..... (For Example: 3rd Wednesday of every month) | **Week (1st, 2nd, 3rd, 4th, last)** _____ **Weekday (Mon, Tue, Wed, Thu, Fri)** _____ | **Week (1st, 2nd, 3rd, 4th, last)** _____ **Weekday (Mon, Tue, Wed, Thu, Fri)** _____ |
| 2. I will mail my premium to the company every 3, 6, or 12 months. (Monthly billing is not allowed. Select frequency of billing)..... | **every_____months** Insert 3, 6, or 12 | **every_____months** Insert 3, 6, or 12 |

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

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

## Part II. Payor Information

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

U8421_1219

## Part III. Account Information

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

**Can attach voided check here**

**Applicant A**
Account Type (check one): ☐ Checking ☐ Savings

Name of Financial Institution

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

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

Name as Shown on Account

**Applicant B** ☐ Same account as Applicant A
Account Type (check one): ☐ Checking ☐ Savings

Name of Financial Institution

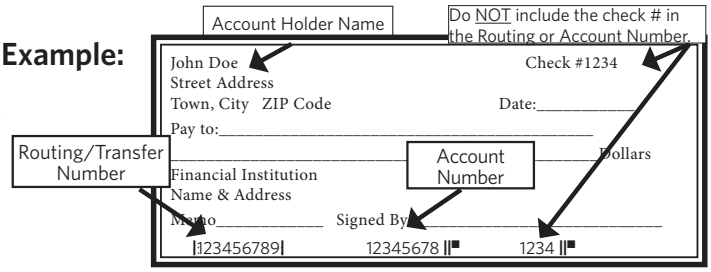
Routing Number (9 digits on lower left side of check)

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

Name as Shown on Account

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

**Example:**




I authorize United of Omaha Life Insurance Company ("United of Omaha") 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 United 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, United of Omaha may require written confirmation from me within 14 days after my verbal notice.

**Applicant A**

✍ _____
Authorized Signature as Shown on Account

_____
Date

**Applicant B**

✍ _____
Authorized Signature as Shown on Account

_____
Date

U8421_1219

# United of Omaha Life Insurance Company

A Mutual *of* Omaha Company

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

**Save this notice! It may be important to you in the future.**

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

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 or certificate.

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

**Statement to Applicant by Issuer, Agent, Broker or Other Representative:**

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

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

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

✍ _____ _____

**Signature of Agent, Broker or Other Representative*** **Date**

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

| **Applicant** | **Applicant B** |
|---|---|
| Signature ✍ | Signature ✍ |
| Date | Date |

*Signature not required for direct response sales.



U7563_ME

# 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**

# United of Omaha Life Insurance Company

A Mutual *of* Omaha Company

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

**Save this notice! It may be important to you in the future.**

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

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 or certificate.

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

**Statement to Applicant by Issuer, Agent, Broker or Other Representative:**

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

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

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

✍ _____ _____

**Signature of Agent, Broker or Other Representative*** **Date**

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

| **Applicant** | **Applicant B** |
|---|---|
| Signature ✍ | Signature ✍ |
| Date | Date |

*Signature not required for direct response sales.



U7563_ME

Mutual of Omaha

Underwritten by
United of Omaha Life Insurance Company
A Mutual of Omaha Company

3300 Mutual of Omaha Plaza
Omaha, Nebraska 68175

## Premium Receipt

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

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

**Applicant A**

Received from _____

this _____ day of _____ , _____

an application for Form_____Policy

and/or Riders _____and

Check for _____Dollars.

✍ Agent _____

**Applicant B**

Received from _____

this _____ day of _____ , _____

an application for Form_____Policy

and/or Riders _____and

Check for _____Dollars.

✍ Agent _____

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

## Notice of Information Practices

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

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

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

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

**THE ABOVE IS A GENERAL DESCRIPTION OF OUR INFORMATION PRACTICES. IF YOU WOULD LIKE TO RECEIVE A MORE DETAILED EXPLANATION OF THESE PRACTICES, PLEASE SEND YOUR REQUEST TO: UNITED OF OMAHA LIFE INSURANCE COMPANY, DIRECTOR OF INDIVIDUAL UNDERWRITING, 3300 MUTUAL OF OMAHA PLAZA, OMAHA, NE 68175.**

U8423_0619

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

Mutual of Omaha

Underwritten by
Mutual of Omaha Insurance Company

3300 Mutual of Omaha Plaza
Omaha, Nebraska 68175

## APPLICATION for

# INDIVIDUAL DENTAL INSURANCE WITH OPTIONAL VISION RIDER

## MAINE

MAP642_ME
10/04/2023

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

Monthly Rates (Issue Age 19-99)

| MAINE | | | | | | | |
|---|---|---|---|---|---|---|---|
| **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 | |
| 042-049 | $54.04 | $61.88 | $64.59 | $29.62 | $30.46 | $31.02 | $8.28 |
| 039-041 | $58.28 | $66.74 | $69.65 | $31.94 | $32.85 | $33.45 | $8.28 |

Rates Subject to Change.

*As of 10/05/2023*

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

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

Internal Tracking Code _____
Group # (if applicable) _____

Mutual of Omaha

Underwritten by
Mutual of Omaha Insurance Company

3300 Mutual of Omaha Plaza
Omaha, Nebraska 68175

## Application for Individual Dental Insurance with Optional Vision Rider

# A. Applicant Information

| Name (First, Middle Initial, Last) | Phone Number<br>Home Cell |
|---|---|
| Residence Address (Street, City, State, ZIP) | E-mail |
| Mailing Address (Street, City, State, ZIP) (if different from residence address) | Deliver Policy to<br>☐ Applicant ☐ Producer |

| Gender<br>☐ Male ☐ Female | Date of Birth | Social Security Number |
|---|---|---|

# B. Plan Information

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

# C. Existing Coverage Information

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

**If Yes, answer the following about this existing coverage:**

Name of dental carrier(s) _____

Name of vision carrier(s) _____

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

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

# D. Agreements

I represent the information above is true and complete to the best of my knowledge and belief. All statements and descriptions in this application for insurance are deemed to be representations and not warranties. Any incorrect or misleading answers may void this application and any issued policy. I understand that no insurance shall take effect until a policy is issued and the first premium is received by Mutual of Omaha during my lifetime.

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

✍ _____ _____
Applicant Signature Date Signed at City State

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

✍ _____
Signature of Licensed Insurance Producer Date

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

✍ _____
Signature of Licensed Insurance Producer Date

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

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# METHOD OF PAYMENT FORM

**REQUIRED FORM – PLEASE RETURN 1 & 2**

## Part I . Select Premium Payment Option

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

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

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

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

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

   **OR**

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

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

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

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

## Part II. Payor Information

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

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

## Part III. Muti-Policy Discount

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

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

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# Part IV. Account Information

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

**Can attach voided check here**

**Applicant A**

Account Type (check one): ☐ Checking ☐ Savings

Name of Financial Institution

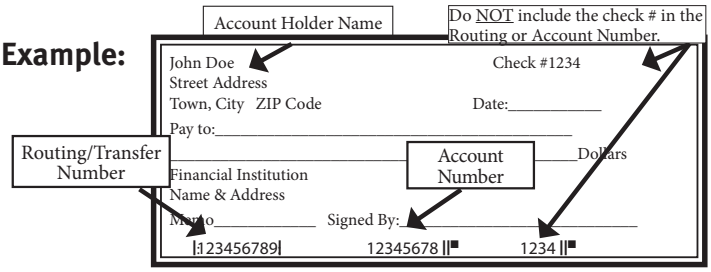
Routing Number (9 digits on lower left side of check)

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

Name as Shown on Account

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

**Example:**




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

**Applicant A**

Authorized Signature as Shown on Account

Date



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## 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.**

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**GIVE THIS NOTICE TO THE APPLICANT**

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

# OUTLINE OF COVERAGE FOR POLICY SERIES DNT2

## INDIVIDUAL DENTAL PREFERRED PROVIDER ORGANIZATION (PPO) INSURANCE

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

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

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

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

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

**DENTAL BENEFITS SUMMARY**

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

You may obtain dental care for covered dental services from any licensed dentist. No matter which dentist you choose, you will be eligible for some level of benefits for covered dental services. However, when you use an in-network dentist who participates in the PPO network, that dentist has agreed to provide dental care at negotiated fees. For in-network dentists, you will not be responsible for the difference between your dentist's submitted amount and the scheduled fee amount that the dentist has contractually agreed to accept as payment in full. The PPO network used by this policy is DenteMax Plus.

If you select a dentist who does not participate in the PPO network, your out-of-pocket expenses may be greater. For out-of-network dentists, you will be responsible for the difference between your dentist's submitted amount and our payment. The amount we use to

calculate our payment will be the lesser of the dentist's submitted amount or the 80th percentile amount for covered dental services as identified by the Dental Charges Database.

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

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

(a) first installation of a denture or fixed bridge, and any inlay and crown that serves as an abutment to replace congenitally missing teeth or to replace teeth all of which were lost while the person was not covered;
(b) services or treatment not prescribed by or under the direct supervision of a dentist;
(c) services or treatment which is experimental or investigational;
(d) services or treatment which is for any illness or bodily injury which occurs in the course of employment if a benefit or compensation is available, in whole or in part, under the provision of any law or regulation or any government unit. This exclusion applies whether or not you claim the benefits or compensation;
(e) services or treatment received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, Veterans Administration hospital or similar person or group;
(f) services or treatment performed prior to the policy effective date;
(g) services or treatment incurred after the termination date of your coverage unless otherwise indicated;
(h) services or treatment which is not dentally necessary or which does not meet generally accepted standards of dental practice;
(i) services or treatment resulting from your failure to comply with professionally prescribed treatment;
(j) telephone consultations;
(k) any charges for failure to keep a scheduled appointment;
(l) any services that are considered strictly cosmetic in nature including, but not limited to, charges for personalization or characterization of prosthetic appliances;
(m) fluoride treatments;
(n) services or treatment provided as a result of intentionally self-inflicted injury or illness;
(o) services or treatment provided as a result of injuries suffered while committing or attempting to commit a felony, engaging in an illegal occupation, or participating in a riot, rebellion or insurrection;
(p) office infection control charges;
(q) charges for copies of your records, charts or x-rays, or any costs associated with forwarding/mailing copies of your records, charts or x-rays;
(r) state, federal, or territorial taxes on dental services performed;
(s) those charges submitted by a dentist, which are for the same services performed on the same date by another dentist;
(t) those dental services provided free of charge by any governmental unit, except where this exclusion is prohibited by law;
(u) those dental services for which you would have no obligation to pay in the absence of this or any similar insurance;
(v) those dental services which are for specialized procedures and techniques;
(w) those dental services performed by a dentist who is compensated by a facility for similar covered services performed for you on the same date;
(x) duplicate, provisional and temporary devices, appliances, and services;
(y) plaque control programs, oral hygiene instruction, and dietary instructions;
(z) services to alter vertical dimension and/or restore or maintain the occlusion. Such procedures include, but are not limited to:
    1. equilibration;
    2. periodontal splinting;
    3. full mouth rehabilitation and;
    4. restoration for misalignment of teeth;
(aa) gold foil restorations;
(bb) services or treatment for injuries resulting from war or act of war, whether declared or undeclared, or from police or military service for any country or organization;
(cc) hospital costs or any additional fees that the dentist or hospital charges for treatment at the hospital (inpatient or outpatient);
(dd) charges by the provider for completing dental forms;
(ee) adjustment of a denture or bridgework which is made within 6 months after installation by the same dentist who installed it;
(ff) use of material or home health aids to prevent decay, such as:
    1. toothpaste;
    2. fluoride gels;
    3. dental floss and;

4. teeth whiteners;

(gg) sealants;
(hh) precision attachments, personalization, precious metal bases and other specialized techniques;
(ii) replacement of dentures that have been:
1. lost;
2. stolen or;
3. misplaced;
(jj) repair of damaged orthodontic appliances;
(kk) replacement of lost or missing appliances;
(ll) fabrication of athletic mouth guard;
(mm) internal bleaching;
(nn) nitrous oxide;
(oo) oral sedation;
(pp) topical medicament carrier;
(qq) orthodontic services, treatment or supplies, including braces and retainers;
(rr) bone grafts when done in connection with:
1. extractions;
2. apicoectomies or;
3. non-covered/non-eligible implants;
(ss) tooth whitening;
(tt) occlusal guards;
(uu) space maintainers;
(vv) services or treatment provided by a member of your immediate family;
(ww) services or treatment received outside of the United States, its possessions or territories, Canada, or Mexico; or
(xx) services related to the diagnosis and treatment of Temporomandibular Joint Dysfunction (TMD, TMJD) and related disorders.

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

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

**Premiums Can Change** – We will not increase your policy's premium due to any change in your health. However, we can change premiums if we make the same change to all policies of this form issued to persons of the same class. We will give you at least 60 days advance written notice required by your state prior to any such premium change.

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

# OUTLINE OF COVERAGE FOR POLICY SERIES DNT5

## INDIVIDUAL DENTAL PREFERRED PROVIDER ORGANIZATION (PPO) INSURANCE

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

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

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

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

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

**DENTAL BENEFITS SUMMARY**

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

You may obtain dental care for covered dental services from any licensed dentist. No matter which dentist you choose, you will be eligible for some level of benefits for covered dental services. However, when you use an in-network dentist who participates in the PPO network, that dentist has agreed to provide dental care at negotiated fees. For in-network dentists, you will not be responsible for the difference between your dentist's submitted amount and the scheduled fee amount that the dentist has contractually agreed to accept as payment in full. The PPO network used by this policy is DenteMax Plus.

If you select a dentist who does not participate in the PPO network, your out-of-pocket expenses may be greater. For out-of-network dentists, you will be responsible for the difference between your dentist's submitted amount and our payment. The amount we use to

calculate our payment will be the lesser of the dentist's submitted amount or an amount equal to the lowest prevailing scheduled fee used for in-network dentists in the geographic area.

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

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

(a) first installation of a denture or fixed bridge, and any inlay and crown that serves as an abutment to replace congenitally missing teeth or to replace teeth all of which were lost while the person was not covered;
(b) services or treatment not prescribed by or under the direct supervision of a dentist;
(c) services or treatment which is experimental or investigational;
(d) services or treatment which is for any illness or bodily injury which occurs in the course of employment if a benefit or compensation is available, in whole or in part, under the provision of any law or regulation or any government unit. This exclusion applies whether or not you claim the benefits or compensation;
(e) services or treatment received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, Veterans Administration hospital or similar person or group;
(f) services or treatment performed prior to the policy effective date;
(g) services or treatment incurred after the termination date of your coverage unless otherwise indicated;
(h) services or treatment which is not dentally necessary or which does not meet generally accepted standards of dental practice;
(i) services or treatment resulting from your failure to comply with professionally prescribed treatment;
(j) telephone consultations;
(k) any charges for failure to keep a scheduled appointment;
(l) any services that are considered strictly cosmetic in nature including, but not limited to, charges for personalization or characterization of prosthetic appliances;
(m) fluoride treatments;
(n) services or treatment provided as a result of intentionally self-inflicted injury or illness;
(o) services or treatment provided as a result of injuries suffered while committing or attempting to commit a felony, engaging in an illegal occupation, or participating in a riot, rebellion or insurrection;
(p) office infection control charges;
(q) charges for copies of your records, charts or x-rays, or any costs associated with forwarding/mailing copies of your records, charts or x-rays;
(r) state, federal, or territorial taxes on dental services performed;
(s) those charges submitted by a dentist, which are for the same services performed on the same date by another dentist;
(t) those dental services provided free of charge by any governmental unit, except where this exclusion is prohibited by law;
(u) those dental services for which you would have no obligation to pay in the absence of this or any similar insurance;
(v) those dental services which are for specialized procedures and techniques;
(w) those dental services performed by a dentist who is compensated by a facility for similar covered services performed for you on the same date;
(x) duplicate, provisional and temporary devices, appliances, and services;
(y) plaque control programs, oral hygiene instruction, and dietary instructions;
(z) services to alter vertical dimension and/or restore or maintain the occlusion. Such procedures include, but are not limited to:
    1. equilibration;
    2. periodontal splinting;
    3. full mouth rehabilitation and;
    4. restoration for misalignment of teeth;
(aa) gold foil restorations;
(bb) services or treatment for injuries resulting from war or act of war, whether declared or undeclared, or from police or military service for any country or organization;
(cc) hospital costs or any additional fees that the dentist or hospital charges for treatment at the hospital (inpatient or outpatient);
(dd) charges by the provider for completing dental forms;
(ee) adjustment of a denture or bridgework which is made within 6 months after installation by the same dentist who installed it;
(ff) use of material or home health aids to prevent decay, such as:
    1. toothpaste;
    2. fluoride gels;
    3. dental floss and;
    4. teeth whiteners;

(gg) sealants;
(hh) precision attachments, personalization, precious metal bases and other specialized techniques;
(ii) replacement of dentures that have been:
    1. lost;
    2. stolen or;
    3. misplaced;
(jj) repair of damaged orthodontic appliances;
(kk) replacement of lost or missing appliances;
(ll) fabrication of athletic mouth guard;
(mm) internal bleaching;
(nn) nitrous oxide;
(oo) oral sedation;
(pp) topical medicament carrier;
(qq) orthodontic services, treatment or supplies, including braces and retainers;
(rr) bone grafts when done in connection with:
    1. extractions;
    2. apicoectomies or;
    3. non-covered/non-eligible implants;
(ss) tooth whitening;
(tt) occlusal guards;
(uu) space maintainers;
(vv) services or treatment provided by a member of your immediate family;
(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.

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

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

**Premiums Can Change** – We will not increase your policy's premium due to any change in your health. However, we can change premiums if we make the same change to all policies of this form issued to persons of the same class. We will give you at least 60 days advance written notice required by your state prior to any such premium change.