

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

APPLICATION for MEDICARE SUPPLEMENT INSURANCE

TEXAS

Med Supp e-App...to be sure

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MUTUAL OF OMAHA INSURANCE COMPANY OUTLINE OF MEDICARE SUPPLEMENT COVERAGE – COVER PAGE BENEFIT PLANS A, F, G, HIGH DEDUCTIBLE G AND N Benefit Chart of Medicare Supplement Plans Sold on or after January 1, 2020

This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plan A available. 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.

| | | | | | | | | | | Medica | Medicare first eligible |
|--|---|----|----------|-----------------------------------|--------|----------------------|--------------|-----|--------------------|--------|-------------------------|
| | | | P | Plans Available to All Applicants | ble to | All Applica | ants | | | befor | before 2020 only |
| Benefits | A | В | D | G | G | К | | Δ | z | ပ | L_L |
| Medicare Part A coinsurance and | | | `` | | | | `` | 、 | | `` | |
| additional 365 days after Medicare | > | > | > | > | | > | > | > | > | > | > |
| benefits are used up) | | | | | | | | | | | |
| Medicare Part B coinsurance or | | | | | | | | | > | | |
| Copayment | > | > | > | > | | 50% | 75% | > | copays | > | > |
| | | | | | | | | | apply [。] | | |
| Blood (first three pints each year) | > | > | > | > | | 50% | <u>75%</u> | > | > | > | > |
| Part A hospice care coinsurance | 7 | `` | `` | 7 | | E002 | 750/2 | `` | 7 | ` | `` |
| or copayment | • | • | • | • | | 0/ 00 | 0/01 | • | • | • | • |
| 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 | | | <u>/</u> | / | | | | ~ | > | > | ~ |
| plan limits) | | | • | | | | | • | • | • | |
| Out-of-pocket limit in 2022 ² | | | | | | \$6,620 ² | $33,310^{2}$ | | | | |

plan pays 100% of covered services for the rest of the calendar year. High deductible plan G does not cover the Medicare part B deductible. However, high deductible plans י הכטווים וט המוועם F and G count your payment of the Medicare Part B deductible toward meeting the plan deductible. כי רכי ייש ייש

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

³Plan 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.

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| | 2, 795-799, 885 |
|----------------|-------------------|
| IIUMS * | 783, 785-792, |
| CO PREN | |
| N-TOBACCO | 769, 778, 780-781 |
| ITHLY NON- | 3, 759, 762-769, |
| MOM | : 755-756 |
| | ZIP CODES |

| Plant Plant <th< th=""><th>Plan A MM20 531.59 106.32 106.32</th><th>Plan F</th><th></th><th></th><th></th><th></th><th></th><th></th><th></th><th></th><th></th></th<> | Plan A MM20 531.59 106.32 106.32 | Plan F | | | | | | | | | |
|--|--|-------------|-------------|-------|--------------|----------|-------------|--------|-------------|-------------|-------------|
| MM24 MM25 MM25 MM35 Age MM20 MM24 MM25 MM35 Age MM21 MM25 MM35 MM35 148.03 108.49 39.05 84.38 65 122.26 170.23 124.75 44.91 148.03 108.49 39.05 84.38 65 122.26 170.23 124.75 44.91 148.03 118.04 39.05 84.38 65 122.26 170.23 124.75 44.91 148.03 118.04 39.05 84.38 65 122.66 170.23 124.76 44.91 155.40 114.93 41.40 33.73 132.59 156.67 47.61 52.34 177.12 114.83 51.07 114.93 130.93 73 132.50 175.46 63.17 177.12 114.83 51.07 114.92 73 132.50 176.46 63.17 177.12 114.93 51.07 114.93 73 137.21 193.75 | 0 0 0 0 | | Plan G | | Plan N | Attained | Plan A | Plan F | Plan G | Plan High G | Plan N |
| Thu 64 61131 Thu 64 61131 Thu 54 61131 Thu 54 61131 Thu 54 61131 Thu 54 6131 Thu 54 6131 Thu 54 6131 Thu 53 124.16 44.91 44.91 148.00 100.49 39.05 84.38 66 122.26 170.23 124.16 44.91 149.00 110.10 39.64 87.29 68 123.05 137.27 129.26 170.23 54.49 155.40 111.74 4.023 93.34 71 133.37 138.90 136.07 45.64 161.53 165.64 170.23 14.16 33.43 73 122.52 47.61 175.84 131.45 47.33 132.56 133.37 189.26 149.07 50.42 176.12 176.13 47.33 131.99 73 149.10 20.22 147.01 20.22 176.14 133.37 131.99 73 149.93 20.61 17.23 24.16 17 | 0000 | MM24 | MM25 | MM36 | MM35 | Age | MM20 | MM24 | MM25 | MM36 | MM35 |
| 1480.03 108.49 390.5 84.38 65 122.26 170.23 134.76 44.91 1480.03 108.49 390.6 84.38 67 122.26 170.23 124.76 44.91 1480.03 108.49 390.6 84.38 67 122.26 170.23 124.76 44.91 155.40 114.30 40.23 93.43 70 123.61 173.25 45.63 155.40 114.30 47.35 97.3 137.64 122.26 47.61 56.3 155.40 114.30 47.35 99.99 71 137.64 132.66 45.68 175.41 134.45 47.32 107.25 74 144.14 20.75 47.61 184.20 134.45 47.32 170.23 137.64 136.95 45.63 184.20 134.45 175.47 144.14 20.25 147.19 56.34 184.20 145.43 137.64 137.64 137.64 137.64 </th <th>2</th> <th></th> <th></th> <th></th> <th></th> <th>Thru 64</th> <th>611.31</th> <th></th> <th></th> <th></th> <th></th> | 2 | | | | | Thru 64 | 611.31 | | | | |
| 14803 108.49 3905 84.38 66 172.26 170.23 124.76 44.91 149.00 11010 39.44 87.29 68 12.106 177.03 124.76 44.91 155.09 114174 41.40 39.43 70 125.60 177.03 124.76 44.91 155.09 114174 41.40 39.43 70 125.60 177.36 45.61 155.09 11814 41.40 39.43 70 125.60 177.37 125.80 45.61 155.04 114192 71 173.27 183.30 136.65 45.63 175.04 135.65 51.01 114.92 75 156.16 65.41 175.04 143.65 53.05 114.92 76 158.63 65.64 175.04 143.65 73.14 73.15 156.16 65.41 175.04 163.76 173.75 173.95 75.61 65.41 175.05 166.99 < | 2 | 148.03 | 108.49 | 39.05 | 84.38 | 65 | 122.26 | 170.23 | 124.76 | 44.91 | 97.04 |
| 148.03 108.49 39.05 84.38 67 122.26 170.23 124.76 44.91 155.40 111.14 40.39 39.34 70 122.96 173.64 132.25 47.61 155.40 111.84 40.33 30.31 69 125.30 173.64 132.25 47.61 155.40 111.84 40.35 30.31 69 125.30 173.64 132.25 47.61 156.43 121.46 40.43 30.33 73 123.36 140.07 50.42 170.12 131.45 47.38 53.60 173.94 157.03 56.44 170.12 131.45 114.92 114.93 77 143.14 202.25 56.44 181.77 136.55 114.93 77 143.14 202.25 56.44 181.77 135.76 153.89 77.61 153.70 157.03 56.44 181.77 152.89 173.91 173.91 173.91 173.91 173.9 | | 148.03 | 108.49 | 39.05 | 84.38 | 66 | 122.26 | 170.23 | 124.76 | 44.91 | 97.04 |
| 149.50 110.10 39.64 87.29 68 12.06 11.134 126.62 45.68 156.30 111.74 41.40 33.33 70 12.533 17.61 46.26 156.30 111.74 41.40 93.43 70 12.960 17.87.0 45.56 156.40 118.34 4.26.60 03.33 73 143.26 140.07 56.43 176.84 131.45 41.40 93.45 17.7 133.73 189.26 140.07 56.43 176.84 131.45 41.30 99.95 73 143.81 20.223 151.16 54.41 187.81 165.61 11.492 76 159.88 176.10 56.41 217.73 157.39 56.88 127.91 71 166.73 56.11 70.12 217.73 157.39 56.88 127.91 77.81 56.73 76.11 72.61 217.73 157.36 57.31 17.80 27.21 17.81 | 5 | 148.03 | 108.49 | 39.05 | 84.38 | 67 | 122.26 | 170.23 | 124.76 | 44.91 | 97.04 |
| 150.99 11174 40.23 90.31 69 125.50 173.64 128.50 47.61 155.40 114.99 41.40 33.43 71 133.77 133.70 128.50 47.61 150.40 114.99 47.84 95.99 72 137.27 169.26 145.61 50.42 175.12 151.45 47.32 107.20 73 133.77 133.90 136.00 48.91 175.14 156.55 49.16 110.99 75 153.88 216.06 155.14 56.41 181.77 156.55 47.32 111.99 77 166.09 22.32.41 194.86 51.72 201.75 157.59 56.89 173.91 78.96 56.41 56.71 217.73 157.59 56.89 173.61 78.61 56.71 56.41 217.73 157.59 57.04 173.91 78.73 56.11 77.31 217.73 157.59 57.040 188.43 27.22 | 0 | 149.50 | 110.10 | 39.64 | 87.29 | 68 | 124.08 | 171.93 | 126.62 | 45.58 | 100.39 |
| 155.40 114.99 41.40 93.43 70 129.60 178.70 132.25 47.61 169.32 118.34 42.60 96.65 71 133.37 138.390 136.09 48.99 170.12 126.53 45.66 100.33 73 142.59 156.64 145.51 52.38 170.12 131.45 41.66 100.20 74 148.14 50.47 50.43 181.71 136.53 43.66 100.20 74 148.14 50.43 50.43 50.43 181.75 155.36 51.07 114.92 76 159.88 216.06 157.09 56.84 123.75 50.40 157.48 50.72 201.75 155.39 56.88 123.75 80 184.36 230.30 157.48 56.17 201.75 155.39 56.88 123.75 80 184.36 270.13 56.73 201.75 155.39 166.38 81 104.36 237.54 214.75 </td <td>1</td> <td>150.99</td> <td>111.74</td> <td>40.23</td> <td>90.31</td> <td>69</td> <td>125.93</td> <td>173.64</td> <td>128.50</td> <td>46.26</td> <td>103.86</td> | 1 | 150.99 | 111.74 | 40.23 | 90.31 | 69 | 125.93 | 173.64 | 128.50 | 46.26 | 103.86 |
| 15992 118.34 42.60 96.65 71 133.37 183.30 136.09 48.99 170.12 121.80 45.64 103.23 73 137.27 189.26 140.07 50.42 170.12 121.80 45.66 107.20 74 148.14 202.22 151.16 54.41 171.73 153.55 45.67 110.99 77 165.09 223.34 163.14 56.54 187.88 150.76 118.99 77 166.09 223.34 169.48 61.02 201.75 152.59 54.94 17.197 73.33 181.16 54.41 217.73 165.37 53.13 112.179 78 171.197 73.32 171.197 73.13 217.73 165.38 53.15 117.197 73.13 118.196 61.17 74.12 217.73 165.38 137.66 81 171.97 23.102 173.16 73.11 217.73 155.73 53.06.11 <t< td=""><td>0</td><td>155.40</td><td>114.99</td><td>41.40</td><td>93.43</td><td>70</td><td>129.60</td><td>178.70</td><td>132.25</td><td>47.61</td><td>107.44</td></t<> | 0 | 155.40 | 114.99 | 41.40 | 93.43 | 70 | 129.60 | 178.70 | 132.25 | 47.61 | 107.44 |
| 164.58 121.80 43.84 99.99 72 137.27 189.26 140.07 50.42 175.17 136.55 43.16 100.333 $14.2.39$ 195.64 146.51 50.42 175.17 136.55 43.16 110.99 75 142.39 209.03 157.03 56.54 187.17 155.56 54.94 114.92 76 153.38 250.03 157.03 56.54 201.75 155.59 54.94 127.99 79 171.97 232.02 157.48 63.17 217.73 165.36 56.68 127.99 56.8 127.99 56.64 57.10 56.74 217.73 165.36 56.13 114.279 82 161.62 201.2 57.16 57.17 224.49 175.37 66.13 171.97 $223.66.4$ 72.61 72.61 224.43 175.77 172.22 171.92 227.60 <td>8</td> <td>159.92</td> <td>118.34</td> <td>42.60</td> <td>96.65</td> <td>71</td> <td>133.37</td> <td>183.90</td> <td>136.09</td> <td>48.99</td> <td>111.16</td> | 8 | 159.92 | 118.34 | 42.60 | 96.65 | 71 | 133.37 | 183.90 | 136.09 | 48.99 | 111.16 |
| 170.12 126.53 45.56 103.53 73 142.59 155.64 145.51 5.238 177.84 131.45 41.32 107.20 74 143.14 202.22 151.16 5.441 187.88 141.86 51.07 114.92 75 153.98 216.06 163.14 58.73 187.88 141.86 51.07 114.92 76 159.88 216.06 163.14 58.73 187.88 147.86 53.05 118.99 77 166.09 223.202 163.13 56.41 217.73 165.37 63.13 127.99 82 171.97 232.02 163.14 58.73 217.73 165.37 63.13 127.99 78 171.97 232.02 161.07 7731 217.73 165.37 63.13 127.99 82 217.64 65.17 77.31 217.73 165.67 81.75.9 82 178.16 217.33 214.75 77.31 234.99 </td <td>9</td> <td>164.58</td> <td>121.80</td> <td>43.84</td> <td><u>99.99</u></td> <td>72</td> <td>137.27</td> <td>189.26</td> <td>140.07</td> <td>50.42</td> <td>114.99</td> | 9 | 164.58 | 121.80 | 43.84 | <u>99.99</u> | 72 | 137.27 | 189.26 | 140.07 | 50.42 | 114.99 |
| 17584 131.45 47.32 107.20 74 148.14 202.22 151.16 54.41 181.77 165.56 4916 110.99 75 153.89 200.03 157.03 56.54 187.76 165.56 51.07 114.92 76 158.98 216.06 157.03 56.54 194.20 147.38 53.05 118.92 76 158.98 200.03 157.49 63.17 209.60 157.39 56.38 127.99 77 160.09 223.34 169.48 61.02 211.75 153.35 160.98 137.66 81 179.05 220.40 188.17 56.41 56.41 211.75 155.77 65.13 147.09 82 231.64 231.76 57.41 56.41 56.41 211.75 155.77 165.08 137.66 81 200.40 188.12 71.32 224.48 173.91 173.05 221.16 214.75 77.31 </td <td>00</td> <td>170.12</td> <td>126.53</td> <td>45.56</td> <td>103.53</td> <td>73</td> <td>142.59</td> <td>195.64</td> <td>145.51</td> <td>52.38</td> <td>119.06</td> | 00 | 170.12 | 126.53 | 45.56 | 103.53 | 73 | 142.59 | 195.64 | 145.51 | 52.38 | 119.06 |
| 181.17 136.55 49.16 110.99 75 153.89 209.00 157.03 56.54 187.88 141.86 51.07 114.92 7 159.88 157.14 58.73 194.20 157.39 53.07 114.92 7 169.08 273.14 58.73 201.75 157.39 58.89 127.39 78 171.97 223.202 175.48 61.17 201.73 163.38 56.94 123.41 78 171.97 232.02 175.48 61.17 217.73 163.38 56.313 142.79 82 171.80 231.06 171.21 234.48 160.37 163.36 175.37 65.15 147.09 83 70.12 242.48 186.74 67.72 141.70 83 214.66 2761 7492 256.44 198.84 71.59 87 217.66 284.34 77.42 266.44 171.31 142.79 82 217.65 214.67 | 32 | 175.84 | 131.45 | 47.32 | 107.20 | 74 | 148.14 | 202.22 | 151.16 | 54.41 | 123.28 |
| 187.88141.8651.07114.9276159.88216.06163.1458.73194.20152.5954.94178.9973178.05241.03181.6965.1220175152.5954.94177.9173176.4665.1261.022016167.9956.89132.7580184.36241.03181.6965.17209.60165.3958.89132.7580184.36250.40188.1267.12217.73165.3956.89132.7580197.65241.03181.1667.12224.09169.3765.15147.0983200.13194.7870.12224.49169.3765.15147.0983200.13194.7870.12244.6965.15151.5284217.16286.75214.7577.31256.44198.8471.6588217.16286.75214.7577.31256.43198.8471.6588231.24316.17235.6684.94256.44198.8471.6588231.24316.17235.6784.38264.41198.8471.7375.35166.09857231.24316.17235.66264.41198.8471.73733.24256.4038.38256.4191.95274.93209.2975.35166.9986256.30342.40256.4191.95280.44231.4777.1673.2436.75240.59< | 32 | 181.77 | 136.55 | 49.16 | 110.99 | 75 | 153.89 | 209.03 | 157.03 | 56.54 | 127.64 |
| 19420 147.38 53.06 118.99 77 166.09 223.34 169.48 61.02 201.75 152.59 56.88 123.41 78 171.97 237.22 175.48 63.17 217.73 163.58 58.98 132.75 80 184.36 256.40 188.15 67.72 217.73 163.58 58.89 132.75 80 184.36 256.40 188.12 67.72 226.20 180.97 65.13 142.79 82 190.89 260.13 194.78 70.12 236.49 175.37 65.13 142.79 82 210.46 287.75 214.75 77.31 244.8 17.53 165.03 87 210.46 287.75 214.75 77.31 256.21 198.64 67.72 155.08 84 210.46 86.64 256.22 198.74 67.22 156.08 85 217.16 214.75 77.31 256.22 186.74 67.32 | 02 | 187.88 | 141.86 | 51.07 | 114.92 | 76 | 159.88 | 216.06 | 163.14 | 58.73 | 132.16 |
| 201.75 152.59 54.94 123.41 78 171.97 232.02 175.48 63.17 209.60 157.99 56.88 127.99 79 187.05 241.03 181.15 65.17 226.20 169.38 60.98 137.275 81 190.89 260.13 194.78 70.12 226.20 169.38 60.98 137.255 81 190.89 260.13 194.78 70.12 224.24 180.97 65.15 147.09 83 203.95 278.85 208.11 74.92 242.44 180.97 65.15 147.09 83 210.46 228.77 201.47 70.12 242.49 180.97 65.15 147.09 83 217.16 27.74 201.6 79.77 242.44 198.84 71.53 166.79 87 221.09 306.40 223.67 82.32 256.24 198.84 71.53 166.79 87 231.24 316.17 235.96 84.94 256.44 198.84 71.53 166.79 87 231.24 316.17 235.69 84.94 256.44 198.84 71.53 166.63 87 231.24 316.17 235.69 84.94 256.44 203.29 175.77 90 245.40 336.40 253.67 82.32 266.44 217.74 217.74 217.74 216.77 90.14 79.75 266.44 219.26 175.23 | 13 | 194.20 | 147.38 | 53.05 | 118.99 | 77 | 166.09 | 223.34 | 169.48 | 61.02 | 136.84 |
| 209.60 157.99 56.88 127.99 77.91 78.05 241.03 181.69 65.41 217.73 163.58 58.89 127.75 80 184.36 220.40 188.12 67.72 217.73 163.58 58.89 127.76 81 197.65 270.42 216.72 67.72 234.99 175.37 63.13 147.09 83 210.46 287.75 214.76 77.61 222.48 190.97 65.15 147.09 83 210.46 287.75 214.76 77.31 250.22 186.74 67.22 151.52 84 210.46 287.75 214.76 77.31 256.44 190.97 65.15 147.09 83 213.45 214.76 77.31 256.44 190.97 65.15 147.09 87 210.46 287.75 214.76 77.31 256.44 213.47 71.34 86.54 213.47 214.76 77.31 74.92 256.44 219.66 72.66 88.27 221.60 224.56 88.36 290.41 256.44 299.56 232.56 88.36 240.59 240.59 246.50 88.38 214.76 77.74 78.32 232.56 232.56 88.38 232.66 290.64 90.14 236.44 299.56 232.66 88.36 232.66 233.66 246.50 88.38 237.45 237.46 88.38 235.67 232 | 54 | 201.75 | 152.59 | 54.94 | 123.41 | 78 | 171.97 | 232.02 | 175.48 | 63.17 | 141.92 |
| 217.73 163.36 58.89 132.75 80 184.36 250.40 188.12 67.72 67.72 226.20 169.38 60.98 137.68 81 190.89 260.13 194.78 70.12 226.22 186.74 63.13 147.09 82 197.65 270.24 201.68 7.731 226.22 186.74 67.22 147.09 83 203.93 273.65 $284.7.75$ 71.731 226.44 180.84 61.72 147.09 85 217.16 296.93 221.60 73.77 256.22 186.74 61.72 166.08 85 217.16 296.93 221.60 73.77 256.44 198.84 71.59 166.79 86 224.09 306.40 228.67 82.32 204.4 209.29 73.87 166.63 87 240.59 336.40 228.67 82.32 204.4 209.29 73.86 172.32 89 240.59 336.40 226.61 82.32 204.4 209.4 205.62 336.4 228.67 90.14 90.14 201.7 217.14 78.89 175.77 90 245.40 335.53 250.41 90.14 201.7 217.14 78.89 238.95 246.50 88.38 246.50 88.38 201.7 217.14 788 237.61 274.64 90.14 237.64 91.95 291.60 236.40 237.64 <td< td=""><td>33</td><td>209.60</td><td>157.99</td><td>56.88</td><td>127.99</td><td>79</td><td>178.05</td><td>241.03</td><td>181.69</td><td>65.41</td><td>147.19</td></td<> | 33 | 209.60 | 157.99 | 56.88 | 127.99 | 79 | 178.05 | 241.03 | 181.69 | 65.41 | 147.19 |
| 22620 169.38 60.98 137.68 81 190.89 260.13 194.78 70.12 234.99 175.37 63.13 142.79 82 197.65 270.24 201.68 72.61 242.48 186.74 67.22 151.52 84 210.46 228.15 214.75 77.32 255022 192.69 69.72 155.15 84 210.46 228.67 $22.32.56$ 84.94 256.44 198.84 71.59 160.79 86 224.09 306.40 228.67 82.32 266.44 198.84 71.59 160.79 86 224.09 306.40 228.67 82.32 274.93 205.19 73.87 165.63 87 231.24 316.17 235.96 84.94 274.93 209.29 75.35 168.95 88 231.24 316.17 235.96 84.94 274.03 217.17 78.39 175.77 90 245.40 336.53 2240.69 86.64 290.417 217.17 78.39 177.57 90 245.40 336.53 240.59 88.38 291.77 217.16 78.75 177.32 89 2245.40 336.53 240.59 86.64 217.17 78.39 177.57 90 247.40 226.57 93.79 90.14 293.55 226.54 81.55 192.26 36.07 256.73 95.66 93.79 200.52 226.54 | | 217.73 | 163.58 | 58.89 | 132.75 | 80 | 184.36 | 250.40 | 188.12 | 67.72 | 152.66 |
| 234.99 175.37 63.13 142.79 82 197.65 270.24 201.68 72.61 72.61 242.48 180.97 65.15 147.09 83 203.95 278.85 208.11 74.92 255.022 186.74 67.22 157.52 156.15 147.09 83 203.95 274.75 77.73 256.44 198.84 71.59 160.79 86 224.109 306.40 228.67 82.32 266.44 198.84 71.53 160.79 86 224.109 306.40 228.67 82.32 274.93 205.19 73.87 165.63 87 231.24 316.17 235.66 84.94 274.93 205.19 73.87 168.95 88 224.059 386.34 $82.35.67$ 82.32 280.44 231.47 76.85 172.32 89 237.26 34.94 90.14 230.45 226.54 81.55 172.77 90 246.59 88.38 233.55 226.54 81.55 182.88 92 255.32 349.09 266.73 333.55 226.54 81.55 182.28 91.557 265.73 95.65 93.76 239.65 231.78 232.569 84.94 237.76 86.54 90.14 2315.82 226.54 81.55 182.28 95.65 93.79 95.65 233.55 226.54 84.94 86.54 235.69 84.94 237.6 | | 226.20 | 169.38 | 60.98 | 137.68 | 81 | 190.89 | 260.13 | 194.78 | 70.12 | 158.32 |
| 242.48 180.97 65.15 147.09 83 203.95 278.85 208.11 74.92 250.22 186.74 67.22 151.52 84 210.46 287.75 214.75 77.31 256.44 192.69 69.37 156.08 85 217.16 287.75 214.75 77.31 266.44 198.84 71.59 160.79 86 224.09 306.40 228.67 82.32 204.42 205.19 77.31 76.85 172.32 87 232.50 240.69 86.44 270.40 213.47 76.85 172.32 89 240.59 328.95 249.69 86.38 291.77 217.74 76.85 172.32 90 245.40 335.53 250.41 90.14 291.77 217.74 76.85 172.32 90 245.40 335.53 250.41 90.14 291.77 217.74 76.85 172.32 90 245.40 335.53 250.41 90.14 297.60 237.67 316.17 77.05 91.96 90.14 90.14 233.55 227.64 81.55 172.23 91.96 $92.65.62$ 335.53 250.41 91.96 297.60 223.10 280.56 84.85 175.72 91.96 $92.65.62$ 335.53 250.41 91.95 233.55 226.54 81.65 81.65 81.65 81.64 82.64 86.54 91.95 233.55 | | 234.99 | 175.37 | 63.13 | 142.79 | 82 | 197.65 | 270.24 | 201.68 | 72.61 | 164.21 |
| 250.22 186.74 67.22 151.52 84 210.46 287.75 214.76 77.31 258.20 192.60 69.37 156.08 85 217.16 296.93 221.60 79.77 266.44 198.84 71.59 166.08 85 217.16 296.93 221.60 79.77 266.44 198.84 71.59 165.63 87 231.24 316.17 235.96 84.94 274.93 209.29 75.35 168.95 88 231.24 316.17 235.96 84.94 280.44 209.29 75.35 168.95 88 231.24 316.17 235.56 84.94 286.04 213.47 76.35 168.95 88 221.60 323.55 249.69 86.64 291.77 209.29 75.35 177.22 89 226.532 3249.69 84.94 293.55 221.07 90 245.40 335.53 256.41 90.14 203.55 221.07 81.86 172.72 89 245.20 91.95 233.55 236.56 84.84 370.45 255.41 91.95 233.55 235.69 84.94 88.38 335.53 256.41 91.95 233.55 221.07 233.53 240.69 246.79 90.14 233.55 235.64 92.76 335.53 256.41 91.95 233.55 231.07 285.62 333.64 256.52 93.66 < | | 242.48 | 180.97 | 65.15 | 147.09 | 83 | 203.95 | 278.85 | 208.11 | 74.92 | 169.16 |
| 258.20 192.69 69.37 156.08 85 217.16 296.93 221.60 79.77 266.44 198.84 71.59 160.79 86 224.09 306.40 228.67 82.32 274.93 205.19 73.87 160.79 86 224.09 306.40 228.67 82.32 274.93 205.19 75.35 160.79 86 224.09 306.40 228.67 82.32 280.44 20929 75.35 168.95 88 2235.87 316.17 235.96 84.94 280.44 20929 75.35 168.95 88 2235.87 322.50 240.69 86.64 291.77 217.74 76.85 172.32 89 226.30 342.24 256.41 90.14 297.60 231.07 81.55 179.29 92 256.32 349.09 260.52 93.79 305.55 225.54 81.85 192.26 92 256.32 349.09 266.73 91.95 300.62 231.07 83.18 186.55 194.07 92 256.32 349.09 266.72 93.79 300.62 231.07 88.27 197.05 92 256.32 349.09 266.72 93.79 300.55 235.61 88.27 197.05 92 256.32 349.09 266.72 93.79 300.56 238.57 240.41 86.55 194.07 95 266.72 93.76 93.76 <td></td> <td>250.22</td> <td>186.74</td> <td>67.22</td> <td>151.52</td> <td>84</td> <td>210.46</td> <td>287.75</td> <td>214.75</td> <td>77.31</td> <td>174.25</td> | | 250.22 | 186.74 | 67.22 | 151.52 | 84 | 210.46 | 287.75 | 214.75 | 77.31 | 174.25 |
| 266.44 198.84 71.59 160.79 86 224.09 306.40 228.67 82.32 274.93 205.19 73.87 165.63 87 231.24 316.17 235.96 84.94 280.44 209.29 73.87 165.63 87 231.24 316.17 235.96 84.94 280.44 209.29 75.35 168.95 88 237.60 325.67 240.69 86.64 280.04 213.47 76.85 172.32 89 240.59 328.95 246.60 88.38 291.77 217.74 78.39 175.77 90 245.40 335.53 240.69 86.64 291.77 217.74 78.39 175.77 90 245.40 335.53 246.60 88.38 291.77 217.74 78.39 175.77 90 246.40 335.53 256.41 90.14 291.77 217.74 78.39 175.77 90 245.40 335.53 256.41 90.14 303.55 226.54 81.57 81.57 81.57 $92.66.52$ 94.65 95.66 309.62 231.07 81.85 912.66 94.85 $92.70.94$ 270.94 271.05 97.56 305.57 246.21 88.27 197.25 95.66 335.42 276.47 99.53 328.57 246.21 88.27 91.95 96.66 91.67 90.26 91.55 335.14 256.12 90.04 | | 258.20 | 192.69 | 69.37 | 156.08 | 85 | 217.16 | 296.93 | 221.60 | 79.77 | 179.50 |
| 274.93 205.19 73.87 165.63 87 231.24 316.17 235.96 84.94 280.44 209.29 75.35 168.95 88 235.87 322.50 240.69 86.64 280.44 209.29 75.35 168.95 88 235.87 322.50 240.69 86.64 291.77 217.74 78.39 175.77 90 245.40 335.53 250.41 90.14 291.77 217.74 78.39 175.77 90 245.40 335.53 256.41 90.14 291.77 217.74 78.39 175.77 90 245.40 335.53 256.41 90.14 291.77 217.74 78.39 175.77 90 245.40 335.53 256.41 91.95 291.77 217.74 78.39 177.20 91 256.30 342.24 255.41 91.95 303.55 222.56 84.85 190.26 94 256.07 265.73 95.66 315.82 237.07 83.18 186.53 93 260.42 363.18 271.06 97.58 315.82 2245.21 88.27 197.95 96 67.67 99.53 95.66 337.65 245.21 88.27 197.95 96 97.68 271.06 97.58 337.85 240.47 265.62 363.18 271.05 97.67 99.53 337.145 256.12 90.04 201.91 97.68 | | 266.44 | 198.84 | 71.59 | 160.79 | 86 | 224.09 | 306.40 | 228.67 | 82.32 | 184.91 |
| 280.44 209.29 75.35 168.95 88 235.87 322.50 240.69 86.64 286.04 213.47 76.85 17.232 89 240.59 328.95 245.50 88.38 291.77 217.74 78.39 175.77 90 245.40 335.53 250.41 90.14 297.60 222.10 79.95 177.22 89 245.50 349.09 245.60 83.38 303.55 226.54 81.55 182.88 92 255.32 349.09 260.52 93.79 303.55 226.54 81.55 182.88 92 255.32 349.09 266.57 90.14 309.62 231.07 81.85 186.53 92 255.32 349.09 266.57 93.79 315.82 235.69 84.85 190.26 94 255.32 356.07 265.73 95.66 315.82 235.69 84.85 190.26 94 255.62 363.18 271.05 97.58 315.82 235.14 256.12 90.04 201.91 97 281.88 335.42 287.63 103.55 328.514 255.12 90.04 201.91 97 281.88 335.42 287.63 103.55 335.14 255.12 90.04 201.91 97 287.52 333.13 293.39 105.62 348.68 260.22 93.68 210.06 $99+$ 233.27 400.99 293.29 107 | | 274.93 | 205.19 | 73.87 | 165.63 | 87 | 231.24 | 316.17 | 235.96 | 84.94 | 190.48 |
| 286.04 213.47 76.85 172.32 89 240.59 328.95 245.50 88.38 291.77 217.74 78.39 175.77 90 245.40 335.53 250.41 90.14 297.60 222.10 79.95 179.29 91 250.30 342.24 256.41 91.95 303.55 226.54 81.55 182.88 92 255.32 349.09 266.52 93.79 309.62 231.07 83.18 186.53 93 260.42 356.07 256.73 95.66 315.82 231.07 83.18 186.53 93 260.42 363.18 271.05 97.58 315.82 235.69 84.85 190.26 94 265.62 363.18 271.05 97.58 315.82 2240.41 88.27 194.07 95 277.094 370.45 276.47 99.53 322.13 240.41 88.27 197.95 96 276.36 377.66 97.58 335.14 256.12 90.04 201.91 97 281.88 385.42 287.63 103.55 341.85 255.12 91.85 206.22 93.68 287.52 393.13 205.26 107.52 334.86 260.22 93.68 210.06 99.4 297.52 393.13 205.26 107.73 348.68 260.22 93.68 210.06 99.4 293.27 400.99 290.26 107.73 | | 280.44 | 209.29 | 75.35 | 168.95 | 88 | 235.87 | 322.50 | 240.69 | 86.64 | 194.29 |
| 291.77 217.74 78.39 175.77 90 245.40 335.53 250.41 90.14 90.14 297.60 222.10 79.95 179.29 91 250.30 342.24 255.41 91.95 303.55 226.54 81.55 182.88 92 255.32 349.09 260.52 93.79 309.62 231.07 83.18 186.53 93 260.42 356.07 266.73 95.66 315.82 235.69 84.85 190.26 94 265.62 363.18 271.05 97.58 315.82 235.69 84.85 190.26 94 265.62 363.18 271.05 97.58 322.13 240.41 86.55 194.07 95 277.094 370.45 276.47 99.53 328.57 245.21 88.27 197.95 96 276.36 377.66 276.47 99.53 335.14 256.12 90.04 201.91 97 287.63 337.33 103.55 341.85 255.12 91.85 205.95 96 287.52 393.13 293.39 105.62 348.68 260.22 91.85 201.94 287.52 393.13 293.39 105.62 334.86 260.22 93.68 210.06 $99+$ 293.27 400.99 290.26 107.73 | | 286.04 | 213.47 | 76.85 | 172.32 | 89 | 240.59 | 328.95 | 245.50 | 88.38 | 198.17 |
| 297.60 222.10 79.95 179.29 91 250.30 342.24 255.41 91.95 303.55 226.54 81.55 182.88 92 255.32 349.09 260.52 93.79 303.62 231.07 83.18 186.53 93 256.32 349.09 266.73 95.66 315.82 235.69 84.85 190.26 94 265.62 363.18 271.05 97.58 315.82 2340.41 86.55 194.07 95 270.94 370.45 276.47 99.53 322.13 240.41 86.55 194.07 95 270.94 370.45 276.47 99.53 328.57 245.21 88.27 197.95 96 276.36 377.46 287.63 103.55 335.14 250.12 90.04 201.91 97 281.88 385.42 287.63 103.55 341.85 255.12 91.85 205.95 98 287.52 393.13 293.39 105.62 348.68 260.22 93.68 210.06 $99+$ 293.27 400.99 299.26 107.73 | | 291.77 | 217.74 | 78.39 | 175.77 | 06 | 245.40 | 335.53 | 250.41 | 90.14 | 202.14 |
| 303.55 226.54 81.55 182.88 92 255.32 349.09 260.52 93.79 93.79 309.62 231.07 83.18 186.53 93 255.32 349.09 266.73 95.66 315.82 231.07 83.18 186.53 93 260.42 356.07 265.73 95.66 315.82 235.69 84.85 190.26 94 265.62 363.18 271.05 97.58 322.13 240.41 86.55 194.07 95 270.94 370.45 276.47 99.53 328.57 245.21 88.27 197.95 96 276.36 377.46 287.07 101.52 335.14 256.12 90.04 201.91 97 281.88 385.42 287.63 103.55 341.85 255.12 91.85 206.42 335.13 293.39 105.62 348.68 260.22 93.61 270.45 287.63 103.55 303.33 105.62 107.73 </td <td></td> <td>297.60</td> <td>222.10</td> <td>79.95</td> <td>179.29</td> <td>91</td> <td>250.30</td> <td>342.24</td> <td>255.41</td> <td>91.95</td> <td>206.18</td> | | 297.60 | 222.10 | 79.95 | 179.29 | 91 | 250.30 | 342.24 | 255.41 | 91.95 | 206.18 |
| 309.62 231.07 83.18 186.53 93 260.42 356.07 265.73 95.66 95.66 315.82 235.69 84.85 190.26 94 265.62 363.18 271.05 97.58 322.13 240.41 86.55 194.07 95 270.94 370.45 271.05 99.53 328.57 245.21 88.27 197.95 96 276.36 377.86 282.00 101.52 335.14 250.12 90.04 201.91 97 281.88 385.42 287.63 103.55 335.14 255.12 91.85 206.95 98 287.52 393.13 293.39 103.55 341.85 255.12 91.85 205.95 98 287.52 393.13 293.39 105.62 348.68 260.22 93.64 293.39 105.62 107.73 | | 303.55 | 226.54 | 81.55 | 182.88 | 92 | 255.32 | 349.09 | 260.52 | 93.79 | 210.31 |
| 315.82 235.69 84.85 190.26 94 265.62 363.18 271.05 97.58 97.58 322.13 240.41 86.55 194.07 95 270.94 370.45 276.47 99.53 328.57 245.21 88.27 197.95 96 276.36 377.86 282.00 101.52 335.14 250.12 90.04 201.91 97 281.88 385.42 287.63 103.55 341.85 255.12 91.85 205.95 98 287.52 393.13 293.39 105.65 348.68 260.22 93.68 210.06 99+ 293.27 400.99 299.26 107.73 | | 309.62 | 231.07 | 83.18 | 186.53 | 93 | 260.42 | 356.07 | 265.73 | 95.66 | 214.51 |
| 322.13 240.41 86.55 194.07 95 270.94 370.45 276.47 99.53 328.57 245.21 88.27 197.95 96 276.36 377.86 282.00 101.52 335.14 250.12 90.04 201.91 97 281.88 385.42 287.63 103.55 341.85 255.12 91.85 205.95 98 287.52 393.13 293.39 105.65 348.68 260.22 93.68 210.06 99+ 293.27 400.99 299.26 107.73 | | 315.82 | 235.69 | 84.85 | 190.26 | 94 | 265.62 | 363.18 | 271.05 | 97.58 | 218.80 |
| 328.57 245.21 88.27 197.95 96 276.36 377.86 282.00 101.52 335.14 250.12 90.04 201.91 97 281.88 385.42 287.63 103.55 341.85 255.12 91.85 205.95 98 287.52 393.13 293.39 105.62 348.68 260.22 93.68 210.06 99+ 293.27 400.99 299.26 107.73 | 0 | 322.13 | 240.41 | 86.55 | 194.07 | 95 | 270.94 | 370.45 | 276.47 | 99.53 | 223.17 |
| 335.14 250.12 90.04 201.91 97 281.88 385.42 287.63 103.55 341.85 255.12 91.85 205.95 98 287.52 393.13 293.39 105.62 348.68 260.22 93.68 210.06 99+ 293.27 400.99 299.26 107.73 | | 328.57 | 245.21 | 88.27 | 197.95 | 96 | 276.36 | 377.86 | 282.00 | 101.52 | 227.64 |
| 341.85 255.12 91.85 205.95 98 287.52 393.13 293.39 105.62 348.68 260.22 93.68 210.06 99+ 293.27 400.99 299.26 107.73 | 2 | 335.14 | 250.12 | 90.04 | 201.91 | 97 | 281.88 | 385.42 | 287.63 | 103.55 | 232.19 |
| 348.68 260.22 93.68 210.06 99+ 293.27 400.99 299.26 107.73 241. | 2 | 341.85 | 255.12 | 91.85 | 205.95 | 98 | 287.52 | 393.13 | 293.39 | 105.62 | 236.84 |
| | 2 | 348.68 | | | 210.06 | +66 | 293.27 | 400.99 | | 107.73 | |

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

TX MOO AGY 001

| G Plan N Attained MM25 Plan A MM24 Plan F MM25 Plan G MM24 MM35 Age MM20 MM24 MM25 96.99 65 140.53 195.67 143.40 96.99 65 140.53 195.67 143.40 96.99 65 140.53 195.67 143.40 96.99 66 140.53 195.67 143.40 96.99 67 144.75 195.67 143.40 96.99 67 144.75 195.67 143.40 107.39 70 144.75 195.67 143.40 111.09 71 153.30 211.38 157.51 147.70 114.33 72 153.30 217.55 161.00 147.70 114.185 77 153.30 217.55 167.25 167.25 136.77 77 190.91 256.71 194.80 77.22 152.76 133.75 248.35 167.25 167.25 1 | FEMALE | | | | | i | MALE | | : |
|---|--------|---------------------|----------------|-----------|----------------|----------------|----------------|---------------------|----------------|
| million Thrue di 702.66 million million 6162 140.53 195.67 143.40 51.62 96.99 66 140.53 195.67 143.40 51.62 96.99 66 140.53 195.67 143.40 51.62 96.99 66 140.53 195.67 143.40 51.62 96.99 66 142.62 197.62 145.44 51.62 100.340 69 144.75 199.59 147.70 53.17 101.39 71 148.97 2.05.41 152.01 54.63 101.310 71 148.97 2.05.41 152.75 60.21 114.9.00 73 167.89 2.17.35 167.25 60.21 114.132 75 167.80 2.04.3 70.13 114.135 77 167.25 167.20 62.54 113.2.17 75 167.80 2.04.3 61.60 114.135 77 184 77.84 <td< th=""><th></th><th>Plan High G MM36</th><th>Plan N MM35</th><th>Attained</th><th>Plan A MM20</th><th>Plan F MM24</th><th>Plan G מאסק</th><th>Plan High G MM36</th><th>Plan N MM35</th></td<> | | Plan High G MM36 | Plan N MM35 | Attained | Plan A MM20 | Plan F MM24 | Plan G מאסק | Plan High G MM36 | Plan N MM35 |
| 96.39 65 140.53 195.67 143.40 51.62 96.39 66 140.53 195.67 143.40 51.62 96.39 66 140.53 195.67 143.40 51.62 96.39 66 144.75 199.59 147.70 51.62 100.380 69 144.75 199.59 147.70 53.17 100.380 69 144.75 199.59 147.70 53.17 100.380 69 144.75 199.59 147.70 53.17 101.39 73 163.90 224.87 157.68 52.34 114.93 75 61.00 57.96 60.21 114.93 75 161.00 57.96 60.21 122.01 76 183.77 248.35 187.52 67.50 132.10 77.14 190.91 256.71 194.80 77.184 132.10 77.14 230.75 246.84 75.61 77.61 141.185 | _ | | | Thru 64 | 702.66 | - 7 14 14 1 | | | |
| 96.99 66 140.53 195.67 143.40 51.62 96.99 67 140.53 195.67 143.40 51.62 96.99 67 140.53 195.67 143.40 51.62 103.80 69 144.75 199.59 147.70 53.17 101.39 71 153.30 211.38 156.31 56.31 111.09 71 153.30 217.55 167.26 56.31 114.03 72 157.78 205.44 177.75 56.31 114.03 73 163.07 232.44 177.35 62.54 123.210 76 176.89 240.26 70.13 70.13 137.71 76 170.27 232.44 177.35 62.54 137.10 77 190.30 248.35 70.13 70.13 137.71 73.61 230.52 230.52 231.81 83.46 141.65 70 254.33 164.33 70.13 64.56 | | 44.89 | 96.99 | 65 | 140.53 | 195.67 | 143.40 | 51.62 | 111.54 |
| 96.99 67 140.53 195.67 143.40 51.62 100.34 68 142.62 197.62 143.70 51.63 100.39 70 148.97 205.41 152.01 54.72 111.09 71 153.30 211.38 156.43 56.31 111.09 71 153.30 211.38 156.43 56.31 111.09 71 153.30 211.38 156.43 56.31 111.09 71 153.30 211.38 156.43 56.31 111.09 71 153.30 211.38 156.43 56.31 122.01 74 170.27 223.44 173.75 62.54 122.01 76.18 240.56 21.01 55.31 135.71 784 173.75 67.50 57.56 137.12 77.14 173.75 67.50 57.61 141.12 77 197.63 27.105 208.46 76.18 142.11 81.66 | | 44.89 | 96.99 | <u>66</u> | 140.53 | 195.67 | 143.40 | 51.62 | 111.54 |
| 100.34 68 142.62 197.62 145.54 52.39 103.80 69 144.75 199.59 147.70 53.17 110.39 70 153.30 211.38 156.43 56.31 111.09 71 153.30 211.38 155.201 54.72 111.00 72 157.78 215.55 161.00 57.96 119.00 73 153.30 211.38 155.46 52.34 123.21 74 170.27 232.44 173.27 60.21 136.77 77 190.91 256.71 194.80 70.13 137.17 77 190.91 256.71 194.80 70.13 141.85 77 77 190.50 64.98 66.24 141.12 79 193.61 237.05 248.35 77.84 152.56 81 219.41 230.05 213.81 83.46 152.58 80 211.91 256.71 248.33 77.84 | | 44.89 | 96.99 | 67 | 140.53 | 195.67 | 143.40 | 51.62 | 111.54 |
| 103.80 69 144.75 199.59 147.70 53.17 107.33 72 145.73 205.41 152.01 54.72 111.100 73 157.33 217.55 161.00 57.66 114.100 73 157.33 217.55 161.00 57.66 114.100 75 157.33 224.487 167.25 60.21 114.00 75 157.73 232.444 173.75 62.54 123.21 7 137.77 243.025 187.65 60.21 123.77 7 136.77 77 190.91 256.71 173.75 62.54 123.77 77 190.91 256.71 194.80 70.13 154.71 77 190.91 266.71 194.80 70.13 154.76 77 190.91 277.05 256.74 76.41 154.77 77 190.91 277.05 266.69 70.13 154.76 77.44 330.75 266.69< | - 1 | 45.56 | 100.34 | 68 | 142.62 | 197.62 | 145.54 | 52.39 | 115.39 |
| 107.39 70 148.97 205.41 152.01 54.72 111.09 71 163.70 217.55 161.00 54.72 114.03 72 163.70 217.55 161.00 56.31 114.03 72 163.70 224.815 161.00 56.31 114.03 73 163.30 221.55 167.50 64.98 127.57 75 176.89 240.26 180.50 64.38 132.10 76 163.77 236.33 187.52 67.50 132.11 77 190.10 $27.7.65$ 201.70 75.16 141.85 78 197.67 266.69 201.70 75.16 147.12 79 204.66 277.05 203.84 75.16 158.25 80 211.91 287.33 320.52 231.62 77.84 159.07 88 249.61 341.30 277.62 99.65 174.1 84 | | 46.24 | 103.80 | 69 | 144.75 | 199.59 | 147.70 | 53.17 | 119.37 |
| 111.09 71 153.30 211.38 156.43 56.31 114.93 72 157.78 217.55 161.00 57.96 114.93 72 157.78 217.55 161.00 57.96 127.57 75 176.89 240.26 187.52 66.24 123.210 76 183.77 232.44 173.75 62.54 136.77 77 190.91 256.71 194.80 70.13 136.77 77 190.91 256.71 194.80 70.13 136.77 76 183.77 228.35 187.52 67.50 136.77 77 190.91 287.50 231.61 70.13 141.85 78 17.12 231.62 231.81 83.46 152.58 81 294.66 231.31 83.46 94.62 152.58 81 294.33 216.23 231.81 83.46 169.07 $83.21.92$ | | 47.58 | 107.39 | 20 | 148.97 | 205.41 | 152.01 | 54.72 | 123.50 |
| 114.93 72 157.78 217.55 161.00 57.96 123.21 73 163.90 224.87 167.25 60.21 123.21 75 176.390 224.87 167.25 60.21 123.21 75 176.92 232.244 173.75 66.254 123.21 76 183.77 248.35 187.52 67.50 132.10 76 183.77 248.35 187.52 67.50 132.10 76 183.77 248.35 187.52 67.50 132.10 76 183.77 248.35 187.52 67.50 141.85 78 190.91 256.71 299.02 70.13 152.58 80 211.91 299.02 233.26 70.13 154.13 82 227.18 310.62 256.74 91.69 169.07 86 174.17 84 241.91 33.0.75 246.84 76.16 169.07 86 237.33 </td <td></td> <td>48.97</td> <td>111.09</td> <td>71</td> <td>153.30</td> <td>211.38</td> <td>156.43</td> <td>56.31</td> <td>127.76</td> | | 48.97 | 111.09 | 71 | 153.30 | 211.38 | 156.43 | 56.31 | 127.76 |
| 119.00 73 163.90 224.87 167.25 60.21 123.21 74 170.27 232.44 173.75 62.54 123.10 75 187.50 67.50 67.50 132.15 77 190.51 284.35 187.52 67.50 136.77 77 199.167 266.69 201.70 72.61 141.85 76 197.67 266.69 201.70 72.61 147.12 79 204.66 277.05 208.84 75.18 158.25 81 211.91 287.82 216.23 70.13 158.25 81 219.41 287.82 216.23 77.84 169.07 83 23.30.52 239.29 80.60 76.18 174.11 84 249.61 330.75 246.84 88.86 16 174.13 82 249.61 341.30 277.22 97.63 91.66 174.11 84 249.61 341.30 262.41 </td <td></td> <td>50.40</td> <td>114.93</td> <td>72</td> <td>157.78</td> <td>217.55</td> <td>161.00</td> <td>57.96</td> <td>132.17</td> | | 50.40 | 114.93 | 72 | 157.78 | 217.55 | 161.00 | 57.96 | 132.17 |
| 123.21 74 170.27 232.44 173.75 62.54 127.57 75 17689 240.26 180.50 64.98 136.77 77 183.77 248.35 187.52 67.50 136.77 77 19091 256.71 198.55 70.13 147.12 79 204.66 277.05 208.84 75.18 147.12 79 204.66 277.05 208.84 75.18 147.12 79 204.66 277.05 208.84 75.18 147.13 80 211.91 287.82 216.23 77.84 158.25 81 219.41 289.00 233.05 246.23 77.84 164.13 82 241.91 330.75 248.46 88.61 83.46 179.41 85 244.91 330.75 248.42 86.11 83.46 179.41 86 27.14 330.75 248.46 86.61 86.1 179.41 85 | | 52.36 | 119.00 | 73 | 163.90 | 224.87 | 167.25 | 60.21 | 136.86 |
| 127.57 75 176.89 240.26 180.50 64.98 135.77 77 190.91 256.71 194.80 70.13 135.77 77 190.91 256.71 194.80 70.13 141.85 78 197.67 248.35 187.52 67.50 64.98 141.85 78 197.67 266.69 201.70 72.61 70.13 147.12 79 20466 277.05 230.23 75.48 75.18 152.58 80 211.91 299000 223.89 80.60 70.13 158.26 81 219.41 299000 223.392 86.11 77.84 159.28 219.41 299000 223.392 86.61 70.13 179.14 85 241.91 330.75 246.84 83.86 174.17 84 219.43 330.65 237.25 239.21 91.63 179.41 191.36 276.64 | | 54.39 | 123.21 | 74 | 170.27 | 232.44 | 173.75 | 62.54 | 141.70 |
| 132.1076183.77248.35187.5267.50136.7777190.91256.71194.8070.13136.7777190.91256.71194.8070.13147.1279204.66277.05208.8475.18152.5880211.91287.82216.237784152.588121941299.00223.8980.60154.1382227.18310.62231.8186.11164.138223443330.75246.8488.66174.1784241.91330.75246.8488.66174.1784241.91330.75246.8488.66174.1784241.91330.75246.8494.62174.1784241.91330.75246.8494.62179.4185257.58352.19262.8494.62190.3887265.79363.42271.2297.63194.1986271.12370.69276.6599.59194.1986277.12373.33293.45101.58194.1987265.79365.41201.6597.63194.1988271.12370.69277.2297.63194.1986277.12393.38294.54101.56202.0490287.71393.38273.2397.63198.0789276.54378.11287.82103.61202.0490287.71393.38 <td< td=""><td></td><td>56.50</td><td>127.57</td><td>75</td><td>176.89</td><td>240.26</td><td>180.50</td><td>64.98</td><td>146.71</td></td<> | | 56.50 | 127.57 | 75 | 176.89 | 240.26 | 180.50 | 64.98 | 146.71 |
| 136.77 77 190.91 256.71 194.80 70.13 141.85 78 197.67 266.69 201.70 72.61 147.12 79 204.66 277.05 208.84 75.18 147.12 79 204.66 277.05 208.84 75.18 152.58 80 211.91 287.82 216.23 77.84 152.58 80 211.91 287.82 216.23 77.84 158.25 81 219.41 299.00 223.89 80.60 158.25 81 219.41 299.00 223.89 80.60 164.13 82 221.18 310.62 231.81 86.11 164.13 82 221.43 320.52 233.2921 83.66 179.41 84 241.91 330.755 246.84 88.61 179.41 84 249.13 330.755 246.84 88.61 179.41 86 277.12 370.69 276.65 99.59 190.38 87 257.58 353.42 271.22 97.63 190.38 87 257.54 378.11 282.18 101.56 190.38 87 257.54 370.69 277.22 97.63 190.38 87 257.54 370.69 277.22 97.63 102.00 88 271.12 370.69 277.22 97.63 202.04 90 287.71 333.38 223.28 107.61 202.04 < | | 58.70 | 132.10 | 76 | 183.77 | 248.35 | 187.52 | 67.50 | 151.91 |
| 141.85 78 197.67 266.69 201.70 72.61 147.12 79 204.66 277.05 208.84 75.18 152.58 80 211.91 287.82 216.23 77.84 152.58 81 219.41 299.00 223.89 80.60 164.13 82 211.91 287.82 216.23 77.84 164.13 82 219.41 299.00 223.89 80.60 164.13 82 227.18 310.62 231.81 83.46 164.13 82 227.18 310.62 231.81 83.46 169.07 83 223.43 320.52 239.21 86.11 174.17 84 241.30 254.71 91.69 179.41 85 246.64 34.30 256.71 91.69 179.18 87 241.30 254.71 91.69 76.3 190.38 87 257.58 352.19 262.84 94.62 | | 60.98 | 136.77 | 77 | 190.91 | 256.71 | 194.80 | 70.13 | 157.28 |
| 147.12 79 204.66 277.05 208.84 75.18 75.18 152.58 80 211.91 287.82 216.23 77.84 77.84 152.58 81 219.41 299.00 223.89 80.60 80.60 164.13 82 227.18 310.62 231.81 83.46 83.46 164.13 82 227.18 310.62 231.81 83.46 86.11 164.13 83 223.43 320.52 239.21 86.11 93.46 174.17 84 241.91 330.75 246.84 88.86 179.41 85 257.58 352.19 254.71 91.69 179.41 85 277.12 391.65 277.22 97.63 190.38 87 265.79 353.42 277.22 97.63 190.38 87 277.12 391.65 103.61 103.61 200.01 88 271.12 393.56 282.18 103.63 103.63 | | 63.15 | 141.85 | 78 | 197.67 | 266.69 | 201.70 | 72.61 | 163.13 |
| 152.58 80 211.91 287.82 216.23 77.84 158.25 81 219.41 299.00 223.89 80.60 164.13 82 227.18 310.62 231.81 83.46 164.13 82 227.18 310.62 231.81 83.46 164.13 83 234.43 320.52 239.21 86.11 174.17 84 241.91 330.75 246.84 88.86 174.17 84 241.91 330.75 246.84 88.86 179.41 85 249.61 341.30 254.71 91.69 190.38 87 257.58 355.19 265.79 363.42 271.22 190.38 87 256.79 363.42 271.22 91.69 94.62 190.38 87 265.79 363.42 271.22 91.69 94.62 190.38 87 265.74 378.11 282.18 101.58 91.63 190.419 88 | | 65.37 | 147.12 | 79 | 204.66 | 277.05 | 208.84 | 75.18 | 169.19 |
| 158.25 81 219.41 299.00 223.89 80.60 164.13 82 227.18 310.62 231.81 83.46 164.13 82 227.18 310.62 231.81 83.46 169.07 83 234.43 320.52 239.21 86.11 174.17 84 241.91 330.75 246.84 88.86 174.17 84 241.91 330.75 246.84 88.86 179.41 85 249.61 341.30 254.71 91.69 179.41 85 271.12 341.30 252.84 94.62 190.38 87 265.79 363.42 271.22 97.63 190.38 87 265.4 378.11 282.18 101.58 190.38 276.54 378.11 282.18 101.66 202.04 90 287.71 393.36 103.61 206.08 91 287.65 97.63 103.61 206.08 91 | | 67.69 | 152.58 | 80 | 211.91 | 287.82 | 216.23 | 77.84 | 175.47 |
| 164.13 82 227.18 310.62 231.81 83.46 169.07 83 234.43 320.52 239.21 86.11 174.17 84 241.91 330.75 246.84 88.86 174.17 84 241.91 330.75 246.84 88.86 174.17 84 241.91 330.75 246.84 88.86 179.41 85 249.61 341.30 254.71 91.69 190.38 87 257.58 352.19 262.84 94.62 190.38 87 256.79 363.42 271.22 97.63 190.38 87 256.79 363.42 271.22 97.63 190.38 87 256.79 363.42 271.22 97.63 190.38 87 256.79 363.42 271.22 97.63 190.39 87 276.54 376.55 103.61 103.61 202.04 90 282.06 385.67 287.82 103.61 <td></td> <td>70.09</td> <td>158.25</td> <td>81</td> <td>219.41</td> <td>299.00</td> <td>223.89</td> <td>80.60</td> <td>181.98</td> | | 70.09 | 158.25 | 81 | 219.41 | 299.00 | 223.89 | 80.60 | 181.98 |
| 169.07 83 234.43 320.52 239.21 86.11 174.17 84 241.91 330.75 246.84 88.86 174.17 84 241.91 330.75 246.84 88.86 179.41 85 249.61 341.30 254.71 91.69 179.41 85 257.58 352.19 265.79 36.3.42 94.62 190.38 87 265.79 363.42 271.22 97.63 97.63 190.38 87 265.79 363.42 271.22 97.63 97.63 190.38 87 257.53 355.19 265.79 36.3.42 91.63 190.03 88 271.12 370.69 271.22 97.63 202.04 90 287.71 393.33 293.58 101.56 210.20 92 287.61 383.67 287.82 103.61 210.441 93 287.13 411.45 311.55 107.81 210.20 92< | | 72.56 | 164.13 | 82 | 227.18 | 310.62 | 231.81 | 83.46 | 188.74 |
| 174.17 84 241.91 330.75 246.84 88.86 179.41 85 249.61 341.30 254.71 91.69 179.41 85 249.61 341.30 254.71 91.69 184.81 86 257.58 352.19 265.79 363.42 271.22 97.63 190.38 87 265.79 363.42 271.22 97.63 94.62 190.38 87 265.79 353.42 271.22 97.63 97.63 198.07 89 276.54 378.11 287.13 91.65 99.59 202.04 90 282.06 383.567 287.82 103.61 202.04 91 237.12 393.38 293.58 105.69 210.20 92 233.47 401.25 287.82 107.81 210.20 92 299.45 107.81 105.69 214.41 93 205.31 417.45 311.55 112.16 214.41 93 </td <td></td> <td>74.88</td> <td>169.07</td> <td>83</td> <td>234.43</td> <td>320.52</td> <td>239.21</td> <td>86.11</td> <td>194.43</td> | | 74.88 | 169.07 | 83 | 234.43 | 320.52 | 239.21 | 86.11 | 194.43 |
| 179,41 85 249.61 341.30 254.71 91.69 184.81 86 257.58 352.19 265.79 355.19 265.84 94.62 190.38 87 265.79 363.42 271.22 97.63 97.63 190.38 87 265.79 363.42 271.22 97.63 97.63 190.38 87 275.54 378.11 287.82 101.58 97.63 198.07 89 276.54 378.11 282.18 101.58 97.63 202.04 90 282.06 385.67 287.82 103.61 97.65 200.08 91 287.71 393.38 293.58 105.69 97.65 210.20 92 293.47 401.25 287.82 107.81 97.81 210.20 92 293.47 401.25 299.45 107.81 97.81 214.41 93 305.31 417.45 311.55 112.16 223.61.3 223.61.3 223.61.3 | | 77.27 | 174.17 | 84 | 241.91 | 330.75 | 246.84 | 88.86 | 200.29 |
| 184.81 86 257.58 352.19 262.84 94.62 190.38 87 265.79 363.42 271.22 97.63 190.38 87 265.79 363.42 271.22 97.63 190.38 87 265.79 363.42 271.22 97.63 194.19 88 271.12 370.69 276.65 99.59 198.07 89 276.54 378.11 282.18 101.58 202.04 90 282.06 385.67 287.82 103.61 202.04 90 287.71 393.38 293.58 105.69 202.04 91 287.71 393.38 293.58 105.69 201.20 92 293.47 401.25 287.82 107.81 214.41 93 274.41 93.56 107.81 214.41 93 205.31 417.45 311.55 112.16 214.41 93 305.41 317.65 112.16 223.23 <tr< td=""><td></td><td>79.73</td><td>179.41</td><td>85</td><td>249.61</td><td>341.30</td><td>254.71</td><td>91.69</td><td>206.32</td></tr<> | | 79.73 | 179.41 | 85 | 249.61 | 341.30 | 254.71 | 91.69 | 206.32 |
| 190.38 87 265.79 363.42 271.22 97.63 97.63 194.19 88 271.12 370.69 276.65 99.59 97.63 194.19 88 271.12 370.69 276.65 99.59 95.9 198.07 89 276.54 378.11 282.18 101.58 90.59 202.04 90 282.06 385.67 287.82 103.61 103.61 202.04 90 287.71 393.38 293.58 105.69 103.61 202.04 91 287.71 393.38 293.58 105.69 103.61 202.04 92 287.71 393.38 293.58 105.69 107.81 214.41 93 287.71 393.38 293.58 107.81 107.81 214.41 93 274.00 317.65 417.45 311.55 112.16 223.07 95 311.43 425.81 317.78 114.41 223.08 97 <t< td=""><td></td><td>82.28</td><td>184.81</td><td>86</td><td>257.58</td><td>352.19</td><td>262.84</td><td>94.62</td><td>212.54</td></t<> | | 82.28 | 184.81 | 86 | 257.58 | 352.19 | 262.84 | 94.62 | 212.54 |
| 194.19 88 271.12 370.69 276.65 99.59 198.07 89 276.54 378.11 282.18 101.58 202.04 90 282.06 385.67 287.82 103.61 202.03 91 287.71 393.38 293.58 105.69 206.08 91 287.71 393.38 293.58 105.69 210.20 92 293.47 401.25 299.45 107.81 214.41 93 299.34 409.27 305.44 109.96 214.41 93 205.31 417.45 311.55 112.16 218.69 94 305.31 417.45 311.55 112.16 223.07 95 311.43 425.81 317.78 114.41 223.08 97 324.03 332.4.13 116.69 236.72 98 330.61 119.02 234.13 116.69 236.72 98 330.49 451.87 337.23 121.40 | | 84.90 | 190.38 | 87 | 265.79 | 363.42 | 271.22 | 97.63 | 218.94 |
| 198.07 89 276.54 378.11 282.18 101.58 202.04 90 282.06 385.67 287.82 103.61 206.08 91 287.71 393.38 293.58 105.69 210.20 92 293.47 401.25 299.45 107.81 214.41 93 299.34 409.27 305.44 109.96 218.69 94 305.31 417.45 311.55 112.16 218.69 94 305.31 417.45 311.55 112.16 223.07 95 311.43 425.81 317.78 114.41 223.08 97 324.00 443.01 330.61 119.02 236.72 98 330.49 451.87 337.23 121.40 241.45 99+ 337.09 460.91 343.37 123.83 | | 86.61 | 194.19 | 88 | 271.12 | 370.69 | 276.65 | 99.59 | 223.32 |
| 202.04 90 282.06 385.67 287.82 103.61 206.08 91 287.71 393.38 293.58 105.69 210.20 92 293.47 401.25 299.45 107.81 214.41 93 299.34 409.27 305.44 109.96 218.69 94 305.31 417.45 311.55 112.16 218.69 94 305.31 417.45 311.55 112.16 218.69 94 305.31 417.45 317.58 114.41 223.07 95 311.43 425.81 317.78 114.41 223.08 97 324.00 443.01 330.61 114.41 236.72 98 330.49 451.87 337.23 121.40 241.45 99+ 337.09 460.91 343.97 123.83 | | 88.33 | 198.07 | 89 | 276.54 | 378.11 | 282.18 | 101.58 | 227.78 |
| 206.08 91 287.71 393.38 293.58 105.69 210.20 92 293.47 401.25 299.45 107.81 211.41 93 299.34 409.27 305.44 109.96 218.69 94 305.31 417.45 311.55 112.16 223.07 95 311.43 425.81 317.78 114.41 223.08 97 324.00 443.01 330.61 114.41 236.72 98 330.49 451.87 337.23 116.69 236.72 98 330.49 451.87 337.23 121.40 241.45 99+ 337.09 460.91 343.97 123.83 | | 90.10 | 202.04 | 06 | 282.06 | 385.67 | 287.82 | 103.61 | 232.34 |
| 210.20 92 293.47 401.25 299.45 107.81 214.41 93 299.34 409.27 305.44 109.96 218.69 94 305.31 417.45 311.55 112.16 223.07 95 311.43 425.81 317.78 114.41 223.08 97 324.00 443.01 330.61 119.02 235.72 98 330.49 451.87 337.23 116.69 236.72 98 330.49 451.87 337.23 121.40 241.45 99+ 337.09 460.91 343.97 123.83 | | 91.90 | 206.08 | 91 | 287.71 | 393.38 | 293.58 | 105.69 | 236.99 |
| 214.41 93 299.34 409.27 305.44 109.96 218.69 94 305.31 417.45 311.55 112.16 223.07 95 311.43 425.81 317.78 114.41 227.53 96 317.65 434.33 324.13 116.69 232.08 97 324.00 443.01 330.61 119.02 236.72 98 330.49 451.87 337.23 121.40 241.45 99+ 337.09 460.91 343.97 123.83 | | 93.74 | 210.20 | 92 | 293.47 | 401.25 | 299.45 | 107.81 | 241.73 |
| 218.69 94 305.31 417.45 311.55 112.16 223.07 95 311.43 425.81 317.78 114.41 227.53 96 317.65 434.33 324.13 116.69 227.53 96 317.65 434.33 324.13 116.69 232.08 97 324.00 443.01 330.61 119.02 236.72 98 330.49 451.87 337.23 121.40 241.45 99+ 337.09 460.91 343.97 123.83 | | 95.61 | 214.41 | 93 | 299.34 | 409.27 | 305.44 | 109.96 | 246.56 |
| 223.07 95 311.43 425.81 317.78 114.41 227.53 96 317.65 434.33 324.13 116.69 227.53 96 317.65 434.33 324.13 116.69 232.08 97 324.00 443.01 330.61 119.02 236.72 98 330.49 451.87 337.23 121.40 241.45 99+ 337.09 460.91 343.97 123.83 | | 97.53 | 218.69 | 94 | 305.31 | 417.45 | 311.55 | 112.16 | 251.50 |
| 227.53 96 317.65 434.33 324.13 116.69 232.08 97 324.00 443.01 330.61 119.02 236.72 98 330.49 451.87 337.23 121.40 236.12 99+ 337.09 460.91 343.97 123.83 | | 99.48 | 223.07 | 95 | 311.43 | 425.81 | 317.78 | 114.41 | 256.52 |
| 232.08 97 324.00 443.01 330.61 119.02 236.72 98 330.49 451.87 337.23 121.40 241.45 99+ 337.09 460.91 343.97 123.83 | | 101.47 | 227.53 | 96 | 317.65 | 434.33 | 324.13 | 116.69 | 261.65 |
| 236.72 98 330.49 451.87 337.23 121.40 241.45 99+ 337.09 460.91 343.97 123.83 | | 103.49 | 232.08 | 97 | 324.00 | 443.01 | 330.61 | 119.02 | 266.89 |
| 241.45 99+ 337.09 460.91 343.97 123.83 | | 105.57 | 236.72 | 98 | 330.49 | 451.87 | 337.23 | 121.40 | 272.23 |
| | | 107.68 | 241.45 | +66 | 337.09 | 460.91 | 343.97 | 123.83 | 277.67 |

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

TX MOO AGY 001

| | , 784, 793-794 |
|-----------------------|--|
| | , 782 |
| MS* | 779 |
| PREMIU | 776-777, |
| 000 | 774, |
| / NON-TOBACCO PREMIUI | 8, 760-761, 774, 776-777, 779, 782, ⁻ |
| ILY NON | 4, 757-758, |
| MONTH | : 733, 750-754, |
| | ES: 733, |
| | ZIP CODES |

| | | Plan N | CCIN | | 104.50 | 4.50 | 104.50 | 108.11 | 111.84 | 115.71 | 119.71 | 123.83 | 128.22 | 132.76 | 137.46 | 142.33 | 147.36 | 152.84 | 158.52 | 164.40 | 170.50 | 176.84 | 182.17 | 187.66 | 193.31 | 9.13 | 205.13 | 209.24 | 213.42 | 217.69 | 222.04 | 6.49 | 231.01 | 235.63 | 240.34 | 245.15 | 250.05 | 255.06 | 0.15 |
|---------------------------------------|--------|-------------|---------|---------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|------------|--------|--------|--------|--------|--------|--------|--------|--------|-------|
| | | | IW | | 10 | 10 | 10 | 10 | 11 | 11 | 1 | 12 | 12 | 13 | 13 | 14 | 14 | 15 | 15 | 16 | 17 | 17 | 18 | 18 | 19 | 19 | 20 | 20 | 21 | 21 | 22 | 22 | 23 | 23 | 24 | 24 | 25 | 25 | C |
| | | Plan High G | OCININ | | 48.37 | 48.37 | 48.37 | 49.08 | 49.82 | 51.27 | 52.76 | 54.30 | 56.41 | 58.60 | 60.88 | 63.25 | 65.71 | 68.03 | 70.44 | 72.93 | 75.51 | 78.19 | 80.68 | 83.26 | 85.91 | 88.65 | 91.48 | 93.31 | 95.18 | 97.08 | 99.02 | 101.01 | 103.02 | 105.08 | 107.19 | 109.33 | 111.51 | 113.75 | |
| | MALE | Plan G | CZININI | | 134.35 | 134.35 | 134.35 | 136.36 | 138.39 | 142.42 | 146.56 | 150.84 | 156.70 | 162.79 | 169.11 | 175.69 | 182.52 | 188.98 | 195.66 | 202.60 | 209.77 | 217.19 | 224.12 | 231.27 | 238.64 | 246.26 | 254.11 | 259.20 | 264.38 | 269.67 | 275.06 | 280.57 | 286.18 | 291.90 | 297.74 | 303.69 | 309.76 | 315.96 | |
| 1.001 (101) 1001 | | Plan F | | | 183.33 | 183.33 | 183.33 | 185.15 | 187.00 | 192.45 | 198.05 | 203.82 | 210.69 | 217.78 | 225.10 | 232.68 | 240.52 | 249.86 | 259.57 | 269.66 | 280.14 | 291.03 | 300.30 | 309.89 | 319.77 | 329.97 | 340.49 | 347.31 | 354.26 | 361.34 | 368.56 | 375.94 | 383.46 | 391.12 | 398.95 | 406.93 | 415.06 | 423.37 | 00101 |
| · · · · · · · · · · · · · · · · · · · | | Plan A | | 658.34 | 131.67 | 131.67 | 131.67 | 133.63 | 135.62 | 139.57 | 143.63 | 147.82 | 153.56 | 159.53 | 165.73 | 172.17 | 178.87 | 185.20 | 191.75 | 198.55 | 205.57 | 212.85 | 219.64 | 226.65 | 233.87 | 241.33 | 249.03 | 254.02 | 259.10 | 264.27 | 269.56 | 274.96 | 280.45 | 286.06 | 291.79 | 297.62 | 303.56 | 309.64 | |
| | | Attained | Age | Thru 64 | 65 | 66 | 67 | 68 | 69 | 20 | 71 | 72 | 73 | 74 | 75 | 76 | 77 | 78 | 62 | 80 | 81 | 82 | 83 | 84 | 85 | 86 | 87 | 88 | 89 | 0 6 | 91 | 92 | 93 | 94 | 95 | 96 | 97 | 98 | |
| | | Plan N | CCININ | | 90.87 | 90.87 | 90.87 | 94.01 | 97.26 | 100.62 | 104.09 | 107.68 | 111.50 | 115.44 | 119.53 | 123.76 | 128.15 | 132.90 | 137.84 | 142.96 | 148.27 | 153.78 | 158.40 | 163.18 | 168.09 | 173.16 | 178.37 | 181.94 | 185.58 | 189.30 | 193.08 | 196.94 | 200.88 | 204.90 | 209.00 | 213.18 | 217.44 | 221.79 | |
| 000 FO. 100, 1 | | Plan High G | OCININ | | 42.06 | 42.06 | 42.06 | 42.69 | 43.32 | 44.58 | 45.88 | 47.22 | 49.06 | 50.96 | 52.94 | 54.99 | 57.13 | 59.16 | 61.25 | 63.42 | 65.67 | 67.99 | 70.16 | 72.39 | 74.71 | 77.09 | 79.55 | 81.14 | 82.76 | 84.42 | 86.10 | 87.83 | 89.58 | 91.37 | 93.21 | 95.07 | 96.97 | 98.91 | |
| | FEMALE | Plan G | CZININ | | 116.83 | 116.83 | 116.83 | 118.57 | 120.34 | 123.84 | 127.45 | 131.16 | 136.26 | 141.56 | 147.06 | 152.77 | 158.71 | 164.33 | 170.15 | 176.16 | 182.41 | 188.86 | 194.89 | 201.10 | 207.51 | 214.14 | 220.97 | 225.39 | 229.90 | 234.49 | 239.18 | 243.96 | 248.85 | 253.82 | 258.90 | 264.08 | 269.36 | 274.74 | |
| | | Plan F | | | 159.42 | 159.42 | 159.42 | 161.01 | 162.61 | 167.35 | 172.23 | 177.24 | 183.21 | 189.37 | 195.75 | 202.33 | 209.14 | 217.27 | 225.72 | 234.48 | 243.60 | 253.06 | 261.13 | 269.46 | 278.06 | 286.93 | 296.08 | 302.01 | 308.04 | 314.21 | 320.49 | 326.90 | 333.44 | 340.11 | 346.91 | 353.85 | 360.92 | 368.14 | |
| | | Plan A | | 5/2.48 | 114.50 | 114.50 | 114.50 | 116.20 | 117.93 | 121.37 | 124.90 | 128.54 | 133.53 | 138.73 | 144.12 | 149.72 | 155.54 | 161.05 | 166.74 | 172.64 | 178.76 | 185.08 | 190.99 | 197.08 | 203.36 | 209.86 | 216.55 | 220.88 | 225.30 | 229.80 | 234.40 | 239.09 | 243.87 | 248.75 | 253.73 | 258.80 | 263.97 | 269.25 | |

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

TX MOO AGY 001

| | 82, 784, 793-794 |
|---------------------------|---|
| MONTHLY TOBACCO PREMIUMS* | 2. CODES: 733, 750-754, 757-758, 760-761, 774, 776-777, 779, 782, 784 |
| | ZIP C |

| | | n N 35 | | 120.12 | .12 | .12 | .26 | .56 | 00 | .59 | .34 | .38 | .60 | 00. | .59 | .38 | .68 | .20 | .96 | .98 | .26 | .39 | .70 | .20 | .89 | .78 | .50 | .30 | .21 | .22 | .33 | .53 | .84 | .25 | .78 | .41 | .17 | 03 |
|-------------------------|-------|---------------------|---------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|---------|--------|---------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|
| | | Plan N MM35 | | 120 | 120.12 | 120.12 | 124.26 | 128.56 | 133.00 | 137.59 | 142.34 | 147.38 | 152.60 | 158.00 | 163 | 169.38 | 175 | 182.20 | 188.96 | 195.98 | 203 | 209.39 | 215 | 222.20 | 228.89 | 235.78 | 240.50 | 245.30 | 250.21 | 255 | 260 | 265.53 | 270.84 | 276.25 | 281.78 | 287.41 | 293.17 | 200 |
| | | Plan High G MM36 | | 55.60 | 55.60 | 55.60 | 56.42 | 57.26 | 58.93 | 60.64 | 62.42 | 64.84 | 67.36 | 39.98 | 72.70 | 75.53 | 78.19 | 30.97 | 33.83 | 86.80 | 89.88 | 92.74 | 95.70 | 98.75 | 101.90 | 105.14 | 107.25 | 109.40 | 111.58 | 113.82 | 116.10 | 118.41 | 120.79 | 123.21 | 125.67 | 128.17 | 130.74 | 33 36 |
| | | Plan | | 4, | 4, | 4 | 4, | 4, | 4, | | | 9 | | 9 | | 2 | | | <u></u> | | | | | 0, | - | - | - | - | - | - | 1 | 1 | - | 1 | - | 1 | - | ~ |
| MALE | IMALE | Plan G MM25 | | 154.43 | 154.43 | 154.43 | 156.73 | 159.06 | 163.70 | 168.46 | 173.38 | 180.11 | 187.11 | 194.38 | 201.94 | 209.79 | 217.22 | 224.90 | 232.87 | 241.11 | 249.65 | 257.61 | 265.83 | 274.30 | 283.05 | 292.08 | 297.93 | 303.89 | 309.96 | 316.16 | 322.49 | 328.94 | 335.51 | 342.23 | 349.07 | 356.04 | 363.17 | 370.43 |
| 1-001 (101) | - | Plan F MM24 | | 210.72 | 210.72 | 210.72 | 212.82 | 214.94 | 221.21 | 227.64 | 234.28 | 242.17 | 250.32 | 258.74 | 267.45 | 276.46 | 287.20 | 298.36 | 309.95 | 322.00 | 334.51 | 345.18 | 356.19 | 367.55 | 379.28 | 391.37 | 399.20 | 407.19 | 415.33 | 423.63 | 432.11 | 440.76 | 449.57 | 458.56 | 467.73 | 477.08 | 486.63 | 106 26 |
| 110,102 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| · · · · · · · · · · · · | | Plan A MM20 | 756.71 | 151.34 | 151.34 | 151.34 | 153.60 | 155.88 | 160.43 | 165.09 | 169.91 | 176.51 | 183.37 | 190.49 | 197.90 | 205.59 | 212.88 | 220.40 | 228.21 | 236.29 | 244.66 | 252.46 | 260.51 | 268.81 | 277.39 | 286.24 | 291.97 | 297.81 | 303.76 | 309.84 | 316.04 | 322.36 | 328.80 | 335.39 | 342.09 | 348.92 | 355.91 | 262 00 |
| | | Attained Age | Thru 64 | 65 | 66 | 67 | 68 | 69 | 70 | 71 | 72 | 73 | 74 | 75 | 76 | 77 | 78 | 19 | 80 | 81 | 82 | 83 | 84 | 85 | 86 | 87 | 88 | 89 | 06 | 91 | 92 | 93 | 94 | 95 | 96 | 97 | 86 | - 00 |
| | | Plan N MM35 | | 104.45 | 104.45 | 104.45 | 108.06 | 111.79 | 115.65 | 119.64 | 123.77 | 128.16 | 132.69 | 137.39 | 142.26 | 147.29 | 152.76 | 158.44 | 164.32 | 170.42 | 176.75 | 182.07 | 187.56 | 193.21 | 199.03 | 205.03 | 209.13 | 213.31 | 217.58 | 221.93 | 226.37 | 230.90 | 235.51 | 240.23 | 245.03 | 249.93 | 254.93 | |
| | | Plan High G MM36 | | 8.34 | 8.34 | 48.34 | 49.07 | 9.79 | 1.24 | 2.73 | 4.27 | 6.39 | 58.58 | 0.85 | 3.21 | 5.67 | 8.00 | 70.40 | 2.89 | 75.48 | 8.15 | 0.64 | 3.21 | 5.87 | 88.61 | 91.43 | 93.27 | 5.13 | 97.03 | 98.97 | 0.95 | 102.97 | 105.03 | 107.13 | 19.27 | 111.46 | 113.69 | 115 00 |
| | | Plan M | | 4 | 4 | 4 | 4 | 4 | 5 | 5 | 2 | 5 | 2 | 9 | 9 | 9 | 9 | 7 | 7 | 7 | 7 | 8 | 8 | 00 | 8 | 6 | 6 | 6 | 6 | 6 | 1(| 1(| 1(| 1(| 1(| , | ÷ | - |
| EEMAI E | | Plan G MM25 | | 134.29 | 134.29 | 134.29 | 136.29 | 138.32 | 142.35 | 146.49 | 150.76 | 156.62 | 162.71 | 169.03 | 175.60 | 182.43 | 188.89 | 195.57 | 202.49 | 209.66 | 217.08 | 224.01 | 231.15 | 238.52 | 246.14 | 253.99 | 259.06 | 264.25 | 269.53 | 274.92 | 280.42 | 286.03 | 291.75 | 297.59 | 303.54 | 309.61 | 315.80 | 200 10 |
| | - | Plan F MM24 | | 183.24 | 33.24 | 183.24 | 185.06 | 36.91 | 92.35 | 7.96 | 203.72 | 0.58 | 217.67 | 25.00 | 32.56 | t0.39 | 19.73 | 59.45 | 39.52 | 280.00 | 90.87 | 0.15 | 9.73 | 19.61 | 329.81 | 10.33 | 347.14 | 354.07 | 361.16 | 368.38 | 75.75 | 383.26 | 390.93 | 98.74 | 406.72 | 414.85 | 423.15 | 121 61 |
| | | <u> </u> | | 18 | 15 | 18 | 15 | 18 | 15 | 19 | 2(| 21 | 21 | 22 | 23 | 24 | 24 | 25 | 26 | 28 | 26 | 30 | 30 | 3, | 32 | 34 | 34 | 36 | 36 | 36 | 37 | 36 | 36 | 36 | 40 | 41 | 42 | 01 |
| | | Plan A MM20 | 658.02 | 131.60 | 31.60 | 131.60 | 33.56 | 35.55 | 39.50 | 143.56 | 47.75 | 153.49 | 159.46 | 165.65 | 72.09 | 178.78 | 85.11 | 191.66 | 198.44 | 05.47 | 12.74 | 19.53 | 26.53 | 33.75 | 241.22 | 48.91 | 53.88 | 58.97 | 264.14 | 59.42 | 74.81 | 30.31 | 285.92 | 91.64 | 297.47 | 303.42 | 309.48 | 15 68 |

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

TX MOO AGY 001

| | Blan N | MM35 | | 129.03 | 129.03 | 129.03 | 133.48 | 138.09 | 142.86 | 147.80 | 152.89 | 158.32 | 163.92 | 169.72 | 175.73 | 181.95 | 188.71 | 195.72 | 202.98 | 210.52 | 218.34 | 224.92 | 231.70 | 238.68 | 245.87 | 253.27 | 258.34 | 263.50 | 268.78 | 274.15 | 279.64 | 285.23 | 290.93 | 296.75 | 302.68 | 308.74 | 314.92 | |
|-------------------------|-------------|-------------|---------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|--------|------------|--------|--------|--------|--------|--------|--------|--------|--------|--|
| | Plan High G | MM36 | | 59.72 | 59.72 | 59.72 | 60.60 | 61.51 | 63.30 | 65.14 | 67.05 | 69.65 | 72.35 | 75.17 | 78.09 | 81.13 | 84.00 | 86.97 | 90.05 | 93.24 | 96.54 | 99.62 | 102.80 | 106.07 | 109.46 | 112.94 | 115.21 | 117.51 | 119.86 | 122.26 | 124.71 | 127.20 | 129.75 | 132.35 | 134.99 | 137.68 | 140.44 | |
| MALE | Plan G | MM25 | | 165.88 | 165.88 | 165.88 | 168.36 | 170.86 | 175.84 | 180.96 | 186.24 | 193.48 | 200.99 | 208.80 | 216.92 | 225.35 | 233.33 | 241.58 | 250.14 | 259.00 | 268.16 | 276.72 | 285.55 | 294.65 | 304.05 | 313.75 | 320.03 | 326.43 | 332.96 | 339.61 | 346.41 | 353.34 | 360.40 | 367.61 | 374.96 | 382.46 | 390.11 | |
| | Plan F | MM24 | | 226.35 | 226.35 | 226.35 | 228.60 | 230.89 | 237.62 | 244.53 | 251.66 | 260.13 | 268.89 | 277.93 | 287.29 | 296.97 | 308.50 | 320.49 | 332.95 | 345.89 | 359.33 | 370.78 | 382.61 | 394.82 | 407.42 | 420.41 | 428.82 | 437.40 | 446.15 | 455.06 | 464.17 | 473.45 | 482.92 | 492.58 | 502.43 | 512.48 | 522.73 | |
| 3, 775 | Plan A | MM20 | 812.84 | 162.57 | 162.57 | 162.57 | 164.99 | 167.44 | 172.33 | 177.34 | 182.52 | 189.60 | 196.97 | 204.62 | 212.58 | 220.85 | 228.67 | 236.75 | 245.14 | 253.82 | 262.81 | 271.19 | 279.84 | 288.76 | 297.97 | 307.47 | 313.63 | 319.91 | 326.30 | 332.82 | 339.49 | 346.28 | 353.19 | 360.27 | 367.47 | 374.80 | 382.31 | |
| ZIP CODES: 770-773, 775 | Attained | Age | Thru 64 | 65 | 66 | 67 | 68 | 69 | 70 | 71 | 72 | 73 | 74 | 75 | 76 | 77 | 78 | 79 | 80 | 81 | 82 | 83 | 84 | 85 | 86 | 87 | 88 | 89 | 0 6 | 91 | 92 | 93 | 94 | 95 | 96 | 97 | 98 | |
| ZIP (| Plan N | MM35 | | 112.20 | 112.20 | 112.20 | 116.07 | 120.08 | 124.23 | 128.51 | 132.96 | 137.66 | 142.54 | 147.58 | 152.81 | 158.22 | 164.10 | 170.19 | 176.51 | 183.07 | 189.87 | 195.58 | 201.48 | 207.54 | 213.79 | 220.24 | 224.65 | 229.13 | 233.72 | 238.39 | 243.16 | 248.03 | 252.99 | 258.05 | 263.21 | 268.47 | 273.84 | |
| | Plan High G | MM36 | | 51.93 | 51.93 | 51.93 | 52.71 | 53.49 | 55.05 | 56.65 | 58.30 | 60.57 | 62.92 | 65.36 | 67.90 | 70.54 | 73.05 | 75.63 | 78.30 | 81.08 | 83.94 | 86.63 | 89.38 | 92.24 | 95.19 | 98.22 | 100.19 | 102.19 | 104.23 | 106.31 | 108.44 | 110.61 | 112.82 | 115.08 | 117.38 | 119.72 | 122.12 | |
| FEMALE | Plan G | MM25 | | 144.25 | 144.25 | 144.25 | 146.40 | 148.58 | 152.91 | 157.36 | 161.95 | 168.24 | 174.78 | 181.57 | 188.62 | 195.96 | 202.90 | 210.08 | 217.51 | 225.22 | 233.18 | 240.63 | 248.30 | 256.22 | 264.40 | 272.83 | 278.28 | 283.85 | 289.52 | 295.31 | 301.22 | 307.25 | 313.39 | 319.66 | 326.05 | 332.58 | 339.22 | |
| | Plan F | MM24 | | 196.83 | 196.83 | 196.83 | 198.79 | 200.77 | 206.62 | 212.65 | 218.84 | 226.20 | 233.82 | 241.69 | 249.82 | 258.23 | 268.26 | 278.69 | 289.51 | 300.77 | 312.45 | 322.42 | 332.71 | 343.32 | 354.28 | 365.57 | 372.89 | 380.34 | 387.95 | 395.71 | 403.63 | 411.69 | 419.93 | 428.32 | 436.89 | 445.63 | 454.55 | |
| | Plan A | MM20 | 706.84 | 141.37 | 141.37 | 141.37 | 143.47 | 145.61 | 149.85 | 154.21 | 158.71 | 164.87 | 171.29 | 177.94 | 184.85 | 192.04 | 198.84 | 205.88 | 213.16 | 220.71 | 228.52 | 235.82 | 243.33 | 251.09 | 259.11 | 267.38 | 272.71 | 278.18 | 283.73 | 289.41 | 295.20 | 301.10 | 307.13 | 313.27 | 319.54 | 325.93 | 332.44 | |

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

| | FEMALE | | | | | | MALE | | |
|----------------------------|--------------------|---------------------|----------------|-----------------|----------------|----------------|----------------|---------------------|----------------|
| Plan A Plan F MM20 MM24 | F Plan G 4 MM25 | Plan High G MM36 | Plan N MM35 | Attained Age | Plan A MM20 | Plan F MM24 | Plan G MM25 | Plan High G MM36 | Plan N MM35 |
| | - | | | Thru 64 | 934.30 | | | | |
| | | 59.69 | 128.96 | 65 | 186.86 | 260.17 | 190.67 | 68.64 | 148.31 |
| | | 59.69 | 128.96 | 66 | 186.86 | 260.17 | 190.67 | 68.64 | 148.31 |
| 162.49 226.25 | | 59.69 | 128.96 | 67 | 186.86 | 260.17 | 190.67 | 68.64 | 148.31 |
| | | 60.59 | 133.42 | 68 | 189.64 | 262.76 | 193.52 | 69.66 | 153.43 |
| | | 61.48 | 138.03 | 69 | 192.46 | 265.39 | 196.40 | 70.70 | 158.73 |
| | | 63.27 | 142.79 | 20 | 198.08 | 273.12 | 202.12 | 72.76 | 164.21 |
| | | 65.11 | 147.72 | 71 | 203.84 | 281.07 | 208.00 | 74.88 | 169.88 |
| | | 67.01 | 152.82 | 72 | 209.79 | 289.26 | 214.07 | 77.07 | 175.74 |
| | | 69.62 | 158.23 | 73 | 217.93 | 299.00 | 222.39 | 80.05 | 181.97 |
| 196.88 268.75 | | 72.32 | 163.83 | 74 | 226.40 | 309.07 | 231.03 | 83.16 | 188.41 |
| | | 75.13 | 169.63 | 75 | 235.20 | 319.46 | 240.00 | 86.41 | 195.08 |
| | | 78.05 | 175.64 | 76 | 244.35 | 330.22 | 249.33 | 89.76 | 201.99 |
| | | 81.08 | 181.86 | 77 | 253.85 | 341.34 | 259.03 | 93.26 | 209.14 |
| | | 83.96 | 188.62 | 78 | 262.84 | 354.60 | 268.20 | 96.55 | 216.91 |
| 34 320.34 | | 86.93 | 195.62 | 79 | 272.13 | 368.38 | 277.68 | 99.97 | 224.96 |
| | | 00.00 | 202.88 | 80 | 281.77 | 382.70 | 287.52 | 103.50 | 233.31 |
| | | 93.19 | 210.42 | 81 | 291.74 | 397.57 | 297.70 | 107.17 | 241.98 |
| | | 96.49 | 218.24 | 82 | 302.08 | 413.02 | 308.24 | 110.97 | 250.97 |
| | | 99.57 | 224.81 | 83 | 311.71 | 426.19 | 318.07 | 114.50 | 258.53 |
| | | 102.74 | 231.58 | 84 | 321.65 | 439.79 | 328.21 | 118.16 | 266.32 |
| | | 106.02 | 238.55 | 85 | 331.90 | 453.81 | 338.68 | 121.92 | 274.34 |
| | | 109.41 | 245.74 | 86 | 342.49 | 468.29 | 349.48 | 125.82 | 282.61 |
| 33 420.20 | | 112.89 | 253.14 | 87 | 353.42 | 483.23 | 360.63 | 129.82 | 291.11 |
| | | 115.16 | 258.21 | 88 | 360.50 | 492.89 | 367.85 | 132.42 | 296.95 |
| | 17 326.26 | 117.46 | 263.37 | 89 | 367.71 | 502.76 | 375.21 | 135.07 | 302.88 |
| | | 119.80 | 268.64 | 0 0 | 375.05 | 512.81 | 382.71 | 137.77 | 308.94 |
| | | 122.20 | 274.02 | 91 | 382.55 | 523.06 | 390.36 | 140.53 | 315.12 |
| 31 463.94 | | 124.64 | 279.50 | 92 | 390.21 | 533.53 | 398.18 | 143.35 | 321.42 |
| | | 127.14 | 285.09 | 93 | 398.02 | 544.20 | 406.14 | 146.20 | 327.85 |
| 353.02 482.68 | 360.22 | 129.68 | 290.79 | 94 | 405.97 | 555.08 | 414.26 | 149.13 | 334.41 |
| | | 132.28 | 296.61 | 95 | 414.10 | 566.18 | 422.54 | 152.12 | 341.09 |
| | | 134.92 | 302.54 | 96 | 422.38 | 577.51 | 430.99 | 155.16 | 347.91 |
| | 22 382.28 | 137.61 | 308.59 | 97 | 430.81 | 589.05 | 439.61 | 158.26 | 354.87 |
| 382.12 522.47 | | 140.37 | 314 76 | 00 | 120 11 | ROD RA | 110 10 | 161 12 | 361 07 |
| | | | | 00 | ++.00+ | 10.000 | 140.40 | 01.101 | |

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

PREMIUM INFORMATION

We, Mutual of Omaha Insurance Company, can only raise your premium if we raise the premium for all the policies like yours in the same geographic area of the state where you live. Until you are age 99, your premium may change each year. All premium changes are subject to approval by the Texas Department of Insurance. You are eligible for a household premium discount if for the past year you have resided with at least one, but no more than three, other adults. The discounted premium will be priced 12% lower than the rates illustrated. The policy's household premium discount will be removed if the other adult no longer resides with you (other than in the case of his or her death).

DISCLOSURE

Use this outline to compare benefits and premiums among policies. The policy contains a provision for returning the unearned portion of any premium paid in the event of cancellation or 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 Mutual of Omaha Insurance Company, 3300 Mutual of Omaha Plaza, Omaha, NE 68175. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

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 Mutual of Omaha Insurance Company nor its agents are connected with Medicare. This outline of coverage does not give all the details of Medicare Coverage. Contact your local Social Security office or consult "Medicare & You" for more details.

LIMITATIONS AND EXCLUSIONS

We will not pay benefits for:

- (a) expenses you incur while your policy is not in force, except as provided in the EXTENSION OF BENEFITS section;
 (b) becauted or chilled purchase facility observes incurred or to the
- (b) hospital or skilled nursing facility charges incurred prior to the coverage effective date of this policy;
- (c) that portion of any expense you incur which is paid for by Medicare;
 (d) that portion of any expense that is payable under any other
 - (d) that portion of any expense that is payable under any other insurance plan, policy, or any employee benefit plan, which pays benefits on an expense-incurred basis;
 - non-Medicare-eligible-expenses, including, but not limited to, routine exams, take-home drugs, and eye refractions;
- (f) services for which a charge is not normally made in the absence of
 - insurance; or
 (g) loss or expense that is payable under any other Medicare Supplement insurance policy or certificate.

REFUND OF PREMIUM

In the event of cancellation or death, we will promptly return the unearned portion of any premium paid. Termination of coverage will not affect any claim originating while the policy is in force.

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.

| In any other facility for ou days in a row. | | | |
|--|---|---|--------------------------------|
| SERVICES | MEDICARE PAYS | PLAN A PAYS | YOU PAY |
| HOSPITALIZATION* Semiinrivate room and hoard general nursing and | | | |
| miscellaneous services and supplies | | | |
| First 60 days | All but \$1,556 | \$0 | \$1,556 (Part A deductible) |
| 61st through 90th day | All but \$389 a day | \$389 a day | \$0 |
| 91st day and after: While using 60 lifetime reserve days | All but \$778 a day | \$778 a day | \$0 |
| Once lifetime reserve davs 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 | | | |
| atter leaving the nospital. | | Ç | C |
| FIRST ZU days | All approved amounts | \$0 | \$0 |
| 21st through 100th day | All but \$194.50 a day | \$0 | Up to \$194.50 a day |
| 101st day and after | \$0 | \$0 | All costs |
| BLOOD | | | |
| First 3 pints | \$0 | 3 pints | \$0 |
| Additional amounts | 100% | \$0 | \$0 |
| HOSPICE CARE | All but very limited | Medicare copayment/coinsurance | \$0 |
| You must meet Medicare's requirements, including a | copayment/coinsurance for outpatient | | |
| doctor's certification of terminal illness | drugs and inpatient respite care | | |
| **NOTICE: When your Medicare Part A hospital benefits are exhausted, we stand in the place of Medicare and will pay whatever amount Medicare would have paid up to | ts 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 | e Benefits". During this time the hospital is | ". During this time the hospital is prohibited from billing you for the balance based on any difference | ce based on any difference |

המשבת טוו מווא טווופופוונפ ww memory willing you for the datation an additional you days as provided in the policy's Core benefits. During this title the hospital is profile between its billed charges and the amount Medicare would have paid.

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PLAN A Medicare (Part B) – Medical Services – Per Calendar Year *Once you have been billed \$233 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 \$233 of Medicare-approved amounts* | \$0 | \$0 | \$233 (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 \$233 of Medicare-approved amounts* | 0\$ | 0\$ | \$233 (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 | | |

| | LAKIO A AND D | | |
|--|---------------|-----|---------------------------|
| HOME HEALTH CARE – MEDICARE-APPROVED SERVICES | | | |
| Medically necessary skilled care services and medical supplies | 100% | \$0 | \$0 |
| DURABLE MEDICAL EQUIPMENT | | | |
| First \$233 of Medicare-approved amounts* | \$0 | \$0 | \$233 (Part B deductible) |
| Remainder of Medicare-approved amounts | 80% | 20% | \$0 |

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PLAN F MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD Medicare first eligible before 2020 only 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 | | | |
| First 60 davs | All hut \$1 556 | \$1 556 (Part A deductible) | U\$ |
| 61st through 90th day | All but \$389 a day | \$389 a day | \$0 |
| 91 st day and after: While using 60 lifetime reserve days | All but \$778 a day | \$778 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 \$194.50 a day | Up to \$194.50 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 | All but very limited copayment/coinsurance for | Medicare copayment/coinsurance | 0\$ |
| | respite care | | |

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.

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

PLAN F

*Once you have been billed \$233 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 \$233 of Medicare-approved amounts* | \$0 | \$233 (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 \$233 of Medicare-approved amounts | \$0 | \$233 (Part B deductible) | \$0 |
| Remainder of Medicare-approved amounts | 80% | 20% | \$0 |
| CLINICAL LABORATORY SERVICES – TESTS FOR | | | |
| DIAGNOSTIC SERVICES | 100% | \$0 | \$0 |
| | | | |

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

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

OTHER BENEFITS – NOT COVERED BY MEDICARE

*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 davs in a row.

| | | DI AN C DAVE | |
|---|---|--|----------------------------------|
| | MEDICARE LAIS | LAN G LAIS | I OU LAI |
| HOSPITALIZATION* | | | |
| Semiprivate room and board, general nursing, and | | | |
| miscellaneous services and supplies | | | |
| First 60 days | All but \$1,556 | \$1,556 (Part A deductible) | \$0 |
| 61st through 90th day | All but \$389 a day | \$389 a day | 0\$ |
| 91st day and after: | | | |
| While using 60 lifetime reserve days | All but \$778 a day | \$778 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 \$194.50 a day | Up to \$194.50 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 | All but very limited | Medicare copayment/coinsurance | \$0 |
| You must meet Medicare's requirements, including a doctor's | copayment/coinsurance for | | |
| certification of terminal illness | outpatient drugs and inpatient | | |
| | respite care | | |
| **NOTICE: When your Medicare Part A hospital benefits are exhausted, we stand in the place of Medicare and will pay whatever amount Medicare would have paid up to an additional 365 days as provided in the policy's "Core Renefits" During this time the hospital is prohibited from billing you for the halance based on any difference | hausted, we stand in the place of I s " During this time the hosnital is r | Medicare and will pay whatever amoun: prohibited from billing you for the balan | t Medicare would have paid up to |

an additional 365 days as provided in the policy's "Core Benetits." 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.

*Once you have been billed \$233 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.

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|--|---------------|---------------|--|
| SERVICES | MEDICARE PAYS | PLAN G PAYS | YOU PAY |
| MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's | | | |
| and supplies, physical and speech therapy, diagnostic tests, durable medical equipment | | | |
| First \$233 of Medicare-approved amounts* | \$0 | \$0 | \$233 (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 \$233 of Medicare-approved amounts* | \$0 | \$0 | \$233 (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 | | | |
|--|------|-----|--------------------------|
| Medically necessary skilled care services and medical supplies | 100% | \$0 | \$0 |
| DURABLE MEDICAL EQUIPMENT | | | |
| First \$233 of Medicare-approved amounts* | \$0 | \$0 | \$233 (Unless Part B |
| | | | deductible has been met) |
| Remainder of Medicare-approved amounts | 80% | 20% | \$0 |

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

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

OTHER BENEFITS – NOT COVERED BY MEDICARE

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 \$2,490 deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are \$2,490. 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.

| |)) | AFTER YOU PAY \$2,490 DEDUCTIBLE*** | IN ADDITION TO \$2,490 DEDUCTIBLE*** |
|---|---|--|---|
| 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 \$1,556 | \$1,556 (Part A deductible) | \$0 |
| 61st through 90th day | All but \$389 a day | \$389 a day | \$0 |
| 91st day and after: While using 60 lifetime reserve days | All but \$778 a day | \$778 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 davs | All approved amounts | 80 | 80 |
| 21st through 100th day | All but \$194.50 a day | Up to \$194.50 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 | All but very limited | Medicare copayment/coinsurance | \$0 |
| You must meet Medicare's requirements, including a doctor's certification of terminal illness | copayment/coinsurance for outpatient drugs and inpatient respite care | | |
| **NOTICE: When your Medicare Part A hospital benefits are exhausted, we stand in the place of Medicare and will pay whatever amount Medicare would have paid up to | nausted. we stand in the place of | Medicare and will pay whatever amoun | : Medicare v |

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 \$233 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 \$2,490 deductible. Benefits from the high deductible Plan G will not begin until 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.

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|--|-------------------------------------|-----------------------|--------------------------|
| | | AFTER YOU PAY \$2,490 | IN ADDITION TO \$2,490 |
| | | DEDUCTIBLE*** | DEDUCTIBLE*** |
| SERVICES | MEDICARE PAYS | PLAN G PAYS | YOU PAY |
| MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND | | | |
| Services, inpatient and outpatient medical and surgical services | | | |
| and supplies, physical and speech therapy, diagnostic tests, | | | |
| durable medical equipment | | | |
| First \$233 of Medicare-approved amounts* | \$0 | \$0 | \$233 (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) | 80 | 100% | \$0 |
| BLOOD | | | |
| First 3 pints | \$0 | All costs | \$0 |
| Next \$233 of Medicare-approved amounts* | \$0 | \$0 | \$233 (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 | | |
| | | | |

| | 0\$ | \$233 (Unless Part B deductible has been met) | 0\$ |
|---------------|---|--|--|
| | 0\$ | \$0 | 20% |
| PARTS A AND B | 100% | \$0 | 80% |
| | HOME HEALTH CARE – MEDICARE-APPROVED SERVICES Medically necessary skilled care services and medical supplies | DURABLE MEDICAL EQUIPMENT First \$233 of Medicare-approved amounts* | Remainder of Medicare-approved amounts |

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

***This high deductible plan pays the same benefits as Plan G after you have paid a calendar year \$2,490 deductible. Benefits from the high deductible Plan G will not begin until 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.

| OIHEK | UTHER BENEFILS - NOT COVERED BY MEDICARE | D BY MEDICAKE | |
|--|--|--|---|
| | | AFTER YOU PAY \$2,490 DEDUCTIBLE*** | IN ADDITION TO \$2,490 DEDUCTIBLE*** |
| SERVICES | MEDICARE PAYS | PLAN G PAYS | YOU PAY |
| FOREIGN TRAVEL – NOT COVERED BY MEDICARE | | | |
| Medically necessary emergency care services beginning during | | | |
| the first 60 days of each trip outside the USA | | | |
| First \$250 each calendar year | \$0 | \$0 | \$250 |
| Remainder of charges | \$0 | 80% to a lifetime maximum benefit | 20% and amounts over the |
| | | of \$50,000 | \$50,000 lifetime maximum |
| | | | benefit |
| | | | |

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

| SERVICES | MEDICARE PAYS | PLAN N PAYS | YOU PAY |
|---|-------------------------------------|--|----------------------------------|
| HOSPITALIZATION* | | | |
| Semiprivate room and board, general nursing, and | | | |
| miscellaneous services and supplies | | | |
| First 60 days | All but \$1,556 | \$1,556 (Part A deductible) | \$0 |
| 61st through 90th day | All but \$389 a day | \$389 a day | \$0 |
| 91 st day and after: | | ÷110 | ¢ |
| while using ou litetime reserve days | All but \$778 a day | \$1/8 a day | DA |
| 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. | - | C | C e |
| First ZU days | All approved amounts | \$0 | \$0 |
| 21st through 100th day | All but \$194.50 a day | Up to \$194.50 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 | All but very limited | Medicare copayment/coinsurance | \$0 |
| You must meet Medicare's requirements, including a | copayment/coinsurance for | | |
| doctor's certification of terminal illness. | outpatient drugs and inpatient | | |
| | respite care | | |
| **NOTICE: When your Medicare Part A hospital benefits are exhausted, we stand in the place of Medicare and will pay whatever amount Medicare would have paid up to an additional 365 days as provided in the policy's "Core Benefits" During this time the hospital is prohibited from billing you for the balance based on any difference | exhausted, we stand in the place or | f Medicare and will pay whatever amoun | t Medicare would have paid up to |

an additional 365 days as provided in the policy's "Core Benetits." 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.

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*Once you have been billed \$233 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

| SERVICES | MEDICARE PAYS | PLAN N PAYS | YOU PAY |
|---|---------------|--|---|
| MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First \$233 of Medicare-annrowed amounts* | G | Ç | \$233 (Part B deductible) |
| Remainder of Medicare-approved amounts | Ğenerally 80% | Balance, other than up to \$20 per office visit and up to \$50 per emergency room visit. The copayment of up to \$50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense | Up to \$20 per office visit and up to \$50 per emergency room visit. The copayment of up to \$50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense |
| Part B Excess Charges (above Medicare-approved amounts) | \$0 | \$0 | All costs |
| BLOOD First 3 pints | \$0 | All costs | \$0 |
| Next \$233 of Medicare-approved amounts* | \$0 | \$0 | \$233 (Part B deductible) |
| Remainder of Medicare-approved amounts | 80% | 20% | \$0 |
| CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES | 100% | \$0 | \$0 |

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

| | PARTS A AND B | | |
|--|---------------|-------------|---------------------------|
| SERVICES | MEDICARE PAYS | PLAN N PAYS | YOU PAY |
| HOME HEALTH CARE – MEDICARE-APPROVED SERVICES | | | |
| Medically necessary skilled care services and medical supplies | 100% | \$0 | \$0 |
| DURABLE MEDICAL EQUIPMENT | | | |
| First \$233 of Medicare-approved amounts* | \$0 | \$0 | \$233 (Part B deductible) |
| Remainder of Medicare-approved amounts | 80% | 20% | \$0 |

| | OTHER BENEFITS – NOT COVERED BY MEDICARE | D BY MEDICARE | |
|---|---|---------------------------|---------------------------|
| SERVICES | MEDICARE PAYS | PLAN N PAYS | YOU PAY |
| FOREIGN TRAVEL – NOT COVERED BY MEDICARE | | | |
| 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 | 20% and amounts over the |
| | | benefit of \$50,000 | \$50,000 lifetime maximum |
| | | | benefit |

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| Producer | Information | - Please | Complete |
|----------|-------------|----------|----------|
|----------|-------------|----------|----------|

| | Producer Name | Agent Writing Number or Social Security Number | Commission Share Commission Code Required <u>only</u> if you are r appointed or licensed or changing brokerage firms |
|--|--|---|---|
| Preferred Method of Communication (Select one) Phone Fax Email Contact info: Note: Producers must be under the same commission code to share or split commissions. Please update your contact information at http://www.mutualofomaha.com/. Application Submission Checklist – Omaha Supplemental Ins. Co. Medicare Supplement/Select 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 • 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 F. Please answere all of the following questions 7(a) and 7(b) or question 8 in Section F, they can skip to Section 1 Section S F and G - Refer to the Open Enrollment/Guaranteed Issue worksheet to help identify eligibilit | , | | |
| Phone Fax Email Contact info: Note: Producers must be under the same commission code to share or split commissions. Please update your contact information at http://www.mutualofomaha.com/. Application Submission Checklist – Omaha Supplemental Ins. Co. Medicare Supplement/Select 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 • • Enter Requested Effective Date • Indicate where the policy is to be mailed • Include applicant's Medicare number on the application. This number is required for electronic claim processing. If this number of end varialable 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 F: Previous or Existing Coverage Information • • Please complete ALL questions in full For Sections F and G - Refer to the Open Enrollment/Guarantee | | | % |
| Note: Producers must be under the same commission code to share or split commissions. Please update your contact information at http://www.mutualofomaha.com/. Application Submission Checklist – Omaha Supplemental Ins. Co. Medicare Supplement/Select Coveration Completes the premium based on age at application date 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) Section S 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 F: Please answer all of the following questions 7(a) and 7(b) or question 8 in Section F: Please answer all of the following questions 7(a) and 7(b) or question 8 in Section F: they can skip to Section 1 Section S A H: Health/Medication Information | | | |
| 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 applicant, the applicant/agent must provide this number by calling 1-877-617-5187 order it is received. If not already covered by Medicare, indicate "eligibility" and "enrollment" dates. Section D: Household Premium Discount Information Indicate 'f eligible for a Household Premium Discount Section F: Previous or Existing Coverage Information If either Applicant A or B answered "YES" to BOTH questions 7(a) and 7(b) or question 8 in Section F. Previous on YEST to BOTH questions 7(a) and 7(b) or question 8 in Section F. Applicant fs in an open enrollment or guaranteed issue period Section M: Applicant (s) sign and date the application Make sure applicant(s) sign and date the application Make sure applicant(s) sign and date the application Make sure applicant(s) sign and date the application Use premium determined by the Calculate Your Premium form The full modal premium is collected at the time of application (f applicable) Provide Applicant with the Definition of Eligible Person for Guaranteed Issue Notice | Note: Producers must be under the same | e commission code to share or | split commissions. Please update your contact |
| 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 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 F: Previous or Existing Coverage Information If either Applicant A or B answered "YES" to BOTH questions 7(a) and 7(b) or question 8 in Section F. Previous or Existip to Section 1 Section K and G - Refer to the Open Enrollment/Guaranteed Issue worksheet to help identify eligibility. Section F. Hey can skip to Section 1 Section S and G - Refer to the Open Enrollment or guaranteed issue period Section S and G - Refer to the Open Enrollment or guaranteed issue period Section S and B - Refer to the Open enrollment or guaranteed issue period Section S and G - Refer to the Open enrollment or guaranteed issue period Section S and G - Refer to the Open enrollment or guaranteed issue period Section S and C - Refer tot the Open enrollment or guaranteed issue period <li< td=""><td>Application Submission Checklist</td><th>t – Omaha Supplemental</th><td>Ins. Co. Medicare Supplement/Select Covera</td></li<> | Application Submission Checklist | t – Omaha Supplemental | Ins. Co. Medicare Supplement/Select Covera |
| 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 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 E: Previous or Existing Coverage Information Indicate if eligible for a Household Premium Discount Section F: Previous or Existing Coverage Information Indicate if eligible for a Household Premium Discount Section F: 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: Previous or Existing Coverage Information If either Applicant A or B answered "YES" to BOTH questions 7(a) and 7(b) or question 8 in Section F: Applicant is in an open enrollment or guaranteed issue period Section K: To be Completed by Producer Make sure applicant(s) sign and date the application Make sure applicant(s) sign and date the application Seenion K and a | Provide Applicant with the G | uide to Health Insurance f | or People with Medicare |
| 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 F: Please answer all of the following questions If either Applicant A or B answered "YES" to BOTH questions 7(a) and 7(b) or question 8 in Section F; Please answer all of the following questions If either Applicant A or B answered "YES" to BOTH questions 7(a) and 7(b) or question 8 in Section F; they can skip to Section 1 Section I: Agreement and Authorization Do NOT answer if applicant is in an open enrollment or guaranteed issue period 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 Complete Replacement Notice and leave a copy with the applicant (if applicable) Provide Applicant with the Definition of Eligible Person for Guaranteed Issue Notice Provide Applicant with the Definition of Eligible Person for Guaranteed Issue Notice Provide Applicant with the Definition of Eligible Person for Guaranteed Issue Notice Provide Applicant with the Definition of Eligible Person for Guaranteed Issue Notice Provide Applicant with the Definition of Eligible Person for Guaranteed Issue Notice Provide Applicant with the Definition of Eligible Person for Guaranteed Issue Noti | Provide Applicant with the O | utline of Coverage | |
| 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 F: 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 7(a) and 7(b) or question 8 in Section 1; Agreement and Authorization 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 applicant(s) sign and date the 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 the Definition of Eligible Person for Guaranteed Issue Notice | | | |
| 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 | Sections A & B: Plan and Ap Select plan Enter Requested Effective Indicate where the policy | e Date v is to be mailed | |
| 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 <u>BOTH</u> questions 7(a) and 7(b) or question 8 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 | Include applicant's Medic claim processing. If this n provide this number by ca Medicare, indicate "eligib | are number on the applica number is not available at t alling 1-877-617-5587 onc vility" and "enrollment" da | e it is received. If not already covered by |
| Section F: Please answer all of the following questions If either Applicant A or B answered "YES" to BOTH questions 7(a) and 7(b) or question 8 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) Provide Applicant with the Definition of Eligible Person for Guaranteed Issue Notice | Indicate if eligible for a H Section E: Previous or Existi | ousehold Premium Discou ing Coverage Information | ınt |
| 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) Provide Applicant with the Definition of Eligible Person for Guaranteed Issue Notice | For Sections F and G – Refer to the Op | en Enrollment/Guaranteed Is | ssue worksheet to help identify eligibility. |
| Do NOT answer if applicant is in an open enrollment or guaranteed issue period <u>Section I: Agreement and Authorization</u> Make sure applicant(s) sign and date the application <u>Section K: To be Completed by Producer</u> | Section F: Please answer all If either Applicant A or B Section F, they can skip t | answered "YES" to <u>BOTH</u> of Section | s questions 7(a) and 7(b) or question 8 in |
| Make sure applicant(s) sign and date the application <u>Section K: To be Completed by Producer</u> 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) Provide Applicant with the Definition of Eligible Person for Guaranteed Issue Notice | Do NOT answer if applicar | nt is in an open enrollment | or guaranteed issue period |
| 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) Provide Applicant with the Definition of Eligible Person for Guaranteed Issue Notice | Make sure applicant(s) s | ign and date the application | on |
| 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) Provide Applicant with the Definition of Eligible Person for Guaranteed Issue Notice | Section K: To be Completed Make sure producer(s) si | by Producer gn and date the application | on |
| Complete Replacement Notice and leave a copy with the applicant (if applicable) Provide Applicant with Premium Receipt signed by agent (if applicable) Provide Applicant with the Definition of Eligible Person for Guaranteed Issue Notice | Complete the Method of Pay Use premium determined The full modal premium | ment form and return with I by the Calculate Your Pre is collected at the time of a | I the completed application mium form application |
| Provide Applicant with the Definition of Eligible Person for Guaranteed Issue Notice | | | |
| | | ium Receint signed hy age | ent (if applicable) |
| and the second | | | |

Open Enrollment and Guaranteed Issue Worksheet

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

ELIGIBILITY FOR OPEN ENROLLMENT

Applicant is:

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

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

ELIGIBILITY FOR GUARANTEED ISSUE

Evidence of eligibility is required for the following situations.

Applicant:

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

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

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

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

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

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

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

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

Applicant has the right to obtain their Medicare supplement policy back if that carrier still sells it or, if not available:

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

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

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

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

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

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



Calculate Your Premium

PLEASE COMPLETE

Medicare Supplement Insurance Plan Applicant A _____ Applicant B ____

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

| | Steps | Example Sample rate displayed is used for calculation purposes only. | Applicant A | Applicant B |
|----|---|---|-------------|-------------|
| #1 | Age Write in your age at the time of signing the application. ZIP Code Indicate your ZIP Code used to determine your rate. | 65 78798 | | |
| #2 | Premium Write in your Med supp plan's premium from the Outline of Coverage provided, based on your age and ZIP Code listed in Step #1. | \$98.10 | | |
| #3 | Household Premium Discount Please refer to the application for state specific household discount premium rules. If the rules apply, multiply the amount from Step #2 by .88. If the rules do not apply, enter the amount from Step #2. | \$98.10 x .88 = \$86.33 In this example, the person qualifies for the household premium discount. | | |
| #4 | Rate Adjustment If you're in your open enrollment or guaranteed issue period, skip to Step #5. Locate your height, then weight, on the next page. If your weight is in the Standard column, enter the amount from Step #3 If your weight is in a Decline column, you are ineligible for coverage. | | | |
| #5 | Payment OptionsYour monthly payment is your last premium entered (Step#3 or #4).To determine other payment schedules, multiply your monthly premium by: 3 to pay 4 times a year (quarterly) 6 to pay twice a year (semiannually) 12 to pay once a year (annually) | \$86.33 monthly payment \$258.98 quarterly payment \$517.98 semiannual payment \$1,035.96 annual payment | | |



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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.

| | 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 + |





| | DNIS Auth # |
|--|--|
| Agent Writing # Group # (ii | applicable) Keyline |
| Winderwritten by Underwritten by Mutual of Omaha Insurance Mutual of Omaha Insurance | e Company Omaha, Nebraska 68175 |
| Application for Medicare Supplement Coverage | |
| Applicant acknowledges and agrees that if there is more than one viewed or shared with the other applicant. | e applicant on this application, all information provided may be |
| How Did You Hear About Us? | |
| Please select all that apply. Thank you for providing this helpful info | |
| Agent/Broker/Producer Family Member/Friend | Physician Referral Social Media Radio TV |
| Direct Mail Internet Search A. Plan Information (to be completed by I | |
| Applicant A | Applicant B |
| Plan (select one): Plan A Plan G | Plan (select one): Plan A Plan G |
| High Deductible Plan G Plan N | High Deductible Plan G Plan N |
| OR | OR |
| If your Medicare Part A eligibility date is before 01/01/2020, this additional plan is an available option: | If your Medicare Part A eligibility date is before 01/01/2020, this additional plan is an available option: |
| Plan F | Plan F |
| Requested Effective Date / | Requested Effective Date / |
| Deliver Policy to: | Deliver Policy to: |
| Applicant A Producer | Applicant B Producer |
| B. Applicant Information | |
| Applicant A | Applicant B |
| Name (First/Middle Initial/Last) | Name (First/Middle Initial/Last) |
| Residence Address | Residence Address |
| 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 – – – | Home Phone – – |
| E-mail Address | E-mail Address |
| Current Age | Current Age |
| Date of Birth mo / day / yr | Date of Birth / / / yr |
| MA6026-41 | 1 |

B. Applicant Information (Continued)

| Applicant A | Applicant B |
|---|---|
| Male Female | Male Female |
| Social Security # | Social Security # |
| Height Weight Ft In Lbs | Height Weight Ft In Lbs |
| Have you used any form of tobacco, an electronic cigarette (e-cig) or other nicotine product in the past 12 months? | Have you used any form of tobacco, an electronic cigarette (e-cig) or other nicotine product in the past 12 months? |
| Go paperless! To receive your Explanation of Benefits (EOBs) onli in Section B. If you subscribe, you will <u>not</u> receive paper EOBs, but become available with a link to access each specific EOB. We will reimbursement from Mutual of Omaha Insurance Company. | instead, will receive an e-mail notification when new EOBs |
| Receive statement online? \Box Y \Box N | Receive statement online? \Box Y \Box N |
| C. Medicare Information | |
| Please reference your Medicare card to complete this section | MEDICARE HEALTH INSURANCE Name:Nombre JOHN L SMITH Medicare Number:Namero de Medicare 1EG4-TE5-MK72 Entitled totCon derecho a HOSPITAL (PART A) MEDICAL (PART B) |
| Applicant A | Applicant P |
| Applicant A Medicare Number | Applicant B Medicare Number |
| | |
| Medicare Number Medicare Part A Effective Date If you are not covered under Medicare Part A, what is your | Medicare Number Medicare Part A Effective Date If you are not covered under Medicare Part A, what is your |
| Medicare Number Medicare Part A Effective Date If you are not covered under Medicare Part A, what is your eligibility date Medicare Part B Effective Date Medicare Part B Effective Date If you are not covered under Medicare Part B, indicate the date you plan to enroll | Medicare Number Medicare Part A Effective Date If you are not covered under Medicare Part A, what is your eligibility date Medicare Part B Effective Date Medicare Part B Effective Date If you are not covered under Medicare Part B, indicate the date you plan to enroll |
| Medicare Number Medicare Part A Effective Date //////////////////////////////////// | Medicare Number Medicare Part A Effective Date If you are not covered under Medicare Part A, what is your eligibility date Medicare Part B Effective Date |
| Medicare Number Medicare Part A Effective Date ////// | Medicare Number Medicare Part A Effective Date If you are not covered under Medicare Part A, what is your eligibility date Medicare Part B Effective Date |
| Medicare Number Medicare Part A Effective Date //////////////////////////////////// | Medicare Number Medicare Part A Effective Date If you are not covered under Medicare Part A, what is your eligibility date Medicare Part B Effective Date |

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E. Previous or Existing Coverage Information

| for po co | r guaranteed issue of a Medicare supplement insurance polic licy or certificate, you may be guaranteed acceptance in one | ceived a notice from your prior insurer saying you were eligible y or certificate, or that you had certain rights to buy such a or more of our Medicare supplement plans. Please include a n. PLEASE ANSWER ALL QUESTIONS. Please mark "YES" or | |
|------------------------|---|--|---|
| | the Best of Your Knowledge and Belief: Are you covered for medical assistance through the state N (NOTE TO APPLICANT: If you are participating in a "Spend not met your "Share of Cost," please answer "NO" to this q | -Down Program" and have | |
| | If "YES," answer the following about this existing coverage (a) Will Medicaid pay your premiums for this Medicare su (b) Do you receive any benefits from Medicaid OTHER TH Medicare Part B premium? | pplement policy? Image: Provide the second se | |
| Ple | ease answer questions regarding another Medicare su | pplement or Select plan: | |
| 4. | Do you have another Medicare supplement or Medicare Secretificate in force? If "YES," answer the following about this existing coverage (a) Do you intend to replace your current Medicare supplement | | |
| | with this policy? | | |
| | (b) Indicate planned termination or disenrollment date | Applicant A | |
| | | Applicant B | |
| | (c) With what company, and what plan do you have? |] | _ |
| Ар | oplicant A | Applicant B | |
| Na | ame of Company | Name of Company | |
| Pla | an | Plan | |
| | | | |
| Ple | ease answer questions regarding Medicare plan cover | age (other than Medicare supplement): | |
| | ease answer questions regarding Medicare plan cover Have you had coverage from any Medicare plan other than the past 63 days? (for example, a Medicare Advantage plan If "YES," answer the following about this previous or exist | Applicant A Applicant B Medicare Part A or B within Image: State St | |
| | Have you had coverage from any Medicare plan other than the past 63 days? (for example, a Medicare Advantage plar | Medicare Part A or B within h, or a Medicare HMO or PPO) Applicant A Applicant B Image coverage: Y N Y N vered under this plan, | |
| | Have you had coverage from any Medicare plan other than the past 63 days? (for example, a Medicare Advantage plan If "YES," answer the following about this previous or exist (a) Fill in your start and end dates below. If you are still co | Medicare Part A or B within Applicant A Applicant B n, or a Medicare HMO or PPO) Y N Y N ing coverage: Y N Y N vered under this plan, I I I I I | |
| 5. | Have you had coverage from any Medicare plan other than the past 63 days? (for example, a Medicare Advantage plan If "YES," answer the following about this previous or exist (a) Fill in your start and end dates below. If you are still co leave "END" blank | Medicare Part A or B within h, or a Medicare HMO or PPO) Image coverage: vered under this plan, | |
| 5. | Have you had coverage from any Medicare plan other than the past 63 days? (for example, a Medicare Advantage plan If "YES," answer the following about this previous or exist (a) Fill in your start and end dates below. If you are still co leave "END" blank (b) If you are still covered under the Medicare plan, do you | Medicare Part A or B within h, or a Medicare HMO or PPO) Applicant A | |
| 5. | Have you had coverage from any Medicare plan other than the past 63 days? (for example, a Medicare Advantage plan If "YES," answer the following about this previous or exist (a) Fill in your start and end dates below. If you are still co leave "END" blank (b) If you are still covered under the Medicare plan, do you coverage with this new Medicare supplement policy? | Medicare Part A or B within Applicant A and care HMO or PPO) ing coverage: vered under this plan, END Image: Applicant A START Image: Applicant B START Image: Applicant B START Image: Image: Applicant B START Image: | |

| (g) Please indicate reason for termination/disenrollment Your Medicare Advantage plan is leaving the Med Your Medicare Advantage organization stopped of Your Medicare Advantage organization stopped of in which you live You moved out of the geographic service area of you You had a Medicare Advantage plan with Medicar in a stand-alone Medicare Part D plan Other: Applicant A | icare program ffering Medicare Advantage p ffering coverage in the area our Medicare Advantage plan re Part D benefits and are enro | Dlans Image: Constraint of the second |
|---|---|--|
| Please answer questions regarding other health insur | ance: | |
| 6. Have you had coverage under any other health insuranc (For example, an employer group health plan, union plan supplement plan.) If "YES," answer the following about this previous or exis (a) What are your dates of coverage under the other polic | ce within the past 63 days? n, or individual non-Medicare sting coverage: cy/certificate? | |
| If you are still covered under this plan, leave "END" bla | ink Applicant A 51 | |
| | Applicant B S | |
| (b) Planned date of termination/disenrollment? | Applica Applic | |
| (c) Have you disenrolled from your current coverage vo(d) Please state the reason for your disenrollment: | luntarily? | |
| Applicant A | | |
| Applicant B (e) With what company and what kind of policy/certific | cate? (List below.) | |
| Applicant A | Applicant B | |
| Name of Company | Name of Company | |
| Policy/Certificate type | Policy/Certificate type | |
| F. Please answer all of the follow | ing questions: | |
| To the Best of Your Knowledge and Belief: | | Applicant A Applicant B |
| 7. Are you applying during an open enrollment period?(a) Did you turn age 65 in the last six months?(b) Did you enroll in Medicare Part B in the last six morther than the last six morther the last six morther than the last six morther than the last six morther than the las | | |

| | If either question 7a or 7b is "YES", indicate your Medicare Part B effective date Applicant A | / | | | |
|--------|--|-----|---|-----|--|
| 5-41 | Applicant B | | | | |
| MA602(| 8. Are you applying during a guaranteed issue period? (NOTE: Refer to the Guide to Health Insurance for People with Medicare to help identify if you are eligible. If the answer above is "YES," attach proof of eligibility.) | Y 🗌 | N | ү [| |

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

| | л |
|---|---|
| 2 | 1 |
| | |

Ν

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

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| | For all plans, answer questions 9-19. | Note: An interviewer may | call to confirm and v | verify the information y | ou have |
|-------------------------------|---------------------------------------|--------------------------|-----------------------|--------------------------|---------|
| provided on this application. | provided on this application. | | | | |

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

| To t | he | Best of Your Knowledge and Belief: | Applicant A | Applicant B |
|-------|----|--|-------------|-------------|
| | | e you currently confined to a wheelchair or any motorized mobility device? | Υ | ÜΥ□Ν |
| | | e you currently hospitalized, confined to a bed, in a nursing home or assisted living ility? | | |
| | | ve you been medically diagnosed with, treated for, or had surgery for any of the following (Do t include surgery when answering G): | | |
| | Α. | Chronic kidney disease (Stages 3, 4, or 5), kidney failure, or kidney disease requiring dialysis? | ΥΝ Ν | ΠΥΠΝ |
| | Β. | Emphysema, chronic obstructive pulmonary disease (COPD), any other chronic pulmonary disorder or any cardio-pulmonary disorder requiring oxygen? | ΠΥΠΝ | □ y □ n |
| | C. | Alzheimer's disease, dementia or any other cognitive disorder? | Π Y Π N | Ωy Ωn |
| | D. | Parkinson's disease, multiple sclerosis or amyotrophic lateral sclerosis (Lou Gehrig's Disease), Huntington's disease, or cerebral palsy? | □ y □ N | □ y □ n |
| | E. | Systemic lupus, scleroderma or myasthenia gravis? | Υ Ν | ΠΥΠΝ |
| | F. | Chronic hepatitis or cirrhosis? | Υ Ν | ΠΥΠΝ |
| | G. | Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) or tested positive for Human Immunodeficiency Virus (HIV)? | ΠΥΠΝ | □ y □ n |
| | | ve you had an organ or stem cell transplant or been advised to have an organ or stem cell nsplant (excluding cornea implants)? | □ y □ n | |
| 13. [| Do | you have Osteoporosis, and as a result, experienced a fracture? | ΠΥΠΝ | ΠΥΠΝ |
| | | you have diabetes with complications including retinopathy, neuropathy, peripheral artery | | |
| | | ease, peripheral venous thrombotic disease, stroke, transient ischemic attack (TIA), any heart order or any kidney disease? | Y N | Υ Ν |
| | | you have an implanted cardiac defibrillator? | ΠΥΠΝ | ΠΥΠΝ |
| | | | | |

Part B: Medical Questions: (If "YES" is answered to any of the following questions 16-19 that person MAY not be eligible for coverage and is subject to an underwriting review.) If you would like consideration to be given to an application that contains a "Yes" answer to any question in Part B, attach an explanation stating how long the condition has existed and how it is being controlled.

| To the Best of Your Knowledge and Belief: | Applicant A | Applicant B |
|---|-------------|-------------|
| 16. Within the past two years, have you been treated for, or been advised by a physician to have treatment for: | | Applicant |
| A. Coronary artery disease, angina, heart attack, cardiac angioplasty, bypass surgery or stent placement? | | |
| 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? | | Ωy Ωn |
| C. Alcoholism or drug abuse? | | ∐ Y ∐ N |
| D. Any mental or nervous disorder requiring treatment (including hospital confinement)? | | |
| E. Internal cancer, lymphoma or melanoma? | | |
| F. A stroke or transient ischemic attack (TIA)? | | |
| G. Degenerative bone disease, spinal stenosis, rheumatoid arthritis, psoriatic arthritis, arthritis that restricts mobility or have you been advised to have joint replacement? | | |
| 17. Do you have diabetes with high blood pressure and have you: | | |
| A. Taken more than two medications for either condition (insulin dependent or oral medications)? | | ∐ Y ∐ N |
| B. Had any changes in your medications within the past two years? | | |
| 18. Have you been hospital confined three or more times in the past two years for a same or similar condition? | | ΠΥΠΝ |
| 19. Have you been advised by a medical professional to have treatment, further diagnostic evaluation, diagnostic testing, follow up visits or any surgery that has not been performed? | Π Υ Π Ν | |



NOTE: Please verify the completeness and accuracy of the above statements as they may impact claim payment. MA6026-41

H. Medication Information

If you are applying for <u>ANY</u> plan <u>OUTSIDE</u> of an open enrollment or guaranteed issue period, please answer the question. If "yes" list all over-the-counter or prescription medications you are currently taking or have been prescribed in the last 2 years.

| To the Best of Your Knowledge and Belief: | Applicant A | Applicant B |
|---|-------------|-------------|
| 20. Are you currently taking, or have you been prescribed during the previous 2 years any prescription drugs or over-the-counter medications? | □ y □ n | □ y □ n |

Applicant A

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

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 |
|--|--------|-----------|---|--|---------------------|
| | | | Ωy Ωn | Ωy Ωn | |
| | | | ΠY ΠN | Ωy Ωn | |
| | | | UY UN | Ωy Ωn | |
| | | | Ωy Ωn | Y N | |
| | | | Ωy Ωn | Ωy Ωn | |
| | | | Ωy Ωn | Ωy Ωn | |
| r b | | | Ωy Ωn | Ωy Ωn | |
| | | | ΠY ΠN | Ωy Ωn | |



I. Agreement and Authorization

IMPORTANT STATEMENTS



- You do not need more than one Medicare supplement policy.
- If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
- If you are age 65 or older, you may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.
- If, after purchasing the policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

AUTHORIZATION TO DISCLOSE PERSONAL INFORMATION TO MUTUAL OF OMAHA INSURANCE COMPANY

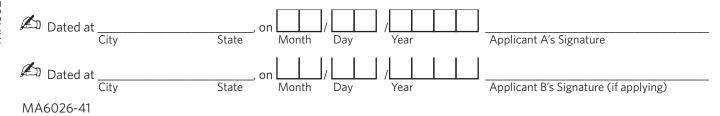
I authorize any physician, medical or dental practitioners, hospitals, clinics, pharmacies, pharmacy benefit managers, other medical care facilities, health maintenance organizations and all other providers of medical or dental services, the group of companies which presently includes Omaha Insurance Company, United World Life Insurance Company, United of Omaha Life Insurance Company, Companion Life Insurance Company, and any additional companies which may become part of this group of companies and their successors, along with other persons and entities which act on behalf of those companies to provide services to them, employers, consumer reporting agencies, and other insurance companies to disclose Personal Information about me to Mutual of Omaha Insurance Company. 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, Mutual of Omaha Insurance Company, [P.O. Box 3608, Omaha, NE 68103-3608]. I realize that my right to revoke this authorization is limited to the extent that

[P.O. Box 3608, Omaha, NE 68103-3608]. I realize that my right to revoke this authorization is limited to the extent that Mutual of Omaha Insurance Company has taken action in reliance on the authorization or the law allows Mutual of Omaha Insurance Company to contest the issuance of the policy or a claim under the policy.

- "Personal Information" means all health information, such as medical history, mental and physical condition, including the presence of HIV infection, AIDS or ARC, prescription drug records, drug and alcohol use and other information such as finances, occupation, general reputation and insurance claims information about me. Personal Information does not include Psychotherapy Notes, which are notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a counseling session, which notes are separated from the rest of the person's medical record. Certain information, such as that relating to prescriptions, diagnosis and functional status, is not included in the term Psychotherapy Notes.
- The Personal Information will be used to determine my eligibility for insurance and to resolve or contest any issues of incomplete, incorrect or misrepresented information on my application which may arise during the processing of my application or in connection with claims for insurance benefits. This authorization will not be used if the applicant is in an open enrollment or guaranteed issue period.
- If the person or entity to whom Personal Information is disclosed is not a health care provider or health plan subject to federal privacy regulations, the Personal Information may then be subject to further disclosure by that person or entity without the protections of the federal privacy regulations.
- I understand that I may refuse to sign this application. I realize that if I refuse to sign, the insurance for which I am applying will not be issued.
- I understand that I will receive a copy of the signed application. A copy of this application is as effective as the original. I acknowledge and agree that if there is more than one applicant on this application, all information provided may be reviewed or shared with the other applicant. I understand that, upon acceptance of the completed application, each applicant will receive a separate policy and a completed and signed application will become part of each applicant's policy.

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

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



K. To be Completed by Producer

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

| App | licant | Α |
|-----|--------|---|
|-----|--------|---|

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 accurately recorded in the application the information supplied by the applicant(s) $[$ | JΥ |] N |
| I/We certify that we have interviewed the proposed applicant(s) | Υ |]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 | Signature of Licensed Producer Dat |
|--------------------------------|------|------------------------------------|
| Printed Name | | Printed Name |
| | | |
| Agent Writing Number | | Agent Writing Number |
| | | |
| | | |

MA6026-41

REQUIRED FORM - PLEASE RETURN PAGES 1 & 2

METHOD OF PAYMENT FORM Part I. Select Premium Payment Option

| Initial Premium Payment (Select option #1 <u>or</u> #2) | Applicant A | Applicant B |
|---|---|---|
| 🖉 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, <u>or</u> #2) | act a state | 1st u u ooth |
| 1. I want my payments automatically withdrawn from my bank | 1 st through the 28 th or the last day of every month | 1 st through the 28 th or the last day of every month |
| a. Choose the day payments will be deducted every month from your bank account | the last day of every month | the last day of every month |
| OR | Week (1 st , 2 nd , 3 rd , 4 th , last) | Week (1 st , 2 nd , 3 rd , 4 th , last) |
| b. Choose the week and weekday that payments will be | | |
| deducted every month from your bank account | Weekday (Mon, Tue, Wed, | Weekday (Mon, Tue, Wed, |
| (For Example: 3rd Wednesday of every month) | Thu, Fri) | Thu, Fri) |
| I will mail my premium to the company every 3, 6, or 12 months. (Monthly billing is not allowed. Select frequency of billing) | everymonths Insert 3, 6, or 12 | everymonths 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 |
|--|-------------|-------------|
| Account Owner Name, if different than applicant's If premium is NOT paid by Proposed Insured/Insured (includes spouse or joint-married account), indicate the bank account owner's relationship to Proposed Insured/Insured by selecting one of the following. Employer (3 app minimum/applicant must be retired. Refer to List-Bill guidelines. N/A for Direct-to-Consumer business) Living Trust Power of Attorney or legal guardian (documentation required) Business owned by applicant or applicant's spouse | | |



Part III. Account Information

| Complete the Following ONLY if <u>Automated Bank Account</u> This section is intended as authorization to debit your bank acc Complete bank account information below OR attach a copy of | ount. | | |
|---|--|--|--|
| Applicant A Account Type (check one): Checking Savings Name of Financial Institution Accounting 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 | | |
| 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. | Account Holder Name Do NOT include the check # in the Routing or Account Number. Example: John Doe Check #1234 John Doe Check #1234 Check #1234 Street Address Town, City ZIP Code Date: | | |
| 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. 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 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 | Applicant B | | |
| <u></u> | <u><u></u></u> | | |
| Authorized Signature as Shown on Account | Authorized Signature as Shown on Account | | |
| Date | Date | | |
| | | | |





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

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

According to your application, you intend to terminate existing Medicare supplement or Medicare Advantage insurance and replace it with a policy to be issued by Mutual of Omaha Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy. You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration and acceptance by the replacing insurer, 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 the benefits provided under this policy.

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

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

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

- 1. Health conditions which you may presently have may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under the present policy.
- 2. 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 for similar benefits to the extent such time was spent under the original policy.
- 3. If, you still wish to terminate your present policy or certificate and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the Company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

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

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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.

Definition of Eligible Person for Guaranteed Issue Premium Receipt



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

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

According to your application, you intend to terminate existing Medicare supplement or Medicare Advantage insurance and replace it with a policy to be issued by Mutual of Omaha Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy. You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration and acceptance by the replacing insurer, 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 the benefits provided under this policy.

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

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

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

- 1. Health conditions which you may presently have may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under the present policy.
- 2. 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 for similar benefits to the extent such time was spent under the original policy.
- 3. If, you still wish to terminate your present policy or certificate and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the Company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

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

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Definition of Eligible Person for Guaranteed Issue

The following are definitions of the categories of the individuals who are eligible for Guaranteed Issue:

- (a) Enrolled under an employee welfare benefit plan and the plan terminates or ceases to provide benefits or the individual is no longer eligible for the plan;
- (b) Enrolled in a Medicare Advantage plan or 65 years of age or older and enrolled with a Program of All-Inclusive Care for the Elderly (PACE) and the organization's certification or plan is terminated or the individual has been notified of an impending termination of certification or the organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides or the individual is no longer eligible to elect the plan because of change in circumstances, or the plan is terminated for all individuals within a residence area; or the organization substantially violated a material policy provision, or a material misrepresentation was made to the individual; or
- (c) Enrolled in a Medicare risk contract, health care prepayment plan, cost contract or Medicare Select Plan, or similar organization, and the organization's certification or plan is terminated or specific circumstances permit discontinuance including, but not limited to a change in residence of the individual, the plan is terminated within a residence area, the organization substantially violated a material policy provision, or a material misrepresentation was made to the individual; or
- (d) Enrolled in a Medicare supplement policy and coverage discontinues due to insolvency, bankruptcy or other involuntary termination of coverage, substantial violation of a material policy provision, or material misrepresentation; or
- (e) Enrolled under a Medicare supplement policy, terminates and enrolls for the first time in a Medicare Advantage, a risk or choice contract, or a Medicare Select plan and then the insured person terminates coverage within 12 months of enrollment, or
- (f) Upon first becoming eligible for benefits under Part B at age 65 or older, enrolled in a Medicare Advantage or in a PACE Program and disenrolls within 12 months.
- (g) Enrolled in a Medicare Part D plan during the initial enrollment period and, at the time of enrollment in Part D, was enrolled under a Medicare supplement policy that covers outpatient prescription drugs and the individual terminated enrollment in the Medicare supplement policy.
- (h) Loses eligibility for health benefits under Title XIX of the Social Security Act (Medicaid).

If any of the definitions apply to you, please complete the Application for Medicare supplement Insurance and submit evidence of the date of termination or disenrollment. Application must be made for coverage no later than 63 days of termination or disenrollment.



M469925_TX



Premium Receipt

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

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

| Applicant A | Applicant B |
|-------------------------------|-------------------------------|
| Received from | Received from |
| this day of , | this day of , |
| an application for FormPolicy | an application for FormPolicy |
| and/or Ridersand | and/or Ridersand |
| Check forDollars. | Check forDollars. |
| | |
| L Agent | 🖉 Agent |

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



Provide the completed premium receipt, if applicable.



APPLICATION for INDIVIDUAL DENTAL INSURANCE WITH OPTIONAL VISION RIDER

TEXAS

MAP642_TX 09/16/2020 Monthly Rates (Issue Age 19-99)

| TEXAS | - | | _ |
|--|------------------------------------|-------------------------------------|-----------------------------|
| ZIP Codes | Mutual Dental Preferred DNT2 | Mutual Dental Protection DNT5 | Vision Rider 0PD1M-41 |
| 754-759, 764, 768, 776-781, 783-785, 790, 791, 793-799 | \$43.66 | \$22.47 | \$8.28 |
| 760-763, 765-767, 769, 770, 774, 775, 782, 788, 789, 792 | \$49.06 | \$25.25 | \$8.28 |
| 733, 750-753, 771-773, 786, 787, 885 | \$50.53 | \$26.01 | \$8.28 |

Rates Subject to Change.

As of 10/01/2020

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)

🧑 Митиаг 🖉 Отана

Underwritten by Mutual of Omaha Insurance Company

3300 Mutual of Omaha Plaza Omaha, Nebraska 68175

Monthly Premium Rate for Vision \$

Total Monthly Premium \$

Internal Tracking Code Group # (if applicable)

Application for Individual Dental Insurance with Optional Vision Rider A. Applicant Information

| Name (First, Middle Initial, Last) | | Phone Number Home Cell | | |
|---|--------------------------------------|--|------------------------|--|
| Residence Address (Street, City, Sta | re, ZIP) | E-mail | | |
| Mailing Address (Street, City, State, ZIP) (if different from residence a | | e address) Deliver Policy to Applicant Producer | | |
| Gender | Date of Birth Social Security Number | | Social Security Number | |
| B. Plan Information | | | | |
| | nnual Maximum \$1,500 | Requested Effective Date | | |
| Mutual Dental Protection A | nual Maximum \$1,000 | Monthly Premium Rate for Dental \$ | | |

C. Existing Coverage Information

Optional Vision Rider (only available with Dental)

| Are you covered by any other dental or vision insurance? | Y N |
|---|---------|
| Name of dental carrier(s) | |
| Name of vision carrier(s) | |
| Is the coverage you are applying for replacing existing dental insurance? | □ Y □ N |
| Is the coverage you are applying for replacing existing vision insurance? | □ Y □ N |

D. Agreements

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

| Applicant Signature | Date | Signed at | City | State |
|--|-------------------------------------|-------------|-----------|--------------|
| I/We acknowledge that if the applicant is replacing coverage | e, I/We have provided a copy of the | replacement | notice, i | if applicabl |
| Æn | | | | |
| Signature of Licensed Insurance Producer | Date | | | |
| | | | | % |
| Printed Name | Agent Writing Numbe | er Cor | nm. % S | share |
| ÆD | | | | |
| Signature of Licensed Insurance Producer | Date | | | |
| | | | | _% |
| Printed Name | Agent Writing Number | er Cor | nm. % S | Share |
| MA6025 | | | | |

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METHOD OF PAYMENT FORM Part I. Select Premium Payment Option

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

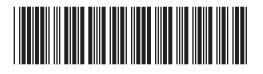
Part II. Payor Information

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



Part IV. Account Information

| Complete the Following ONLY if <u>Automated Bank Account Withdrawal</u> is Chosen: This section is intended as authorization to debit your bank account. Complete bank account information below OR attach a copy of a voided check (Do NOT use a deposit slip) |
|--|
| Applicant A Account Type (check one): Checking Savings Name of Financial Institution Image: State of Financial Institution Account Number (9 digits on lower left side of check) Image: State of Check (9 digits on lower left side of check) Image: State of Check (124) Name as Shown on Account Name as Shown on Account 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. Number Number Number Number Name & Address Signed By: Name & Address Signed By: |
| 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 |





Notice To Applicant Regarding Replacement of Accident and Sickness Insurance

According to your application, you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by Mutual of Omaha Insurance Company. For your own information and protection, you should be aware of and seriously consider certain factors that may affect the insurance protection available to you under the new policy.

- 1. Health conditions which you may presently have, (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits present under the new policy, whereas a similar claim might have been payable under your present policy.
- 2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.
- 3. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to your new policy and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to Mutual of Omaha Insurance Company within ten (10) days if any information is not correct and complete, or if any past medical history has been left out of the application.

The above Notice to Applicant was delivered to me on ____

Date

Applicant's Signature



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

LIMITED BENEFIT DENTAL COVERAGE ONLY

OUTLINE OF COVERAGE FOR POLICY SERIES DNT2

INDIVIDUAL DENTAL NETWORK INSURANCE

BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES.

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

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 network 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/dental-insurance.

| 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 | 50% |
| WAITING PERIOD | TIME FRAME |
| Class I– Diagnostic & Preventive Services | None |
| Class II- Basic Services | None |
| Class III– Major Services | 1 Year |

DENTAL BENEFITS SUMMARY

| MAXIMUM BENEFIT | AMOUNT |
|---|------------|
| Annual Maximum Benefit per Calendar Year | \$1,500.00 |
| Implant Lifetime Maximum Benefit | \$3,000.00 |

You may obtain dental care for covered dental services from any licensed dentist. Coinsurance percentages, deductibles, and maximums will be the same for services rendered by in-network and out-of-network dentists. However, when you use an in-network dentist who participates in the 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 network used by this policy is DenteMax Plus.

If you select a dentist who does not participate in the 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 – Class III 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 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;
- (d) 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;
- (e) services or treatment performed prior to the policy effective date;
- (f) services or treatment incurred after the termination date of your coverage unless otherwise indicated;
- (g) services or treatment which is not dentally appropriate or which does not meet generally accepted standards of dental practice;
- (h) services or treatment resulting from your failure to comply with professionally prescribed treatment;
- (i) telephone consultations;
- (j) any charges for failure to keep a scheduled appointment;
- (k) any services that are considered strictly cosmetic in nature including, but not limited to, charges for personalization or characterization of prosthetic appliances;
- (l) fluoride treatments;
- (m) services or treatment provided as a result of intentionally self-inflicted injury or illness;
- (n) 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;
- (o) office infection control charges;

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- (p) 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;
- (q) state, federal, or territorial taxes on dental services performed;
- (r) those charges submitted by a dentist, which are for the same services performed on the same date by another dentist;
- (s) those dental services provided free of charge by any governmental unit, except where this exclusion is prohibited by law;
- (t) those dental services for which you would have no obligation to pay in the absence of this or any similar insurance;
- (u) those dental services which are for specialized procedures and techniques;
- (v) those dental services performed by a dentist who is compensated by a facility for similar covered services performed for you on the same date;
- (w) duplicate, provisional and temporary devices, appliances, and services;
- (x) plaque control programs, oral hygiene instruction, and dietary instructions;
- (y) 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;
- (z) gold foil restorations;
- (aa) 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;
- (bb) hospital costs or any additional fees that the dentist or hospital charges for treatment at the hospital (inpatient or outpatient);
- (cc) charges by the provider for completing dental forms;
- (dd) adjustment of a denture or bridgework which is made within 6 months after installation by the same dentist who installed it;
- (ee) use of material or home health aids to prevent decay, such as:
 - 1. toothpaste;
 - 2. fluoride gels;
 - 3. dental floss and;
 - 4. teeth whiteners;
- (ff) sealants;
- (gg) precision attachments, personalization, precious metal bases and other specialized techniques;
- (hh) replacement of dentures that have been:
 - 1. lost;
 - 2. stolen or;
 - 3. misplaced;
- (ii) repair of damaged orthodontic appliances;
- (jj) replacement of lost or missing appliances;
- (kk) fabrication of athletic mouth guard;
- (ll) internal bleaching;

(mm)nitrous oxide;

- (nn) oral sedation;
- (oo) topical medicament carrier;
- (pp) orthodontic services, treatment or supplies, including braces and retainers;
- (qq) bone grafts when done in connection with:
 - 1. extractions;
 - 2. apicoectomies or;

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- 3. non-covered/non-eligible implants;
- (rr) tooth whitening;
- (ss) occlusal guards;
- (tt) space maintainers;
- (uu) services or treatment received outside of the United States, its possessions or territories, Canada, or Mexico; or
- (vv) services related to the diagnosis and treatment of Temporomandibular Joint Dysfunction (TMD, TMJD) and related disorders.

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

<u>Guaranteed Renewable For Life</u> – The policy is guaranteed renewable for life. We cannot cancel your policy as long as you pay the required premium when it is due.

<u>Grace Period</u> – Your policy has a 31-day grace period. This means that if you do not pay a premium on or before the date it is due, you can pay it during the following 31 days. Unless we receive a request from you to cancel your policy, your policy will stay in force during the grace period.

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

Total premium amount _____

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

LIMITED BENEFIT DENTAL COVERAGE ONLY

OUTLINE OF COVERAGE FOR POLICY SERIES DNT5

INDIVIDUAL DENTAL NETWORK INSURANCE

BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES.

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

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 network 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/dental-insurance.

| DEDUCTIBLE | AMOUNT |
|--|------------|
| Class I Diagnostic & Preventive | \$100.00 |
| Services, Class II – Basic Services and | |
| Class III – Major Services Combined | |
| COINSURANCE | PERCENTAGE |
| | PAYABLE |
| Class I – Diagnostic & Preventive Services | 100% |
| Class II – Basic Services | 50% |
| Class III – Major Services | 50% |
| WAITING PERIOD | TIME FRAME |
| Class I– Diagnostic & Preventive Services | None |
| Class II– Basic Services | None |
| Class III– Major Services | 1 Year |
| MAXIMUM BENEFIT | AMOUNT |

DENTAL BENEFITS SUMMARY

| Annual Maximum Benefit per Calendar Year | \$1,000.00 |
|---|------------|
| Implant Lifetime Maximum Benefit | \$2,000.00 |

You may obtain dental care for covered dental services from any licensed dentist. Coinsurance percentages, deductibles, and maximums will be the same for services rendered by in-network and out-of-network dentists. However, when you use an in-network dentist who participates in the 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 network used by this policy is DenteMax Plus.

If you select a dentist who does not participate in the 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 – Class III 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 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;
- (d) 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;
- (e) services or treatment performed prior to the policy effective date;
- (f) services or treatment incurred after the termination date of your coverage unless otherwise indicated;
- (g) services or treatment which is not dentally appropriate or which does not meet generally accepted standards of dental practice;
- (h) services or treatment resulting from your failure to comply with professionally prescribed treatment;
- (i) telephone consultations;
- (j) any charges for failure to keep a scheduled appointment;
- (k) any services that are considered strictly cosmetic in nature including, but not limited to, charges for personalization or characterization of prosthetic appliances;
- (l) fluoride treatments;
- (m) services or treatment provided as a result of intentionally self-inflicted injury or illness;
- (n) 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;
- (o) office infection control charges;

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- (p) 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;
- (q) state, federal, or territorial taxes on dental services performed;
- (r) those charges submitted by a dentist, which are for the same services performed on the same date by another dentist;
- (s) those dental services provided free of charge by any governmental unit, except where this exclusion is prohibited by law;
- (t) those dental services for which you would have no obligation to pay in the absence of this or any similar insurance;
- (u) those dental services which are for specialized procedures and techniques;
- (v) those dental services performed by a dentist who is compensated by a facility for similar covered services performed for you on the same date;
- (w) duplicate, provisional and temporary devices, appliances, and services;
- (x) plaque control programs, oral hygiene instruction, and dietary instructions;
- (y) 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;
- (z) gold foil restorations;
- (aa) 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;
- (bb) hospital costs or any additional fees that the dentist or hospital charges for treatment at the hospital (inpatient or outpatient);
- (cc) charges by the provider for completing dental forms;
- (dd) adjustment of a denture or bridgework which is made within 6 months after installation by the same dentist who installed it;
- (ee) use of material or home health aids to prevent decay, such as:
 - 1. toothpaste;
 - 2. fluoride gels;
 - 3. dental floss and;
 - 4. teeth whiteners;
- (ff) sealants;
- (gg) precision attachments, personalization, precious metal bases and other specialized techniques;
- (hh replacement of dentures that have been:
 - 1. lost;
 - 2. stolen or;
 - 3. misplaced;
- (ii) repair of damaged orthodontic appliances;
- (jj) replacement of lost or missing appliances;
- (kk) fabrication of athletic mouth guard;
- (ll) internal bleaching;

(mm)nitrous oxide;

- (nn) oral sedation;
- (oo) topical medicament carrier;
- (pp) orthodontic services, treatment or supplies, including braces and retainers;
- (qq bone grafts when done in connection with:
 - 1. extractions;
 - 2. apicoectomies or;

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- 3. non-covered/non-eligible implants;
- (rr) tooth whitening;
- (ss) occlusal guards;
- (tt) space maintainers;
- (uu) services or treatment received outside of the United States, its possessions or territories, Canada, or Mexico; or
- (vv) services related to the diagnosis and treatment of Temporomandibular Joint Dysfunction (TMD, TMJD) and related disorders.

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

<u>Guaranteed Renewable For Life</u> – The policy is guaranteed renewable for life. We cannot cancel your policy as long as you pay the required premium before it is due.

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Total premium amount _____