Omaha Insurance Co. Coverage Outline

Thank you for your interest in the Omaha Insurance Company Medicare Supplement plan!

Attached is a copy of the policy Outline of Coverage and we have supplied you with a link to a printable copy of the Enrollment Form as well as a link to their online application.

Should you decide to apply by mail/fax/email, the printable application needs to be reviewed and signed by an Agent before it can be submitted to Omaha Insurance Company. You may email, fax or mail it in to CDA Insurance:

- Fax: 1.541.284.2994
- Email: client.services@cda-insurance.com
- Secure File Upload: Click here
- Mail: CDA Insurance LLC
  PO Box 26540
  Eugene, Oregon 97402

Other Important Information
Download Medicare's Choosing a Medigap Policy Guide (.pdf) **Online Application** Download Plan Outline (.pdf) Download Application Instructions (.pdf)

Our website: http://www.medicare-texas.net

If you should have any questions on the application, please call us at 1.800.884.2343 or 1.541.434.9613.

Select the Medicare Supplement Insurance Plan that's Right for You

	Medicare Pays	Plan A Pays	Plan F Pays	Plan G Pays
Medicare Part A Hospital Insurance*				
First 60 days	All but $1,260			
Deductible	Nothing		$1,260	$1,260
Coinsurance 61-90 days	All but $315 a day	$315 a day	$315 a day	$315 a day
Coinsurance 91-150 days	All but $630 a day	$630 a day	$630 a day	$630 a day
Extended Hospital Coverage (up to an additional 365 days in your lifetime)	Nothing	Eligible Expenses	Eligible Expenses	Eligible Expenses
Benefit for Blood	All but three pints	Three pints	Three pints	Three pints
Skilled Nursing Facility Care				
First 20 days	100%			
Coinsurance 21-100 days	All but $157.50 a day		Up to $157.50 a day	Up to $157.50 a day
Hospice Care				
Outpatient Prescription Drugs	All but $5	$5	$5	$5
Inpatient Respite Care	All but 5%	5% of Medicare's approved amount	5% of Medicare's approved amount	5% of Medicare's approved amount
Medicare Part B Medical Insurance*				
Deductible	Nothing		$147	
Coinsurance	Generally 80%	Generally 20%	Generally 20%	Generally 20%
Excess Benefits			100% up to Medicare's limit	100% up to Medicare's limit
Benefit for Blood	All but three pints	Three pints	Three pints	Three pints
Additional Benefit*				
Emergency Care Received Outside the U.S.	Nothing		80% to lifetime max of $50,000	80% to lifetime max of $50,000
		Your Premium	**Your Premium**	**Your Premium**
		$ _____	$ _____	$ _____

* Refer to the next page and your outline of coverage for more information.

Medicare Part A Hospital Coverage

Medicare Part A hospital/skilled nursing facility care eligible expenses include charges for semiprivate room and board, general nursing and miscellaneous services and supplies.

Deductible – Plans F and G pay the $1,260 inpatient hospital deductible for each benefit period, which begins the first full day you're hospitalized and ends when you haven't been in a hospital or skilled nursing facility for 60 days in a row.

Coinsurance – All plans pay $315 a day when you're hospitalized from the 61st through the 90th day. And, when you're in the hospital from the 91st day through the 150th day, you receive $630 a day for each Lifetime Reserve day used.

Extended Hospital Coverage – When you're in the hospital longer than 150 days during a benefit period, and you've exhausted your 60 days of Medicare Lifetime Reserve, all plans pay the Medicare Part A eligible expenses for hospitalization, paid at the rate Medicare would have paid, subject to a lifetime maximum benefit of an additional 365 days.

Benefit for Blood – All plans pay Medicare's one calendar-year deductible for blood that is the cost of the first three pints needed.

Skilled Nursing Facility Care Benefit

Coinsurance – Plans F and G pay up to $157.50 a day from the 21st through the 100th day during which you receive skilled nursing care. You must enter a Medicare-certified skilled nursing facility within 30 days of being hospitalized for at least three days.

Hospice Care Benefit

Outpatient Prescription Drugs – All plans pay $5 per prescription for outpatient prescription drugs for pain and symptom management.

Inpatient Respite Care – All plans pay 5% of the Medicare-approved amount for inpatient respite care (short-term care given by another caregiver, so the usual caregiver can rest).

Medicare Part B Medical Coverage

Medicare Part B eligible expenses include charges for physicians' services, hospital outpatient services and supplies, physical and speech therapy and ambulance service.

Deductible – Plan F pays the $147 calendar-year deductible.

Coinsurance – After the Medicare Part B deductible, all plans pay generally 20% of eligible expenses. For hospital outpatient services, the copayment amount will be paid under a prospective payment system. If this system is not used, then generally 20% of Medicare approved expenses will be paid.

Excess Benefits – Your bill for Medicare Part B services and supplies may exceed the Medicare eligible expense. When that occurs, Plans F and G pay 100% of the difference, up to the charge limitation established by Medicare.

Benefit for Blood – All plans pay Medicare's one calendar-year deductible for blood that is the cost of the first three pints needed.

Additional Benefit

Medically Necessary Emergency Care Received Outside the U.S. – After you pay a $250 calendar-year deductible, Plans F and G pay you 80% of eligible expenses for health care you need because of a covered injury or illness beginning during the first 60 days of each trip up to a lifetime maximum of $50,000. Emergency care is care needed immediately because of an injury or an illness of sudden and unexpected onset.

Plan Overview

Of the 11 Medicare supplement insurance plans, Omaha Insurance Company offers you three coverages that can help pay some eligible expenses not paid for by Medicare Part A and Medicare Part B. **There may be charges above what Medicare and Omaha Insurance Company pay.** Plan A is available to persons under age 65 on Medicare due to a disability.

Your Medicare supplement insurance does not pay for:
- any expense incurred before your policy date
- expense incurred while this policy is not in force
- expense paid for by Medicare
- services for non-Medicare eligible expenses
- services for which no charge is made when there is no insurance
- loss or expense that is payable under any other Medicare supplement insurance policy or certificate

Medicare eligible expenses means charges of the kinds covered by Medicare Parts A and B, to the extent Medicare recognizes them as reasonable and medically necessary.

Coinsurance is the portion of the eligible expense not paid by Medicare and paid by Omaha Insurance Company.

Open enrollment means you can't be denied any Medicare supplement insurance policy if your application is submitted during the six-month period beginning with the first month in which you first enroll for Medicare Part B benefits at age 65 or older, or upon attaining age 65 if you were previously enrolled in Medicare Part B before turning age 65.

If you're under age 65, you can purchase any plan an insurer offers to people under age 65, during the six-month period beginning with the first month in which you first enroll for Medicare Part B benefits.

Features Give You More Peace of Mind

You're covered immediately. There is no waiting period for preexisting conditions and benefits will be paid from the time your policy is in force.

You have a 30-day free look. If you're not satisfied with your policy, send it back to us within 30 days after receiving it, and we'll refund your premium. Then, this policy will be considered as though it were never issued.

Your policy cannot be canceled. It will be renewed as long as the premiums are paid on time and the information is correct on your application.

Your Medicare supplement insurance benefits will automatically increase as Medicare deductibles and coinsurance increase. Benefits are not paid for any expense paid by Medicare.

Benefits are paid to you, your hospital or doctor. This policy's benefits and premiums may be suspended for up to 24 months if you become entitled to Medicaid benefits. You must request that your policy be suspended within 90 days of becoming entitled to Medicaid. If you lose (are no longer entitled to) Medicaid benefits, this policy can be reinstated if you request reinstatement within 90 days of losing such benefits and pay the required premium.

You have 31 days from your renewal date to pay your premium. Your policy will stay in force during this 31-day grace period.

You can't be singled out for a rate increase, no matter how many times you receive benefits. Your premium changes: (a) each year, as you age, on the renewal date coinciding with or following the anniversary of your policy date; and (b) when the same premium change is made on all in-force Medicare supplement insurance policies of the same form issued to persons of your classification that are renewed in the same state where you live at the same time we change premiums. Your policy's two-person household premium discount ends if the person you live with terminates his or her policy or moves to a different residence.

This is a brief description of your coverage. The outline of coverage must accompany this brochure. For complete information on benefits, exceptions, limitations and reductions, please read your outline of coverage and your policy.

This is a solicitation of insurance and an insurance agent will contact you by telephone.

Neither Omaha Insurance Company nor its Medicare supplement insurance policies are connected with or endorsed by the U.S. government or the federal Medicare program.

OMAHA INSURANCE COMPANY

A Mutual of Omaha Company

OUTLINE OF MEDICARE SUPPLEMENT COVERAGE--COVER PAGE

This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plan A available. Some plans may not be available in your state.

BASIC BENEFITS

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

Plan A	Plan B	Plan C	Plan D	Plan F F*	Plan G	Plan K	Plan L	Plan M	Plan N
Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	**Basic, including 100% Part B coinsurance**	**Basic, including 100% Part B coinsurance**	Hospitalization and preventive care paid at 100%, other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%, other basic benefits paid at 75%	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance, except up to $20 copayment for office visits, and up to $50 copayment for ER
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	**Skilled Nursing Facility Coinsurance**	**Skilled Nursing Facility Coinsurance**	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	**Part A Deductible**	**Part A Deductible**	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Part B Deductible		**Part B Deductible**					
				Part B Excess (100%)	**Part B Excess (100%)**				
		Foreign Travel Emergency	Foreign Travel Emergency	**Foreign Travel Emergency**	**Foreign Travel Emergency**			Foreign Travel Emergency	Foreign Travel Emergency
*Plan F also has an option called high deductible Plan F. The high deductible plan pays the same benefits as Plan F after a 2,180 calendar year deductible has been paid. High deductible Plan F benefits will not begin until out-of-pocket expenses exceed 2,180. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy/certificate. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.						Out-of-pocket limit 4,940; paid at 100% after limit reached	Out-of-pocket limit 2,470; paid at 100% after limit reached		

MONTHLY NON-TOBACCO PREMIUMS*

ZIP CODES: 754-759, 762-769, 778-781, 783, 785-792, 795-799, 885

FEMALE				MALE		
Plan A NM20	**Plan F NM23**	**Plan G NM24**	**Attained Age**	**Plan A NM20**	**Plan F NM23**	**Plan G NM24**
712.11			**Thru 64**	800.11		
89.58	129.82	101.11	**65**	100.64	145.86	113.61
89.58	129.82	101.11	**66**	100.64	145.86	113.61
89.58	129.82	101.11	**67**	100.64	145.86	113.61
91.47	132.57	103.25	**68**	102.78	148.96	116.02
93.37	135.33	105.40	**69**	104.91	152.05	118.42
95.01	137.68	107.23	**70**	106.74	154.70	120.49
96.64	140.05	109.07	**71**	108.57	157.35	122.56
99.89	144.76	112.74	**72**	112.23	162.65	126.68
103.41	149.87	116.73	**73**	116.20	168.40	131.16
106.94	154.99	120.72	**74**	120.16	174.15	135.64
110.47	160.10	124.69	**75**	124.13	179.89	140.11
114.00	165.22	128.68	**76**	128.09	185.64	144.59
117.53	170.33	132.66	**77**	132.06	191.39	149.06
121.06	175.45	136.64	**78**	136.02	197.13	153.53
124.58	180.56	140.63	**79**	139.99	202.88	158.01
128.12	185.67	144.61	**80**	143.95	208.62	162.48
131.37	190.39	148.29	**81**	147.61	213.93	166.62
134.63	195.12	151.96	**82**	151.27	219.23	170.75
137.89	199.84	155.64	**83**	154.92	224.53	174.88
141.14	204.56	159.32	**84**	158.59	229.84	179.01
143.96	208.65	162.50	**85**	161.76	234.44	182.59
146.84	212.82	165.75	**86**	164.99	239.13	186.24
149.79	217.08	169.07	**87**	168.30	243.90	189.96
152.78	221.42	172.46	**88**	171.66	248.78	193.76
155.83	225.85	175.90	**89**	175.10	253.75	197.64
158.95	230.37	179.42	**90**	178.59	258.84	201.60
162.13	234.97	183.01	**91**	182.17	264.01	205.62
165.37	239.67	186.67	**92**	185.81	269.30	209.74
168.68	244.47	190.40	**93**	189.53	274.68	213.93
172.05	249.35	194.21	**94**	193.32	280.17	218.21
175.49	254.34	198.10	**95**	197.19	285.78	222.58
179.00	259.42	202.05	**96**	201.13	291.50	227.03
182.59	264.62	206.10	**97**	205.15	297.32	231.57
186.24	269.91	210.21	**98**	209.26	303.27	236.20
189.96	275.30	214.42	**99+**	213.44	309.33	240.92

*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.

MONTHLY TOBACCO PREMIUMS*

ZIP CODES: 754-759, 762-769, 778-781, 783, 785-792, 795-799, 885

FEMALE				MALE		
Plan A NM20	**Plan F NM23**	**Plan G NM24**	**Attained Age**	**Plan A NM20**	**Plan F NM23**	**Plan G NM24**
818.51			**Thru 64**	919.67		
102.96	149.22	116.22	**65**	115.68	167.65	130.58
102.96	149.22	116.22	**66**	115.68	167.65	130.58
102.96	149.22	116.22	**67**	115.68	167.65	130.58
105.14	152.38	118.68	**68**	118.13	171.22	133.35
107.33	155.55	121.15	**69**	120.59	174.77	136.12
109.21	158.26	123.26	**70**	122.69	177.81	138.49
111.08	160.97	125.37	**71**	124.79	180.86	140.87
114.81	166.39	129.59	**72**	129.00	186.96	145.61
118.86	172.27	134.17	**73**	133.56	193.56	150.76
122.92	178.15	138.75	**74**	138.11	200.17	155.91
126.98	184.02	143.33	**75**	142.68	206.78	161.05
131.03	189.91	147.91	**76**	147.23	213.38	166.19
135.09	195.79	152.49	**77**	151.79	219.99	171.33
139.15	201.66	157.06	**78**	156.35	226.58	176.47
143.20	207.54	161.64	**79**	160.91	233.20	181.62
147.26	213.42	166.22	**80**	165.46	239.80	186.76
151.00	218.84	170.45	**81**	169.67	245.90	191.52
154.75	224.27	174.67	**82**	173.87	251.99	196.26
158.49	229.70	178.89	**83**	178.07	258.08	201.01
162.23	235.13	183.12	**84**	182.29	264.19	205.76
165.47	239.82	186.79	**85**	185.93	269.47	209.87
168.79	244.62	190.52	**86**	189.65	274.86	214.07
172.17	249.52	194.34	**87**	193.45	280.35	218.35
175.61	254.51	198.23	**88**	197.31	285.96	222.71
179.12	259.60	202.19	**89**	201.26	291.67	227.17
182.70	264.79	206.23	**90**	205.28	297.51	231.72
186.35	270.08	210.36	**91**	209.39	303.46	236.35
190.08	275.48	214.56	**92**	213.58	309.54	241.08
193.89	281.00	218.85	**93**	217.85	315.72	245.90
197.76	286.61	223.23	**94**	222.21	322.04	250.82
201.72	292.35	227.70	**95**	226.66	328.48	255.83
205.75	298.19	232.25	**96**	231.18	335.05	260.96
209.87	304.16	236.90	**97**	235.81	341.75	266.18
214.07	310.24	241.62	**98**	240.53	348.59	271.49
218.35	316.44	246.46	**99+**	245.33	355.55	276.92

*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.

MONTHLY NON-TOBACCO PREMIUMS*

ZIP CODES: 733, 750-753, 760-761, 774, 776-777, 782, 784, 793-794

FEMALE				MALE		
Plan A NM20	**Plan F NM23**	**Plan G NM24**	**Attained Age**	**Plan A NM20**	**Plan F NM23**	**Plan G NM24**
807.06			**Thru 64**	906.79		
101.52	147.13	114.59	**65**	114.06	165.31	128.75
101.52	147.13	114.59	**66**	114.06	165.31	128.75
101.52	147.13	114.59	**67**	114.06	165.31	128.75
103.67	150.25	117.02	**68**	116.48	168.82	131.49
105.82	153.37	119.45	**69**	118.90	172.32	134.21
107.68	156.04	121.53	**70**	120.97	175.32	136.55
109.52	158.72	123.62	**71**	123.05	178.33	138.90
113.21	164.06	127.78	**72**	127.19	184.34	143.57
117.20	169.86	132.29	**73**	131.69	190.85	148.65
121.20	175.65	136.81	**74**	136.18	197.37	153.73
125.20	181.45	141.32	**75**	140.68	203.88	158.79
129.20	187.25	145.84	**76**	145.17	210.39	163.87
133.20	193.05	150.35	**77**	149.67	216.91	168.93
137.20	198.84	154.86	**78**	154.16	223.41	174.00
141.19	204.63	159.38	**79**	158.66	229.93	179.08
145.20	210.43	163.89	**80**	163.14	236.44	184.14
148.89	215.78	168.06	**81**	167.29	242.46	188.84
152.58	221.13	172.23	**82**	171.44	248.46	193.52
156.27	226.48	176.39	**83**	175.58	254.47	198.19
159.96	231.83	180.56	**84**	179.73	260.49	202.88
163.16	236.47	184.17	**85**	183.33	265.70	206.93
166.42	241.20	187.85	**86**	186.99	271.01	211.08
169.76	246.02	191.62	**87**	190.74	276.43	215.29
173.15	250.95	195.45	**88**	194.55	281.95	219.60
176.61	255.96	199.36	**89**	198.44	287.59	223.99
180.14	261.08	203.34	**90**	202.41	293.35	228.48
183.75	266.30	207.41	**91**	206.45	299.21	233.04
187.42	271.62	211.56	**92**	210.59	305.20	237.71
191.17	277.06	215.79	**93**	214.80	311.30	242.46
194.99	282.60	220.10	**94**	219.10	317.53	247.31
198.89	288.25	224.51	**95**	223.48	323.88	252.25
202.87	294.01	228.99	**96**	227.95	330.36	257.30
206.93	299.91	233.58	**97**	232.51	336.96	262.45
211.07	305.90	238.24	**98**	237.16	343.71	267.69
215.29	312.01	243.01	**99+**	241.90	350.58	273.04

*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.

MONTHLY TOBACCO PREMIUMS*

ZIP CODES: 733, 750-753, 760-761, 774, 776-777, 782, 784, 793-794

FEMALE				MALE		
Plan A NM20	**Plan F NM23**	**Plan G NM24**	**Attained Age**	**Plan A NM20**	**Plan F NM23**	**Plan G NM24**
927.65			**Thru 64**	1,042.29		
116.69	169.12	131.71	**65**	131.10	190.01	147.99
116.69	169.12	131.71	**66**	131.10	190.01	147.99
116.69	169.12	131.71	**67**	131.10	190.01	147.99
119.16	172.70	134.51	**68**	133.89	194.05	151.13
121.64	176.29	137.30	**69**	136.67	198.07	154.27
123.77	179.36	139.69	**70**	139.05	201.52	156.96
125.89	182.44	142.09	**71**	141.43	204.98	159.65
130.12	188.58	146.87	**72**	146.20	211.89	165.03
134.71	195.24	152.06	**73**	151.37	219.37	170.86
139.31	201.90	157.25	**74**	156.53	226.86	176.70
143.91	208.56	162.44	**75**	161.70	234.35	182.52
148.50	215.23	167.63	**76**	166.86	241.83	188.35
153.10	221.89	172.82	**77**	172.03	249.32	194.18
157.70	228.55	178.00	**78**	177.19	256.80	200.00
162.29	235.21	183.19	**79**	182.37	264.29	205.84
166.89	241.87	188.38	**80**	187.52	271.77	211.66
171.14	248.02	193.18	**81**	192.29	278.68	217.06
175.38	254.17	197.96	**82**	197.05	285.59	222.43
179.62	260.32	202.75	**83**	201.82	292.50	227.81
183.87	266.48	207.54	**84**	206.59	299.41	233.19
187.54	271.80	211.69	**85**	210.72	305.40	237.85
191.29	277.24	215.92	**86**	214.93	311.51	242.62
195.13	282.79	220.25	**87**	219.24	317.73	247.46
199.02	288.45	224.66	**88**	223.62	324.09	252.41
203.00	294.21	229.14	**89**	228.09	330.56	257.46
207.06	300.09	233.72	**90**	232.65	337.18	262.62
211.20	306.09	238.41	**91**	237.30	343.92	267.86
215.42	312.21	243.17	**92**	242.06	350.81	273.23
219.74	318.46	248.03	**93**	246.89	357.82	278.68
224.13	324.83	252.99	**94**	251.84	364.98	284.26
228.61	331.33	258.06	**95**	256.88	372.28	289.95
233.18	337.95	263.21	**96**	262.01	379.73	295.75
237.85	344.72	268.48	**97**	267.25	387.31	301.67
242.61	351.60	273.84	**98**	272.60	395.07	307.69
247.46	358.63	279.32	**99+**	278.04	402.96	313.84

*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.

MONTHLY NON-TOBACCO PREMIUMS*
ZIP CODES: 770-773, 775

FEMALE				MALE		
Plan A NM20	**Plan F NM23**	**Plan G NM24**	**Attained Age**	**Plan A NM20**	**Plan F NM23**	**Plan G NM24**
917.83			**Thru 64**	1,031.25		
115.45	167.33	130.32	**65**	129.71	187.99	146.43
115.45	167.33	130.32	**66**	129.71	187.99	146.43
115.45	167.33	130.32	**67**	129.71	187.99	146.43
117.89	170.87	133.08	**68**	132.47	191.99	149.53
120.35	174.42	135.85	**69**	135.22	195.98	152.63
122.46	177.46	138.21	**70**	137.57	199.39	155.30
124.56	180.51	140.58	**71**	139.94	202.81	157.96
128.74	186.58	145.32	**72**	144.65	209.64	163.28
133.29	193.17	150.45	**73**	149.77	217.05	169.05
137.84	199.76	155.59	**74**	154.87	224.46	174.82
142.39	206.35	160.72	**75**	159.99	231.86	180.59
146.93	212.95	165.85	**76**	165.10	239.27	186.36
151.48	219.54	170.99	**77**	170.21	246.68	192.12
156.03	226.13	176.12	**78**	175.32	254.08	197.88
160.57	232.72	181.25	**79**	180.44	261.49	203.66
165.13	239.31	186.39	**80**	185.53	268.89	209.42
169.32	245.40	191.13	**81**	190.25	275.73	214.76
173.52	251.48	195.87	**82**	194.97	282.57	220.08
177.72	257.57	200.60	**83**	199.68	289.40	225.39
181.92	263.65	205.34	**84**	204.40	296.24	230.72
185.55	268.92	209.45	**85**	208.49	302.17	235.34
189.27	274.30	213.64	**86**	212.66	308.21	240.05
193.06	279.79	217.92	**87**	216.92	314.37	244.84
196.92	285.39	222.28	**88**	221.25	320.65	249.74
200.85	291.09	226.72	**89**	225.68	327.06	254.73
204.87	296.92	231.25	**90**	230.19	333.61	259.84
208.97	302.85	235.88	**91**	234.79	340.28	265.03
213.14	308.91	240.59	**92**	239.49	347.09	270.33
217.41	315.09	245.41	**93**	244.28	354.03	275.73
221.75	321.39	250.31	**94**	249.17	361.11	281.25
226.19	327.82	255.33	**95**	254.16	368.34	286.88
230.71	334.37	260.42	**96**	259.23	375.71	292.62
235.34	341.07	265.64	**97**	264.42	383.21	298.47
240.04	347.88	270.94	**98**	269.71	390.88	304.44
244.84	354.83	276.36	**99+**	275.10	398.70	310.52

*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.

MONTHLY TOBACCO PREMIUMS*
ZIP CODES: 770-773, 775

FEMALE				MALE		
Plan A NM20	**Plan F NM23**	**Plan G NM24**	**Attained Age**	**Plan A NM20**	**Plan F NM23**	**Plan G NM24**
1,054.97			**Thru 64**	1,185.35		
132.70	192.33	149.79	**65**	149.10	216.09	168.30
132.70	192.33	149.79	**66**	149.10	216.09	168.30
132.70	192.33	149.79	**67**	149.10	216.09	168.30
135.51	196.40	152.97	**68**	152.26	220.68	171.88
138.33	200.48	156.15	**69**	155.43	225.26	175.44
140.75	203.97	158.86	**70**	158.13	229.18	178.50
143.17	207.48	161.59	**71**	160.85	233.11	181.56
147.98	214.46	167.03	**72**	166.26	240.97	187.68
153.20	222.04	172.93	**73**	172.14	249.48	194.31
158.43	229.61	178.84	**74**	178.01	258.00	200.95
163.66	237.19	184.73	**75**	183.90	266.51	207.57
168.88	244.77	190.63	**76**	189.76	275.02	214.21
174.12	252.35	196.54	**77**	195.65	283.54	220.83
179.35	259.92	202.43	**78**	201.52	292.04	227.45
184.57	267.50	208.34	**79**	207.40	300.57	234.09
189.80	275.07	214.24	**80**	213.25	309.07	240.71
194.63	282.07	219.69	**81**	218.68	316.94	246.85
199.45	289.06	225.13	**82**	224.10	324.79	252.96
204.28	296.06	230.57	**83**	229.52	332.64	259.07
209.10	303.05	236.03	**84**	234.95	340.51	265.20
213.28	309.11	240.75	**85**	239.64	347.32	270.50
217.55	315.29	245.56	**86**	244.44	354.26	275.92
221.91	321.60	250.48	**87**	249.33	361.34	281.43
226.34	328.04	255.49	**88**	254.31	368.57	287.05
230.86	334.59	260.59	**89**	259.40	375.93	292.80
235.48	341.28	265.80	**90**	264.58	383.46	298.67
240.19	348.10	271.13	**91**	269.87	391.13	304.63
244.99	355.06	276.54	**92**	275.28	398.96	310.73
249.90	362.18	282.08	**93**	280.78	406.93	316.94
254.89	369.41	287.72	**94**	286.40	415.07	323.28
259.99	376.80	293.48	**95**	292.13	423.38	329.74
265.19	384.33	299.34	**96**	297.97	431.85	336.34
270.50	392.03	305.34	**97**	303.93	440.48	343.07
275.91	399.86	311.43	**98**	310.01	449.29	349.93
281.43	407.86	317.65	**99+**	316.20	458.27	356.92

*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.

Disclosures
Use this outline to compare benefits and premiums among policies.

Premium Information
We, Omaha Insurance Company, can only raise your premium if we raise the premium for all policies like yours in this state. Your premium may change each year as you age. This change will only be made on the first renewal date that coincides with or follows each anniversary of the policy date. Schedules of rates may vary depending upon the policy date.

Household Premium Discount
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 Medicare-eligible adults who own or are issued a Medicare supplement policy underwritten by us or our affiliates. The discounted premium will be priced 7% lower than the rates illustrated. The policy's household premium discount will be removed if your spouse or other Medicare supplement policyholder chooses to terminate his or her Medicare supplement policy or he or she no longer resides with you (other than in the case of his or her death).

Read The Policy Very Carefully
This is only an outline describing the 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 us.

Right to Return Policy
If you find that you are not satisfied with the policy, you may return it to us at 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 we nor our agents are connected with Medicare. This outline does not give all the details of Medicare coverage. Contact your local Social Security office or consult "Medicare & You" for more details.

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

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

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

Services	Medicare Pays	Plan A Pays	You Pay
HOSPITALIZATION* Semiprivate room and board, general nursing, and miscellaneous services and supplies First 60 days	All but $1,260	$0	$1,260 (Part A deductible)
61st through 90th day	All but $315 a day	$315 a day	$0
91st day and after: While using 60 lifetime reserve days	All but $630 a day	$630 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 $157.50 a day	$0	Up to $157.50 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 You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

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

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

*Once you have been billed $147 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 $147 of Medicare-approved amounts*	$0	$0	$147 (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 $147 of Medicare-approved amounts*	$0	$0	$147 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A AND B

HOME HEALTH CARE—MEDICARE-APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment First $147 of Medicare-approved amounts*	$0	$0	$147 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

PLANS F AND G

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

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

Services	Medicare Pays	Plan F Pays	You Pay	Plan G Pays	You Pay
HOSPITALIZATION* Semiprivate room and board, general nursing, and miscellaneous services and supplies First 60 days	All but $1,260	$1,260 (Part A deductible)	$0	$1,260 (Part A deductible)	$0
61st through 90th day	All but $315 a day	$315 a day	$0	$315 a day	$0
91st day and after: While using 60 lifetime reserve days	All but $630 a day	$630 a day	$0	$630 a day	$0
Once lifetime reserve days are used: Additional 365 days	$0	100% of Medicare-eligible expenses	$0**	100% of Medicare-eligible expenses	$0**
Beyond the additional 365 days	$0	$0	All costs	$0	All costs
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	$0	$0
21st through 100th day	All but $157.50 a day	Up to $157.50 a day	$0	Up to $157.50 a day	$0
101st day and after	$0	$0	All costs	$0	All costs
BLOOD First 3 pints	$0	3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0	Medicare copayment/ coinsurance	$0

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

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

*Once you have been billed $147 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

Services	Medicare Pays	Plan F Pays	You Pay	Plan G Pays	You Pay
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 $147 of Medicare-approved amounts*	$0	$147 (Part B deductible)	$0	$0	$147 (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0	Generally 20%	$0
Part B Excess Charges (above Medicare-approved amounts)	$0	100%	$0	100%	$0
BLOOD First 3 pints	$0	All costs	$0	All costs	$0
Next $147 of Medicare-approved amounts*	$0	$147 (Part B deductible)	$0	$0	$147 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0	20%	$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0	$0	$0

PARTS A AND B

HOME HEALTH CARE—MEDICARE-APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	$0	$0	$0	$0
Durable medical equipment First $147 of Medicare-approved amounts*	$0	$147 (Part B deductible)	$0	$0	$147 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0	20%	$0

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

OTHER BENEFITS — NOT COVERED BY MEDICARE

Services	Medicare Pays	Plan F Pays	You Pay	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	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum benefit	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum benefit