

# UNITED OF OMAHA LIFE INSURANCE COMPANY

A MUTUAL of OMAHA COMPANY

Mutual of Omaha Plaza, Omaha, NE 68175



## MEDICARE SUPPLEMENT INSURANCE POLICY - PLAN A

### 30-DAY RIGHT TO EXAMINE POLICY

Please read your policy. If, for any reason, you are not satisfied with your policy, you may return it to us or to your agent within 30 days of its delivery. We will then promptly refund all premiums paid, minus any claims paid. The policy will then be considered never to have been issued.

### PLEASE READ YOUR APPLICATION

Please read the attached copy of your application. If anything is incorrect, or if any of your medical history is missing, you should tell us right away. We issued your policy on the presumption that all of the information in your application was correct and complete. If it is not, your policy may not be valid.

### GUARANTEED RENEWABLE FOR LIFE

Your policy is guaranteed renewable for life. This means you have the right to continue your policy for as long as you live. Unless there has been a *material misrepresentation*, we cannot cancel your coverage as long as you pay the required premium when it is due.

### PREMIUM CHANGES

The premium for your policy will change. Because the premium rate is based on your attained age, the premium will increase each year as you grow older from age 65 through *age 99*. This annual premium change will occur on the first *policy renewal date* which coincides with or follows the policy anniversary date.

We may also change the premium for your policy for reasons other than your attained age. If you cease to be eligible for the household premium discount described in the HOUSEHOLD PREMIUM DISCOUNT provision, your policy's discount will be removed. This premium change will occur on the first *policy renewal date* coinciding with or following the date we learned your eligibility ended.

A premium change for any other reason can occur on any *policy renewal date*. However, we cannot make such a change unless we make the same change to all policies of this form issued to persons of the same classification, living in the same geographic area of your state. We will give you the advance written notice required by your state before we change your premium.

**This Is a Legal Contract Between You and Us.**

**READ YOUR POLICY CAREFULLY.**

**NOTICE TO BUYER:**

**THIS POLICY MAY NOT COVER ALL OF YOUR MEDICAL EXPENSES.**

**This is a non-participating policy. No dividends will be paid.**

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## DEFINITIONS

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This section provides an alphabetical list of certain terms and their meanings as used in your policy. As you read through your policy, keep in mind that any word you see in *italics* is a defined term.

**Age 99** means your insurance age on the first *policy renewal date* following the policy anniversary date which coincides with or next follows your 99th birthday.

**Benefit period** means the period of time *Medicare* defines as a benefit period under *Medicare* Part A. A benefit period begins on the first day you are admitted to a *hospital* as an inpatient. A benefit period generally ends when you have not received any inpatient *hospital* care or skilled nursing facility care for 60 days in a row.

**Hospital** means a place *Medicare* has defined and approved for payment as a hospital.

**Material misrepresentation** means the failure to disclose information you were requested to disclose on your application which, if disclosed, would have required a different premium or caused us to deny issuing your policy. Any material misrepresentation is subject to the **Time Limit on Certain Defenses** provision.

**Medicare** means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended. Traditional Medicare is divided into two parts, Part A (*hospital*/skilled nursing facility coverage) and Part B (medical/surgical coverage).

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

**Policy date** means the date your coverage starts under this policy.

**Policy renewal date** means the date your policy's premium is due. The frequency of the policy renewal date will vary depending on whether you pay premiums monthly, quarterly, semiannually, or annually.

**We, us, and our** mean United of Omaha Life Insurance Company.

**You and your** mean the person named as the insured on the policy schedule.

## BASIC CORE BENEFITS

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Your policy is designed to coordinate with *Medicare*. We will consider our benefits:

- (a) as if you are enrolled in both Part A and Part B of *Medicare* (even if you are not enrolled in Part B); and
- (b) as if *Medicare* has paid its portion of the expense incurred.

When you incur *Medicare-eligible expenses*, we will pay basic core benefits as follows:

### MEDICARE PART A INPATIENT HOSPITAL BENEFITS

#### Coinsurance Benefit

We will pay the *Medicare* Part A coinsurance amount for each day you are confined in a *hospital*, from the 61st day through the 90th day of each *Medicare benefit period*.

### **Lifetime Reserve Days Benefit**

After you have been confined in a *hospital* for 90 days in a *Medicare benefit period*, we will pay the *Medicare* Part A coinsurance amount for each lifetime reserve day you use. Lifetime reserve days are those last remaining days of inpatient *hospital* confinement available to you before *Medicare* Part A inpatient *hospital* benefits become exhausted. Lifetime reserve days are limited to a maximum of 60 days during your entire lifetime.

### **Medicare Exhaustion Benefit**

When you have exhausted all of your *Medicare* inpatient *hospital* coverage, including the lifetime reserve days, we will pay 100% of your Part A *Medicare-eligible expenses* for hospitalization at the applicable prospective payment system (PPS) rate, or other appropriate *Medicare* standard of payment. This benefit is subject to a lifetime maximum of an additional 365 days. The provider must accept our payment as payment in full and may not bill you for any balance.

### **MEDICARE PART A OR PART B BLOOD DEDUCTIBLE BENEFIT**

We will pay the expense you incur for the reasonable cost of the first three pints of unreplaced blood (or equivalent quantities of packed red blood cells) you receive per calendar year under *Medicare* Part A or Part B. *Medicare* calls this amount the blood deductible. Once we have paid this blood deductible under either *Medicare* Part A or Part B, you do not have to meet this deductible under the other Part. Anyone may donate blood to replace the blood you use, in accordance with federal regulations.

### **MEDICARE PART A HOSPICE AND RESPITE CARE BENEFIT**

We will pay the copayment/coinsurance amount for all Part A *Medicare-eligible expenses* you incur for hospice care and respite care.

### **MEDICARE PART B COINSURANCE BENEFIT**

After you have satisfied the *Medicare* Part B calendar year deductible, we will pay the coinsurance amount for Part B *Medicare-eligible expenses* you incur. The coinsurance amount is generally 20% of the amount *Medicare* has approved for medical services. In the case of *hospital* outpatient department services paid under a prospective payment system, we will pay the copayment amount.

## **AUTOMATIC ADJUSTMENT FOR CHANGES IN MEDICARE**

If *Medicare* changes any of its deductible amounts or coinsurance percentages, we will automatically adjust your benefits to coordinate with such changes. We may also adjust your premium to correspond with these benefit changes, subject to the PREMIUM CHANGES section. Likewise, if *Medicare* changes the period of time or number of days applicable to a particular benefit, we will adjust your policy accordingly.

## **EXTENSION OF BENEFITS**

If you incur expense for a continuous loss which began while your policy was in force, we will extend benefits for such loss beyond the date insurance ends. This extension of benefits will be:

- (a) conditioned upon your continuous total disability; and
- (b) limited to the duration of the *Medicare benefit period* or, if none is applicable, our payment of the maximum benefits.

We will pay benefits during this extension as if your coverage had not ended. However, we will extend benefits only for those sicknesses and/or injuries causing your continuous loss while your policy was still in force. In determining a continuous loss, we will not consider your receipt of *Medicare* Part D outpatient prescription drug benefits.

## **SUSPENSION OF COVERAGE**

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### **SUSPENSION AVAILABLE DURING MEDICAID ENTITLEMENT**

If you become entitled to Medicaid benefits, you may request that we suspend benefits and premiums under your policy for up to 24 months. You must notify us within 90 days of the date you become entitled to Medicaid benefits.

When we receive your timely request, we will refund any unearned premium for the period of time you are eligible for Medicaid. We will reduce your refund by the amount of any claims paid for the period you are eligible for Medicaid.

If you lose your Medicaid benefits during this suspension of coverage, we will reinstitute your policy effective the date your Medicaid eligibility ends, as long as you notify us within 90 days of losing your Medicaid benefits. You must pay the applicable policy premium. When we reinstitute your policy, we will:

- (a) provide coverage substantially the same as the coverage you had prior to the date of suspension; and
- (b) charge a premium at least as favorable as the premium you paid before we suspended your coverage.

### **SUSPENSION AVAILABLE WHILE COVERED UNDER A GROUP HEALTH PLAN**

If you are entitled to benefits under Section 226(b) of the Social Security Act and are covered under a group health plan, you may request that we suspend benefits and premiums under your policy. This suspension of coverage can last as long as federal regulation allows.

When we receive your request, we will refund any unearned premium for the period of time you were covered under the group health plan. We will reduce your refund by the amount of any claims paid for the period you were covered under the group health plan.

If you lose coverage under the group health plan during this suspension of coverage, we will reinstitute your policy effective the date your coverage under the group health plan ends, as long as you notify us within 90 days of losing your coverage. You must pay the applicable policy premium. When we reinstitute your policy, we will:

- (a) provide coverage substantially the same as the coverage you had prior to the date of suspension; and
- (b) charge a premium at least as favorable as the premium you paid before we suspended your coverage.

## **TERMINATION**

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Your policy will terminate on the earliest of:

- (a) the date we receive your written or verbal request to cancel the policy, or a future date you specify in such request (in either case the grace period will not apply);
- (b) the coverage effective date on which this policy is replaced by another *Medicare* supplement or *Medicare Select* policy (in which case the grace period will not apply);
- (c) the *policy renewal date*, if the required premium has not been paid before the end of the grace period; or
- (d) the date of your death.

In the event of cancellation or death, we will promptly return the unearned portion of any premium paid. Termination will not affect any claim that began while your policy was in force.

## EXCLUSIONS

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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) your confinement in a *hospital* or skilled nursing facility during a *Medicare Part A benefit period* that begins while your policy is not in force;
- (c) that portion of any expense you incur which is paid for by *Medicare*;
- (d) non-*Medicare-eligible expenses*, including, but not limited to, routine exams, take-home drugs, and eye refractions;
- (e) services for which a charge is not normally made in the absence of insurance; or
- (f) loss or expense that is payable under any other *Medicare* supplement insurance policy or certificate.

## HOUSEHOLD PREMIUM DISCOUNT

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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. If you live with another adult who is your legal spouse, we will waive the one-year requirement. For the purposes of this discount, a civil union partner or domestic partner will be considered a legal spouse when such partnerships are valid and recognized in your state of residence. We may request additional documentation to determine eligibility.

Your premium will be reduced by the percentage shown on the policy schedule.

Your policy's household premium discount will be removed if the 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).

## CLAIMS PROVISIONS

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### NOTICE OF CLAIM

Written notice of a claim must be given to us within 20 days after a covered loss starts, or as soon as reasonably possible. You may give the required notice or someone else may do it for you. The notice should include your name and policy number. Notice should be mailed to the address shown on the face page of your policy, or to any of our agents.

## **ELECTRONIC NOTICE OF CLAIM**

Your health care providers will usually electronically submit to *Medicare* the billed charges for any medical or *hospital* expenses you incur. *Medicare* then processes benefits for expenses eligible under Part A and/or Part B, and then passes your claim electronically to us. We will accept *Medicare's* electronic submission of your claim as your notice of claim. For expenses that are not submitted electronically, you or your health care provider may submit a paper copy of your *Medicare* Summary Notice or *Medicare* Benefit Notice. These *Medicare* statements show your *Medicare-eligible expenses* and the amount approved and paid by *Medicare*.

## **CLAIM FORMS**

When we receive your notice of claim, we will send you forms for filing proof of loss. If we do not send you these forms within 15 days of such notice, you can meet the proof of loss requirement by giving us a written statement of your claim. We must receive this statement within the time given for filing proof of loss.

## **PROOF OF LOSS**

Written proof of loss must be given to us within 90 days after the onset of such loss. If it was not reasonably possible to give us written proof within the required time, we will not reduce or deny your claim for this reason if the proof is supplied as soon as reasonably possible. In any case, proof must be given no more than 12 months from the time specified, unless you were legally incapacitated.

## **TIME OF PAYMENT OF CLAIMS**

We will pay benefits for a covered loss as soon as we receive proper written proof of loss.

## **PAYMENT OF CLAIMS**

We will pay benefits to you, if you are living, unless you send us a written request to pay your health care provider directly. Benefits unpaid at your death which are not assigned will be paid to your estate.

If any benefits are payable to your estate, or to a minor or any person not legally able to give a valid release, we may pay up to \$1,000 to any relative of yours whom we find entitled to the payment. If we make a payment in good faith, we will be fully discharged to the extent of that payment.

## **TERM OF COVERAGE**

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Your coverage starts on the *policy date* at 12:01 a.m. where you reside. It ends at 12:01 a.m. where you reside on the first *policy renewal date*. Each time you renew your policy by paying the premium within the 31-day grace period, a new term begins when the old term ends.

## **POLICY PROVISIONS**

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### **CONSIDERATION**

In consideration of the first premium you paid, the application you completed, and our reliance on your answers to the application questions, we have put your policy in force as of the *policy date*. That date is shown on the policy schedule. A copy of your application is attached.

## **ENTIRE CONTRACT AND CHANGES**

This policy is a contract between you and us. The entire contract consists of:

- (a) the policy;
- (b) the attached signed application;
- (c) any supplemental applications made part of the policy;
- (d) any riders; and
- (e) any endorsements or amendments.

No change in your policy will be effective until approved by a company officer. This approval must be noted on or attached to your policy. No agent can change your policy or waive any of its provisions. Any rider, endorsement, or application added after the *policy date* which reduces or eliminates coverage under your policy will require your signed acceptance to be valid.

## **TIME LIMIT ON CERTAIN DEFENSES**

After two years from the date you become insured under this policy, only fraudulent misrepresentations in the application can be used to void the policy or deny a claim for loss incurred or disability that starts after the two-year period.

## **GRACE PERIOD**

Your policy has a 31-day grace period. This means that if you do not pay a renewal premium on or before the date it is due, you can pay it during the following 31 days. During the grace period your policy will stay in force.

## **REINSTATEMENT**

Your policy will lapse if you do not pay your premium before the end of the grace period. If we accept a late premium without requiring you to complete an application for reinstatement, your policy will be reinstated.

If we require you to complete an application for reinstatement, we will give you a conditional receipt for the premium. If we approve your application, we will reinstate your policy as of the approval date. If we do not approve your application within 45 days of the application date, we will reinstate your policy on the 45th day following the date of the conditional receipt, unless we have previously given you written notice of its disapproval.

Your reinstated policy will only cover *Medicare-eligible expenses* incurred after the date of reinstatement. In all other respects, your rights and our rights will remain the same as before the policy lapsed.

We will apply any premium we accept for reinstatement to a period for which premium has not previously been paid. We will not apply a premium to any period more than 60 days prior to the reinstatement date.

## **PHYSICAL EXAMINATIONS AND AUTOPSY**

We have the right to have you examined, at our expense, as often as reasonably necessary while a claim is pending. We may also have an autopsy done, at our expense, unless prohibited by law.



## **LEGAL ACTIONS**

You cannot bring a legal action to recover under this policy until at least 60 days after you have given us satisfactory written proof of loss. You cannot bring a legal action more than three years from the date proof of loss is required.

## **OTHER INSURANCE WITH US**

You can be insured under only one of our *Medicare* supplement policies at any one time. If you are insured under more than one such policy, you must select the one that is to remain in effect. In the event of your death, your estate will make this selection. We will refund all premiums paid, minus any claims paid, for the policy you cancel.

## **UNPAID PREMIUM**

When we pay benefits for a claim under your policy, we may reduce those benefits by the amount of any premium then due and unpaid.

## **CONFORMITY WITH STATE AND FEDERAL LAWS**

Any provision of your policy which, on its effective date, is in conflict with the laws of the state in which you reside on that date, is amended to conform to the minimum requirements of those laws. Any provision of your policy which, on its effective date, is in conflict with any federal laws relating to *Medicare*, is amended to conform to the minimum requirements of those laws.

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**POLICY SCHEDULE**

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<b>POLICY NUMBER</b> UM20-[000000-00M]	<b>POLICY DATE</b> [01-01-2012]	<b>FIRST RENEWAL DATE</b> [01-01-2013]
<b>INITIAL PREMIUM</b> [\$0,000.00]	<b>RENEWAL PREMIUM</b> [\$0,000.00**]	[Annual, Semiannual, Quarterly, Monthly]
<b>POLICY BENEFIT</b>	<b>SERIES</b> [24101]	

AS SPECIFIED IN THE POLICY

**INSURED**

[James J. Jones]  
[123 Main Street]  
[Anytown, AL 00000]

**INITIAL PREMIUM** \$[0,000.00]

**MGR**

[Don Jones]  
[J Brown 09999]

**ADDITIONAL COVERAGE AND POLICY ADJUSTMENTS SHOWN BELOW**

**(NOTE: INFORMATION MAY CONTINUE ON REVERSE--PLEASE READ)**

\*\*Renewal Premium Subject To Change

HOUSEHOLD PREMIUM DISCOUNT: [7%, None]

[RISK CLASS I - 10%]  
[RISK CLASS II - 20%]

**CLAIM INFORMATION CALL [1-XXX-XXX-XXXX]**  
**OTHER SERVICE QUESTIONS CALL [1-XXX-XXX-XXXX]**

UM20-24101