United of Omaha Coverage Outline

Thank you for your interest in the United of Omaha Medicare Supplement plan!

This application packet provides you with a link to the Online Application to submit your application directly to United of Omaha, directions about how to access a printable copy of the Enrollment Form and the Outline of Coverage in addition to a link to the Choosing a Medigap Policy Guide.

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

- Fax: 1.541.284.2994
- Email: cs@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 Policy Outline (.pdf) Download Application Instructions (.pdf)

Our website: https://medicare-washington.com

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

Mutual of Omaha

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

3300 Mutual of Omaha Plaza
Omaha, Nebraska 68175

APPLICATION for MEDICARE SUPPLEMENT INSURANCE

WASHINGTON

UAP1132_WA
12/11/2019

UNITED OF OMAHA LIFE INSURANCE COMPANY

A Mutual of Omaha Company

OUTLINE OF MEDICARE SUPPLEMENT COVERAGE – COVER PAGE

BENEFIT PLANS A, F, HIGH DEDUCTIBLE F, G AND N

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 Part B coinsurance or copayments.

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 Co-insurance	Basic, including 100% Part B Co-insurance	Basic, including 100% Part B Co-insurance	Basic, including 100% Part B Co-insurance	**Basic, including 100% Part B Co-insurance***	**Basic, including 100% Part B Co-insurance**	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 Co-insurance	**Basic, including 100% Part B Coinsurance, except up to $20 copayment for office visit, and up to $50 copayment for ER**
		Skilled Nursing Facility Co-insurance	Skilled Nursing Facility Co-insurance	**Skilled Nursing Facility Co-insurance**	**Skilled Nursing Facility Co-insurance**	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Co-insurance	**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**
						Out-of-pocket limit $5,880; paid at 100% after limit reached	Out-of-pocket limit $2,940; paid at 100% after limit reached		

*Plan F also has an option called a high deductible Plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2,340 deductible. Benefits from high deductible Plan F will not begin until out-of-pocket expenses exceed $2,340. 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.

MONTHLY PREMIUMS* (BANK SERVICE PLAN)

Age	Plan A UM20	Plan F UM23	Plan High F UM34	Plan G UM24	Plan N UM35
Issue Age 65 and Over	185.28	262.40	70.13	204.61	140.19

QUARTERLY PREMIUMS*

Age	Plan A UM20	Plan F UM23	Plan High F UM34	Plan G UM24	Plan N UM35
Issue Age 65 and Over	555.85	787.19	210.40	613.84	420.57

SEMIANNUAL PREMIUMS*

Age	Plan A UM20	Plan F UM23	Plan High F UM34	Plan G UM24	Plan N UM35
Issue Age 65 and Over	1,111.70	1,574.37	420.80	1,227.67	841.15

ANNUAL PREMIUMS*

Age	Plan A UM20	Plan F UM23	Plan High F UM34	Plan G UM24	Plan N UM35
Issue Age 65 and Over	2,223.40	3,148.74	841.60	2,455.34	1,682.29

*See PREMIUM INFORMATION regarding Household Premium Discount rating.

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

Premium Information
We, United of Omaha Life 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.

Household Premium Discount
You may be eligible for a household premium discount if, at the time of application, you reside with your spouse, civil union partner, or domestic partner who owns or is issued a Medicare supplement policy underwritten by us. For the purposes of this discount, a civil union partner or domestic partner will be considered eligible 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).

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 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 insurance producers are connected with Medicare. This outline of coverage does not give all the details of Medicare Coverage. Contact your local Social Security office or consult "Medicare & You" for more details.

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

Exclusions
Exclusions apply to your coverage. Please be sure to review the exclusions in your policy.

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 $1,408	$0	$1,408 (Part A deductible)
61st through 90th day	All but $352 a day	$352 a day	$0
91st day and after:			
While using 60 lifetime reserve days	All but $704 a day	$704 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 $176 a day	$0	Up to $176 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 $198 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 $198 of Medicare-approved amounts*	$0	$0	$198 (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 $198 of Medicare-approved amounts*	$0	$0	$198 (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 $198 of Medicare-approved amounts*	$0	$0	$198 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

PLANS F AND HIGH DEDUCTIBLE F

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 High Deductible F Pays (After you pay $2,340 deductible***)	You Pay (In addition to $2,340 deductible***)
HOSPITALIZATION* Semiprivate room and board, general nursing, and miscellaneous services and supplies First 60 days	All but $1,408	$1,408 (Part A deductible)	$0	$1,408 (Part A deductible)	$0
61st through 90th day	All but $352 a day	$352 a day	$0	$352 a day	$0
91st day and after: While using 60 lifetime reserve days	All but $704 a day	$704 a day	$0	$704 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 $176 a day	Up to $176 a day	$0	Up to $176 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. ***High deductible plan F pays the same benefits as Plan F after one has paid a calendar year $2,340 deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses exceed $2,340. 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.

PLANS F AND HIGH DEDUCTIBLE F
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed $198 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 High Deductible F Pays (After You pay $2,340 deductible***)	You Pay (In addition to $2,340 deductible***)
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 $198 of Medicare-approved amounts*	$0	$198 (Part B deductible)	$0	$198 (Part B deductible)	$0
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 $198 of Medicare-approved amounts*	$0	$198 (Part B deductible)	$0	$198 (Part B deductible)	$0
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 $198 of Medicare-approved amounts	$0	$198 (Part B deductible)	$0	$198 (Part B deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0	20%	$0

***High deductible plan F pays the same benefits as Plan F after one has paid a calendar year $2,340 deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses exceed $2,340. 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.

PLANS F AND HIGH DEDUCTIBLE F
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

OTHER BENEFITS – NOT COVERED BY MEDICARE

Services	Medicare Pays	Plan F Pays	You Pay	Plan High Deductible F Pays (After you pay $2,340 deductible***)	You Pay (In addition to $2,340 deductible***)
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

***High deductible plan F pays the same benefits as Plan F after one has paid a calendar year $2,340 deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses exceed $2,340. 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.

PLANS G AND N

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

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

Services	Medicare Pays	Plan G Pays	You Pay	Plan N Pays	You Pay
HOSPITALIZATION* Semiprivate room and board, general nursing, and miscellaneous services and supplies First 60 days	All but $1,408	$1,408 (Part A deductible)	$0	$1,408 (Part A deductible)	$0
61st through 90th day	All but $352 a day	$352 a day	$0	$352 a day	$0
91st day and after: While using 60 lifetime reserve days	All but $704 a day	$704 a day	$0	$704 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 $176 a day	Up to $176 a day	$0	Up to $176 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 G AND N

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

*Once you have been billed $198 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

Services	Medicare Pays	Plan G Pays	You Pay	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 $198 of Medicare-approved amounts*	$0	$0	$198 (Part B deductible)	$0	$198 (Part B deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0	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	100%	$0	$0	All costs
BLOOD First 3 pints	$0	All costs	$0	All costs	$0
Next $198 of Medicare-approved amounts*	$0	$0	$198 (Part B deductible)	$0	$198 (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

PLANS G AND N
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

PARTS A AND B

Services	Medicare Pays	Plan G Pays	You Pay	Plan N Pays	You Pay
HOME HEALTH CARE – MEDICARE-APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	$0	$0	$0	$0
DURABLE MEDICAL EQUIPMENT First $198 of Medicare-approved amounts*	$0	$0	$198 (Part B deductible)	$0	$198 (Part B deductible)
Remainder of Medicare-approved amounts	80%	20%	$0	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

Services	Medicare Pays	Plan G Pays	You Pay	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	$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