UNITED OF OMAHA LIFE INSURANCE COMPANY

A Mutual of Omaha Company

OUTLINE OF MEDICARE SUPPLEMENT COVERAGE — COVER PAGE

STANDARDIZED BENEFIT PLAN A AND SELECT BENEFIT PLANS F AND G

These charts show the benefits included in each of the standard Medicare supplement plans. Every company must make available Plan "A." Some plans may not be available in your state. See Outlines of Coverage sections for details about ALL plans. Plans E, H, I, and J are no longer available for sale.

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.

A	B	C	D	F*	F**	G*	K	L	M	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 Emer-gency	Foreign Travel Emer-gency	**Foreign Travel Emer-gency**		**Foreign Travel Emer-gency**			Foreign Travel Emergency	Foreign Travel Emergency
							Out-of-pocket limit $4,640; paid at 100% after limit reached	Out-of-pocket limit $2,320; paid at 100% after limit reached		

***SELECT PLANS F AND G contain restrictions on your use of providers. Standardized Plan A is also available. NOTICE TO BUYER: This policy/certificate may not cover all costs associated with medical care incurred by the buyer during the period of coverage. The buyer is advised to review all policy/certificate limitations. **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 $2,000 deductible. Benefits from high deductible Plan F will not begin until out-of-pocket expenses exceed $2,000. 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 NON-TOBACCO RATES*

ZIP CODES: 370-385

These rates are used when applying during an Open Enrollment or Guaranteed Issue Period.

FEMALE				MALE		
Plan A UM20	**Plan F UM42****	**Plan G UM43****	**Attained Age**	**Plan A UM20**	**Plan F UM42****	**Plan G UM43****
260.35	317.80	260.67	**Thru 64*****	274.09	334.55	274.37
71.13	86.83	71.22	**65**	74.89	91.41	74.97
71.13	86.83	71.22	**66**	74.89	91.41	74.97
73.92	90.23	74.00	**67**	78.63	95.99	78.73
76.83	93.78	76.92	**68**	82.61	100.84	82.70
79.82	97.44	79.92	**69**	86.75	105.91	86.86
82.80	101.07	82.90	**70**	90.99	111.06	91.10
85.71	104.62	85.80	**71**	95.22	116.24	95.33
88.66	108.24	88.78	**72**	99.64	121.62	99.75
91.64	111.87	91.74	**73**	104.14	127.13	104.27
94.61	115.49	94.72	**74**	108.75	132.76	108.88
97.39	118.88	97.51	**75**	113.24	138.24	113.38
99.76	121.76	99.88	**76**	117.35	143.25	117.49
101.49	123.89	101.62	**77**	119.39	145.76	119.55
103.21	125.98	103.33	**78**	121.42	148.23	121.56
105.11	128.30	105.23	**79**	123.64	150.94	123.79
106.92	130.52	107.04	**80**	125.78	153.54	125.93
109.26	133.37	109.39	**81**	127.06	155.09	127.20
111.55	136.16	111.69	**82**	128.22	156.51	128.37
113.74	138.83	113.87	**83**	129.25	157.78	129.40
115.86	141.43	116.01	**84**	130.19	158.91	130.33
117.89	143.92	118.03	**85**	130.99	159.89	131.14
119.84	146.28	119.98	**86**	131.69	160.75	131.85
121.68	148.54	121.83	**87**	132.25	161.45	132.42
123.42	150.65	123.57	**88**	132.70	161.99	132.85
125.03	152.63	125.19	**89**	133.02	162.38	133.18
126.53	154.44	126.67	**90+**	133.18	162.56	133.33

**SELECT Plans

*See PREMIUM INFORMATION regarding Risk Class and Household Premium Discount rating

To obtain annual, semiannual, or quarterly premiums, multiply the Monthly Premium Amount by 12, 6, and 3, respectively.

***Only individuals who are Disabled or have End Stage Renal Disease are eligible for coverage under the age of 65.

RP12.14.B-TN

MONTHLY TOBACCO RATES*

ZIP CODES: 370-385

FEMALE				MALE		
Plan A UM20	**Plan F UM42****	**Plan G UM43****	**Attained Age**	**Plan A UM20**	**Plan F UM42****	**Plan G UM43****
281.46	343.57	281.80	**Thru 64*****	296.31	361.67	296.62
76.90	93.87	76.99	**65**	80.96	98.82	81.04
76.90	93.87	76.99	**66**	80.96	98.82	81.04
79.91	97.54	80.00	**67**	85.01	103.77	85.11
83.06	101.38	83.15	**68**	89.31	109.02	89.41
86.29	105.34	86.39	**69**	93.79	114.49	93.90
89.51	109.26	89.62	**70**	98.36	120.06	98.48
92.66	113.11	92.76	**71**	102.94	125.66	103.06
95.85	117.02	95.98	**72**	107.71	131.48	107.84
99.07	120.94	99.18	**73**	112.59	137.43	112.72
102.28	124.86	102.40	**74**	117.57	143.52	117.71
105.29	128.52	105.41	**75**	122.42	149.44	122.57
107.85	131.63	107.97	**76**	126.87	154.86	127.02
109.72	133.94	109.86	**77**	129.07	157.58	129.24
111.58	136.20	111.71	**78**	131.27	160.25	131.42
113.63	138.70	113.76	**79**	133.67	163.18	133.83
115.58	141.10	115.72	**80**	135.98	165.99	136.14
118.12	144.19	118.26	**81**	137.36	167.66	137.52
120.59	147.20	120.74	**82**	138.62	169.20	138.78
122.96	150.09	123.10	**83**	139.73	170.57	139.89
125.25	152.90	125.41	**84**	140.74	171.80	140.90
127.45	155.59	127.60	**85**	141.61	172.86	141.78
129.55	158.14	129.70	**86**	142.36	173.78	142.54
131.54	160.58	131.70	**87**	142.98	174.54	143.15
133.43	162.86	133.59	**88**	143.46	175.12	143.62
135.17	165.01	135.34	**89**	143.80	175.54	143.98
136.79	166.97	136.95	**90+**	143.98	175.75	144.14

**SELECT Plans

*See PREMIUM INFORMATION regarding Risk Class and Household Premium Discount rating

To obtain annual, semiannual, or quarterly premiums, multiply the Monthly Premium Amount by 12, 6, and 3, respectively.

***Only individuals who are Disabled or have End Stage Renal Disease are eligible for coverage under the age of 65.

RP12.14.B-TN

Disclosures

Use this outline to compare benefits and premiums among policies.

This outline shows benefits and premiums of policies sold for effective dates on or after June 1, 2010. Policies sold for effective dates prior to June 1, 2010, have different benefits and premiums. Plans E, H, I, and J are no longer available for sale.

Premium Information

We, United of Omaha, can only raise your premium if we raise the premium for all the policies like yours in the same geographic area of the state where you live. Until you are age 90, your premium may change each year. 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 your policy date.

Risk Class Rating

If, according to our underwriting standards, you are overweight or underweight for your height, you will be considered to be a greater insurable risk. In such a case, your premium will be priced either as [Class I - 10%] or [Class II - 20%] higher than the rates illustrated, based on your Body Mass Index (BMI) reading. Risk class rating will not be applicable when you apply for coverage during an open enrollment or guaranteed issue period.

Household Premium Discount

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

Read Your Policy Very Carefully

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

Right to Return Policy

If you find that you are not satisfied with your policy, you may return it to United of Omaha Life Insurance Company, 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 United of Omaha nor its agents are connected with Medicare. This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security office or consult "Medicare & You" for more details.

Complete Answers Are Very Important

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

Restricted Network Provision
The benefits under our Medicare Select policies are payable in full if the insured is hospitalized in a hospital participating in our network. Reduced benefits are payable if the insured is hospitalized in a non-participating hospital. The reduced benefits require the insured to pay the entire Part A deductible amount.

Emergency Care
Benefits are not reduced if hospitalization is for Emergency Care. Emergency Care is defined as care which is needed immediately because of an injury or illness of sudden and unexpected onset.

Urgently Needed Care
The full benefits of your coverage will be paid anywhere if the services are for symptoms requiring Emergency Care or are immediately required because of an injury or illness of sudden unexpected onset.

Referrals
There are no restrictions on Referrals to other hospitals if referred by a network hospital and this Referral is approved by us. Additionally, there are no restrictions on Referrals for outpatient providers regardless of whether that provider is in the service area.

Availability of Other Medicare Supplement Plans
United of Omaha Life Insurance Company also offers standard Medicare Supplement Plans A, F and G, which do not contain restricted network provisions. We offer the Medicare Select coverage under plans F and G. These plans do have a restricted network provision. You have the right to initially or subsequently purchase any of the plans for standard or select coverage.

If you purchase one of the select plans, you will have the right to convert to a standard plan offered by us which is of comparable or lesser benefits. A policy is considered to have comparable or lesser benefits unless it has one or more significant benefits not included in the policy being replaced. You will not have to provide evidence of insurability after the Medicare Select plan has been in force for six (6) months.

In the event the Secretary of Health and Human Services determines that Medicare Select policies issued should be discontinued due to either the failure of the Medicare Select program to be re-authorized or its substantial amendment, United of Omaha Life Insurance Company would continue your coverage for a period of one (1) year from the date we are notified of such discontinuance. Following the one (1) year period, your Medicare Select policy can be converted to a Medicare Supplement policy offered by us which has comparable or lesser benefits and which does not contain a restricted network provision.

Quality Assurance
All participating hospitals within the network must be approved for reimbursement of Medicare benefits. They must also comply with the criteria set forth by The Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

Grievance Procedure

We have a customer service program which provides information to you, handles complaints, and helps to satisfy your concerns. This Grievance Procedure is intended to provide an opportunity of you to achieve mutual agreement for settlement of disputes that have not been settled through the customer service program, or that you desire to have settled by means of a written grievance.

The following procedures are aimed at achieving mutual agreement for settlement of disputes:

(a) All grievances shall be presented to us in written form and must contain the words "This is a Grievance" or other words that clearly state that the intention of the communication is to serve as a written grievance to be handled according to this procedure.

(b) A grievance shall be filed by submitting the complete details in writing to:

Grievance Review
United of Omaha Life Insurance Company
P. O. Box 3608
Omaha, Nebraska 68103-0608

(c) Each grievance shall be processed within a maximum of 60 days after it is first received by us. Each level of the grievance process shall have a person with problem-solving authority. A physician, other than your primary care physician, must be involved in reviewing any medically related grievances.

(d) If a grievance is found to be valid, corrective action shall be taken promptly.

(e) All concerned parties will be notified about the results of a grievance.

(f) You shall have the right to appeal to the Department of Insurance after first completing our grievance process.

(g) Any meeting with you shall be scheduled at a location or in a manner which is convenient and does not necessitate excessive travel or hardship for you.

(h) The time for filing a grievance shall be limited to a period of not less than one year from the date of occurrence.

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 $1,132	$0	$1,132 (Part A Deductible)
61st through 90th day	All but $283 a day	$283 a day	$0
91st day and after: While using 60 lifetime reserve days	All but $566 a day	$566 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 $141.50 a day	$0	Up to $141.50 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, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy/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 $162 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 $162 of Medicare Approved Amounts*	$0	$0	$162 (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 $162 of Medicare Approved Amounts*	$0	$0	$162 (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 $162 of Medicare Approved Amounts*	$0	$0	$162 (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 $1,132	$1,132 (Part A Deductible)	$0	$1,132 (Part A Deductible)	$0
61st through 90th day	All but $283 a day	$283 a day	$0	$283 a day	$0
91st day and after: While using 60 lifetime reserve days	All but $566 a day	$566 a day	$0	$566 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 $141.50 a day	Up to $141.50 a day	$0	Up to $141.50 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, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy/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 $162 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 $162 of Medicare Approved Amounts*	$0	$162 (Part B Deductible)	$0	$0	$162 (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 $162 of Medicare Approved Amounts*	$0	$162 (Part B Deductible)	$0	$0	$162 (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 $162 of Medicare Approved Amounts*	$0	$162 (Part B Deductible)	$0	$0	$162 (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