

MUTUAL OF OMAHA INSURANCE COMPANY

Mutual of Omaha Plaza, Omaha, NE 68175



INDIVIDUAL LONG-TERM CARE INSURANCE POLICY

Read your policy carefully! This policy is a legal contract between you and us. The consideration for this policy is the application and the premium you paid.

TAX-QUALIFIED POLICY

This policy is intended to be a tax-qualified long-term care insurance policy under Section 7702B(b) of the Internal Revenue Code, as amended. This means that we have designed your policy, to the best of our knowledge, to meet certain criteria that qualify it for favorable federal income tax treatment. However, we do not warrant that your policy will always have tax-qualified status. Tax-qualification is a matter of federal law and is not guaranteed.

NOTICE TO BUYER

This policy may not cover all of the costs associated with long-term care incurred by you during the period of coverage. You are advised to review carefully all policy limitations.

30-DAY RIGHT TO REVIEW POLICY

You have 30 days from the date of its delivery to review your policy. If during that time you are not satisfied with your policy, you may return it to us or to your agent. We will refund all premiums paid within 30 days of the return directly to the payer. The policy will then be considered never to have been issued.

CHECK YOUR APPLICATION

Caution: The issuance of this policy is based on your responses to the questions on your application. A copy of your application is attached to and made part of this policy. If your answers are incomplete, incorrect, or untrue, we may have the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises. If, for any reason, any of your answers are incorrect, please contact us.

GUARANTEED RENEWABLE FOR LIFE

Your policy is guaranteed renewable for life. This means you can continue your policy for as long as you live or until you have exhausted your *policy limit*. Subject to the terms of your policy, we cannot cancel your policy as long as you pay the required premium when it is due. **However, we can change your premium rates, as described in your policy's Premiums Can Change provision.**

PREMIUMS CAN CHANGE: Refer to your policy's Premiums Can Change provision.

This is a long-term care insurance policy that covers home health care, adult day care, assisted living facility care, and nursing home care.

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY.

If you are eligible for Medicare, review the Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare available from us.

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

[State Partnership Disclosure Statement]

Mutual of Omaha Insurance Company
[Long-Term Care Service Office]
[P.O. Box 64901]
[St. Paul, MN 55164-0901]
[Toll-Free 1-877-894-2478]

ICC13-LTC13-AG

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SAMPLE

POLICY SCHEDULE

Mutual of Omaha Insurance Company
[Long Term Care Service Office]
[P.O. Box 64901]
[St. Paul, MN 55164-0901]
[Toll Free 1-877-894-2478]

Insured:

[**John Q. Public**]

Issue Age: [**57**]

Sex: [M]

[Partner:

Suzy R. Public]

State: [NE]

[Group: ABC Association]

Policy Series: LTC13

Policy Number: [12345]

Policy Effective Date: [**January 1, 2013**]

Schedule Effective Date: [**January 1, 2013**]

Rate Classification

[Preferred/Select/Class I/Class II]

Allowance

[[Partner] [30%][15%]

[Producer]

[Group Rate]

Policy Schedule Print Date: [01/01/13]

To contact your state insurance department, please call [1-XXX-XXX-XXXX].

[Some long-term care insurance policies may qualify under Iowa's Long-Term Care Partnership Program. Under this program you may be able to protect some of your assets from Medicaid spend-down requirements through a feature known as "asset disregard." Nothing in your policy is a guarantee of Medicaid eligibility nor is it a guarantee of any ability to disregard assets for purposes of Medicaid eligibility. If you have any questions about whether or not your policy currently qualifies under Iowa's Long-Term Care Partnership Program, please contact Mutual of Omaha Insurance Company [at ###-###-####] and request a Long-Term Care Partnership Program Policy Summary.]

[This policy is intended to meet the standards for the Long-Term Care Partnership Program in the state of [Louisiana].]

Your Elimination Period: [0, 30, 60, 90, 180 or 365] [calendar days]

[180-day and 365-day eliminations not available in VT]

Your Policy Limit: [Product of 24, 36, 48 or 60 X \$1,500 - \$10,000 OR \$XXX,XXX.XX]
[\$XXX,XXX.XX]*

Your Maximum Monthly Benefit or MMB: [\$1,500 - \$10,000]*

[\$2,300 - \$10,000 in VT]* [\$1,800 - \$10,000 in WI]*

*If these benefit amounts increase due to any inflation protection that may be part of your coverage, we will send you an updated policy schedule showing the change. The amounts shown do not reflect any benefits we may have paid under your policy. Any benefits we pay are deducted from your Policy Limit unless otherwise stated.

BENEFITS PROVIDED BY YOUR POLICY		
HOME HEALTH CARE BENEFITS		
[Home Health Care Maximum Monthly Benefit]	[[50%][75%][100%] of MMB = [\$x,xxx] per month] [50%, 75% not available in VT]	
ASSISTED LIVING FACILITY BENEFITS		
Assisted Living Facility Maximum Monthly Benefit	[[50%][75%][100%] of MMB = [\$x,xxx] per month] [50%, 75% not available in KS and MD]	
Assisted Living Facility Bed Reservation Benefit	[[100%] of MMB = [\$xx.xx] per day, up to 30 days in a calendar year]	
NURSING HOME BENEFITS		
Nursing Home Maximum Monthly Benefit	[100% of MMB = [\$x,xxx] per month]	
Nursing Home Bed Reservation Benefit	[100% of MMB = [\$xx.xx] per day, up to 30 days in a calendar year]	
BASIC POLICY BENEFITS PROVIDED BY RIDER		Your Premium
[Cash Benefit = [\$X,XXX] per month]	[Included]	[Basic Policy]
OTHER POLICY BENEFITS		
Respite Care Benefit Limit	[Pays up to 100% of MMB for one month in a calendar year = [\$x,xxx]]	
Hospice Care Benefit	Pays Home Health Care Benefits, Assisted Living Facility Benefits, and Nursing Home Benefits for Hospice Care	
International Benefit Limit	[Pays 100% of MMB up to an International Benefit Limit of 12 months = [\$xx,xxx]]	
Waiver of Premium Benefit	Included	
Contingent Nonforfeiture Benefit	[Included][Not included in your coverage]	

CARE COORDINATOR BENEFITS		
Care Coordinator Benefit	<i>THIS BENEFIT IS NOT DEDUCTED FROM YOUR POLICY LIMIT.</i>	
Alternate Care Benefit	As approved by your Care Coordinator; subject to your Policy Limit	
STAY-AT-HOME BENEFITS (AVAILABLE WHEN YOU USE THE CARE COORDINATOR)		
Caregiver Training Benefit	These benefits combined are payable up to your Stay-At-Home Benefit Limit of 2 times the HHC MMB = [\$x,xxx]	
Durable Medical Equipment Benefit		
Home Modification Benefit		
Medical Alert System Benefit		
OTHER BENEFITS INCLUDED IN YOUR COVERAGE		Your Premium
[Professional Home Health Care Maximum Monthly Benefit: [50%][75%][100%] of MMB = [\$2,000] per month]	[Included]	[\$ xxx.xx]
[Security Benefit [60%] Not deducted from your Policy Limit.]	[Included]	[\$ xxx.xx]
[Joint Waiver of Premium]	[Included]	[\$ xxx.xx]
[Shared Care Benefit]	[Included]	[\$ xxx.xx]
[Survivorship Benefit] [Survivorship Benefit Qualification Period]	[Included] [7, 8, 10 Years]	[\$ xxx.xx]
[Compound Inflation Protection - Lifetime: [1%] [1.25%] [1.5%] [1.75%] [2%] [2.25%] [2.5%] [2.75%] [3%] [3.25%] [3.5%] [3.75%] [4%] [4.25%] [4.5%] [4.75%] [5%]]	[Included] [Effective on Schedule Effective Date]	[\$ xxx.xx]
[Compound Inflation Protection With Buy-Up Option: [1%] [1.25%] [1.5%] [1.75%] [2%] [2.25%] [2.5%] [2.75%] [3%] [3.25%] [3.5%] [3.75%] [4%] [4.25%] [4.5%] [4.75%] [5%]][Final Buy-Up Date [Insert Date]]	[Included] [Buy- Up Effective on Schedule Effective Date]	[\$ xxx.xx]
[Compound Inflation Protection - Limited Period [10][15][20] Year: [1%] [1.25%] [1.5%] [1.75%] [2%] [2.25%] [2.5%] [2.75%] [3%] [3.25%] [3.5%] [3.75%] [4%] [4.25%] [4.5%] [4.75%] [5%]]	[Included]	[\$ xxx.xx]
[Compound Inflation Protection - Limited Period With Buy-Up Option [10][15][20] Year: [1%] [1.25%] [1.5%] [1.75%] [2%] [2.25%] [2.5%] [2.75%] [3%] [3.25%] [3.5%] [3.75%] [4%] [4.25%] [4.5%] [4.75%] [5%]][Final Buy-Up Date [Insert Date]]	[Included] [Buy- Up Effective on Schedule Effective Date]	[\$ xxx.xx]

[Return of Premium at Death (Minus Claims Paid) Benefit]	[Included]	[\$ xxx.xx]
[Return of Premium (Minus Claims Paid) if Death Occurs Before Age 65 Benefit]	[Included]	[\$ xxx.xx]
[Three Times the Maximum Monthly Benefit Return of Premium at Death (Minus Claims Paid) Benefit]	[Included]	[\$ xxx.xx]
[Three Times the Maximum Monthly Benefit Return of Premium Qualification Period]	[10 Years]	
[Nonforfeiture Benefit - Shortened Benefit Period]	[Included]	[\$ xxx.xx]
[Waiver of Elimination Period for Home Health Care Benefits]	[Included]	[\$ xxx.xx]
BASIC POLICY PREMIUM		[\$XXX.XX]
[ANNUAL] TOTAL PREMIUM (BASIC POLICY + OTHER BENEFITS)		[\$XXX.XX]
PREMIUM MODE		[Annual, Semi-Annual, Quarterly, Monthly, PRD, 9pay, 10pay, 11pay, 12pay, 24pay, and 26pay]
YOUR TOTAL POLICY [MODAL] PREMIUM		[\$XXX.XX]

IF YOU ELECT TO PAY PREMIUMS OTHER THAN ANNUALLY, THE TOTAL AMOUNT OF PREMIUM YOU PAY EACH YEAR WILL BE GREATER THAN THE ANNUAL PREMIUM BECAUSE THE COSTS ASSOCIATED WITH ADMINISTERING YOUR POLICY WILL BE GREATER.

Tax Qualified

The policy is intended to be a tax-qualified long-term care insurance policy under §7702B(b) of the Internal Revenue Code, as amended. For additional information concerning the tax status of premiums paid and benefits received under the policy, you should consult your professional tax advisor.

DEFINITIONS

This section contains definitions of terms found within your policy. We have italicized these terms wherever they appear to make them easier for you to find (except for *we, us, our, you, your,* and *yourself*).

Activities of daily living means the following self-care functions:

Bathing means washing oneself by sponge bath; or in either a tub or shower, including the task of getting into or out of the tub or shower;

Continence means the ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag);

Dressing means putting on and taking off all items of clothing and any necessary braces, fasteners, or artificial limbs;

Eating means feeding oneself by getting food into the body from a receptacle (such as a plate, cup, or table) or by a feeding tube or intravenously. *Eating* does not include preparing meals;

Toileting means getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene. *Toileting* does not include other activities that take place in the bathroom or lavatory; and

Transferring means moving into or out of a bed, chair, or wheelchair. *Transferring* does not include mobility outside of the *home* or facility, including but not limited to transportation.

Adult day care means a program that is a licensed or certified program of *adult day care* in the state where the care will be provided. If the state where the care will be provided does not license or certify such programs, then *adult day care* is a program in an *adult day care center* for six or more individuals of social or health-related services, or both types of services, provided during the day in a community group setting for the purpose of supporting frail, impaired elderly, or other disabled adults who can benefit from care in a group setting outside the *home*.

An *adult day care* program located in a state that licenses or certifies such programs under another name may be considered *adult day care* if the program meets the requirements contained in this definition.

Adult day care center means a *facility* that is licensed or certified to provide a planned program of *adult day care* by the state in which it operates. If the state does not license or certify such facilities, then it must be operated pursuant to law and meet all of the following requirements:

- (a) it provides care while you continue to reside at *home*;
- (b) it provides *adult day care* in a protective setting and under appropriate supervision, including personal, social, and related supportive services that are designed to meet the needs of functionally or cognitively impaired adults through an individualized service plan;
- (c) it operates on less than a 24-hour basis;
- (d) it keeps a written record of services for each person; and
- (e) it has established procedures for obtaining appropriate aid in the event of a medical emergency.

An *adult day care center* located in a state that licenses or certifies such *facilities* under another name may be considered an *adult day care center* if the *facility* meets the requirements contained in this definition.

Alzheimer's facility means a specialized *facility* engaged primarily in providing care for persons with Alzheimer's disease or similar *severe cognitive impairment* and is licensed or certified as:

- (a) an Alzheimer's unit in the state where you receive benefits, if required;
- (b) a *nursing home*; or
- (c) an *assisted living facility*.

If the *facility* is licensed or certified as a specialized Alzheimer's unit only, and not as a *nursing home* or *assisted living facility*, that *facility* must meet the requirements for either a *nursing home* or *assisted living facility* based on your policy's definitions of those terms and the level of care provided, and will be classified accordingly.

If the *facility* has multiple licenses or certifications, that *facility* must meet the requirements for either a *nursing home* or *assisted living facility* based on your policy's definitions of those terms and on the level of care provided in that portion, wing, or ward designated as an Alzheimer's unit, and will be classified accordingly.

Ancillary services means:

- (a) physical, occupational, speech, and respiratory therapies,
- (b) wound care,
- (c) medication management,
- (d) supplies and services for continence care support, and
- (e) similar care-related services or supplies that support *activities of daily living*.

Assessment means an evaluation done by a *licensed health care practitioner*, independent of you or us, whom we select to determine or verify that you are *chronically ill*. The *assessment* must use generally accepted tests and instruments that objectively measure physical or cognitive impairment to determine whether you are *chronically ill*.

Assisted living facility means a *facility* or distinctly separate part of a *facility* that is engaged primarily in providing non-skilled long-term care. If required by the state in which it is located, an *assisted living facility* must have the appropriate state licensure, certification, or registration to operate as an *assisted living facility*.

If the state in which it is located does not require an *assisted living facility* to be licensed, certified, or registered, the *facility* must meet the following requirements:

- (a) it provides services and care on a continuous 24-hour basis for 3 or more people requiring *substantial assistance* with *activities of daily living* or *substantial supervision* due to *severe cognitive impairment*;
- (b) it maintains trained staff, awake and on duty, in the *facility* at all times to provide the services and care;
- (c) it provides at least three meals a day and accommodates special dietary needs;
- (d) it provides residential services and *maintenance or personal care services* in one location;
- (e) it maintains formal arrangements with a *physician* or *nurse* to furnish medical care in case of an emergency;
- (f) it keeps a written record of services for each person; and
- (g) it maintains appropriate procedures to provide onsite assistance with prescription medications.

An *assisted living facility* located in a state that licenses or certifies such *facilities* under another name may be considered an *assisted living facility* if the *facility* meets the requirements contained in this definition.

An *Alzheimer's facility* or a *hospice care facility* located in a state that does not require licensure, certification, or registration may be considered an *assisted living facility* if such *facility* meets the requirements contained in this definition.

Assisted living facility does not include a hospital or clinic; a place that operates primarily for the treatment of alcoholism, drug addiction, or mental or nervous disorders; a *nursing home*; a domiciliary care facility; your primary place of residence in an area used principally for independent residential living; or a similar establishment.

Beneficiary means the person(s) or legal entity you designate to receive any benefits under your policy or any attached rider in the event of your death.

Care coordinator means a *licensed health care practitioner* who is qualified by training and experience to assess and coordinate the overall care needs of a person who is *chronically ill*. The *care coordinator* may provide services independent of, or be employed by or under contract to, an agency. Such *care coordinator* and/or agency must be designated by us as an approved *care coordinator*.

Class means persons that have the same application date, policy form, sex, *issue age*, issue year, rate classification, coverage, and state of policy issuance as listed on the policy schedule as you do.

Confinement or **confined** means your admission as a resident to a medical *facility* or institution, separate from the *home*, for a period of time for which a charge is incurred for room and board.

Covered services means services or supplies you receive for which a benefit may be payable under your policy. You must incur actual charges in order for services and supplies to be *covered services*. A service must also be a *qualified long-term care service* in order to be considered a *covered service*.

Covered services do not include *physician's* charges, hospital and laboratory charges, the cost of drugs, or mileage fees. *Covered services* do not include transportation costs, unless otherwise specified. We will not pay for comfort and convenience items, such as televisions, telephones, beauty care, or entertainment. Also, we will not pay for expense incurred by or for people other than you, such as guest meals or *partner* charges, unless otherwise specified.

Elimination period means the initial number of calendar days that you must be *chronically ill* before we will pay benefits under your policy. The *elimination period* begins on the first day you are *chronically ill* and receive a *covered service*. Subsequent days on which you are *chronically ill* will be used to satisfy the *elimination period*, even if you do not receive a *covered service* on those days. If you cease to be *chronically ill* during the *elimination period*, the *elimination period* will stop. The *elimination period* will resume on the next date that you are *chronically ill* and receive a *covered service*.

The length of the *elimination period* is shown on the policy schedule. Your policy's *elimination period* must be satisfied only once in your lifetime. Any days for which *Medicare* pays benefits for *qualified long-term care services* can be used to satisfy the *elimination period*. The *elimination period* applies to all benefits unless otherwise stated in a specific benefit provision.

Facility means a location designed and formally designated for, and in the business of, providing any type of care covered by your policy (other than *home health care*), subject to any federal, state, or local licensing or certification requirements that may apply. Unless otherwise directed by law, a *facility* is distinct from the *home*.

Home means the place where you maintain your primary independent residence. *Home* does not include:

- (a) a *nursing home*;
- (b) a hospital;
- (c) an *assisted living facility*;
- (d) an *Alzheimer's facility*;
- (e) a place that operates primarily for the treatment of alcoholism, drug addiction, or mental or nervous disorders;
- (f) any other institutional setting where you are dependent on others for assistance with *activities of daily living*; or
- (g) the residence of the person who provides *homemaker services* or *home health care*.

Home health care means medical and non-medical services provided to *chronically ill* persons in their *homes* as recommended in a *plan of care*. Such services may include:

- (a) part-time or intermittent skilled services provided by a *nurse*;
- (b) services to help you comply with your medication/treatment regimen;
- (c) home health aide services;
- (d) physical therapy, respiratory therapy, occupational therapy, speech therapy or audiology therapy;
- (e) services provided by a specialist in the field of nutrition or the administration of chemotherapy;
- (f) *homemaker services*;
- (g) *maintenance or personal care services*;
- (h) *respite care*; and
- (i) *hospice care*.

Home health care agency means an entity that is regularly engaged in providing *home health care* services for payment. Such entity must employ staff who are qualified by training or experience to provide such care. The staff must be licensed or certified in the state where the care will be provided, if licensing or certification is required for those services. The entity must:

- (a) be supervised by a qualified professional such as a registered nurse (RN), a licensed social worker, or a *physician*;
- (b) keep clinical records or care plans on all persons receiving care;
- (c) provide ongoing supervision and training to its employees appropriate to the services to be provided; and
- (d) have the appropriate state licensure, accreditation, or certification, where required.

Homemaker services means the services listed below which you receive from a paid eligible provider to maintain an adequate *home* environment:

- (a) laundry services;
- (b) routine food shopping and errands;
- (c) meal preparation and cleanup; and
- (d) domestic or cleaning services.

Homemaker services does not mean any type of pet care, lawn or yard care, snow removal, transportation, or vehicle maintenance. Also, *homemaker services* do not include construction, renovation, or upkeep to your *home*, such as painting.

Hospice care means services designed to provide symptom relief, manage pain, and ease your physical, emotional, and social discomfort if you are *terminally ill* during the time that you are *chronically ill*. *Hospice care* does not include services provided to people other than you.

Hospice care facility means a *facility* which provides a formal *hospice care* program directed by a *physician* on an inpatient basis. Such *facility* must be licensed or certified by the state in which it is located, if such license is required. A *hospice care facility* does not include a hospital, clinic, community living center, or a place providing residential care only.

Immediate family means your *partner* and anyone who is related to you or your *partner* (including adopted, in-law, and step-relatives) as a parent, grandparent, child, grandchild, brother, sister, aunt, uncle, first cousin, nephew, or niece.

Independent provider means any one of the following providers not affiliated with a *home health care agency* or similar organization:

- (a) a home health aide,
- (b) certified nursing assistant,
- (c) *nurse*,
- (d) audiologist,
- (e) nutritional or chemotherapy specialist, or
- (f) physical, occupational, respiratory, or speech therapist.

The *independent provider* must present us with a valid United States federal or state government issued photo identification. The *independent provider* must be licensed or certified in the state where the care will be provided, if licensing or certification is offered in that state in order to provide those services. If the state in which you live does not require licensure or certification for *independent providers*, then we may approve benefits for *independent provider* services if we can determine that the individual is qualified by training and experience to assist with *activities of daily living*. The *independent provider* cannot be an *immediate family* member.

A home health aide or certified nursing assistant must present written proof of completion, within the last five years, of an established training course or written proof of certification. The education must include training in safely assisting persons with *activities of daily living*. We will accept inclusion in a government-sponsored nurse aide registry as proper credentials for a home health aide or certified nursing assistant.

Issue age means the age on which your premium is based when your policy is issued. Your *issue age* is shown on the policy schedule.

Licensed health care practitioner means any of the following who is not an *immediate family* member: a *physician*, a registered nurse (RN), a licensed social worker, or any other individual who meets such requirements as may be prescribed by the Secretary of the Treasury of the United States.

Maintenance or personal care services means any care the primary purpose of which is the provision of needed assistance to help you conduct *activities of daily living* while you are *chronically ill*. This includes protection from threats to health and safety due to *severe cognitive impairment*.

Maximum monthly benefit means the highest dollar amount we will pay in a *month* for all expenses incurred for *covered services* you receive. Your policy's *maximum monthly benefit* amounts are shown on the policy schedule. If benefits are payable for less than a one-*month* period, we will calculate such benefits on a pro-rata basis.

Medicare means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

Month means one calendar *month*. A calendar *month* begins on the first day of the *month* and ends on the last day of the *month*. If we calculate any benefit on a pro-rata basis, we will base the calculation on a 30 day *month* despite the actual number of days in the applicable *month*.

Nurse means someone who is licensed as a registered nurse (RN), licensed practical nurse (LPN), or licensed vocational nurse (LVN) and operates within the scope of that license. *Nurse* does not include you, an *immediate family* member, or anyone who normally resides in your *home*.

Nursing home means a *facility* or distinctly separate part of a *facility* that is engaged primarily in providing nursing care. If required by the state in which it is located, a *nursing home* must have the appropriate state licensure, certification, or registration to operate as a *nursing home*.

If the state in which it is located does not require a *nursing home* to be licensed, certified, or registered, the *facility* must meet the following requirements:

- (a) it provides nursing care for 10 or more people under the continuous, direct, and immediate supervision of a licensed practical nurse (LPN), registered nurse (RN), or *physician* who is awake, on duty, and physically present on-site 24-hours-a-day;
- (b) it maintains a daily medical record of each person receiving care; and
- (c) it provides nursing care at skilled, intermediate, and custodial levels.

An *Alzheimer's facility* or a *hospice care facility* located in a state that does not require licensure, certification, or registration may be considered a *nursing home* if such *facility* meets the requirements contained in this definition.

Nursing home does not include a hospital or clinic; a place which operates primarily for the treatment of alcoholism, drug addiction, or mental or nervous disorders; an *assisted living facility*; an adult residential care home; a domiciliary care facility; your primary place of residence in an area used principally for independent residential living; or a similar establishment.

A *nursing home* located in a state that licenses or certifies such *facilities* under another name may be considered a *nursing home* if the *facility* meets the requirements contained in this definition.

Partner means the one person who is:

- (a) your spouse to whom you are legally married;
- (b) your registered domestic partner or civil union partner; or
- (c) an adult person who:
 1. shares a serious and committed personal relationship with you that is intended to be lifelong;
 2. has shared a common permanent residence with you on a continuous basis for the most recent three years;
 3. is not married, a domestic partner, a civil union partner, or in a committed personal relationship to anyone else; and
 4. is not related to you in any way that would bar marriage in the state where you and he or she reside.

Physician means a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the state in which he or she performs such function or action (as defined in Section 1861(r)(1) of the Social Security Act) other than you or an *immediate family* member. He or she must be providing services within the scope of his or her license.

Plan of care means a written individualized plan of services prescribed for you by a *licensed health care practitioner* that is consistent with your ability to perform *activities of daily living*. We have the right to discuss the *plan of care* with the *licensed health care practitioner*. We may also verify that the *plan of care* is appropriate and consistent with generally accepted standards for care of *chronically ill* persons. The *plan of care* specifies your long-term care needs and the type, frequency, and providers of the services appropriate to meet those needs and the costs, if any, of those services. The *plan of care*

will be modified as required to reflect changes in your functional or cognitive abilities, social situation, and care service needs.

Policy anniversary date means any yearly anniversary of the *policy effective date* while your policy is in effect.

Policy effective date means the date coverage first starts under your policy as shown on the policy schedule. The *policy effective date* determines the *policy anniversary date*.

Policy limit means the maximum dollar amount we will pay in benefits during the remaining life of your policy. The initial *policy limit* is shown on the policy schedule. All benefits paid under your policy, except for the *care coordinator* service and waiver of premium benefit, will reduce the *policy limit*. The initial *policy limit* shown on the policy schedule may be adjusted if you elect to decrease your coverage, we agree to increase your coverage, or if an optional inflation protection rider is attached to your policy.

Policy renewal date means the date your policy's premium is due. The frequency of the *policy renewal date*, or premium mode, can vary depending on whether you pay premiums on a monthly, quarterly, semiannual, annual, or other basis.

Qualified long-term care services means necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, and rehabilitative services and *maintenance or personal care services* which are required by a *chronically ill* person. Such services must be provided pursuant to a *plan of care* prescribed by a *licensed health care practitioner*.

Representative means a person or entity legally empowered to represent you.

Respite care means the supervision and care of you while your *immediate family* or other individuals who normally provide substantial amounts of unpaid care on a daily basis take short-term leave or rest that provides them with temporary relief from the responsibilities of providing care.

Severe cognitive impairment means a loss or deterioration in intellectual capacity that is comparable to (and includes) Alzheimer's disease and similar forms of irreversible dementia. A *severe cognitive impairment* is measured by clinical evidence and standardized tests that reliably measure impairment in your:

- (a) short-term or long-term memory;
- (b) orientation as to people, places, or time;
- (c) deductive or abstract reasoning; and
- (d) judgment as it relates to safety awareness.

Substantial assistance means either *hands-on assistance* or *standby assistance* from someone who is physically present with you:

Hands-on assistance means the physical assistance of another person without which you would be unable to perform *activities of daily living*.

Standby assistance means the presence of another person, within your arm's reach, that is necessary to prevent, by physical intervention, injury while you are performing *activities of daily living*.

Substantial supervision means continual supervision (which may include cueing by verbal prompting, gestures, or other demonstrations) by another person nearby and in the same building that is necessary to protect you from threats to your health or safety. This includes, but is not limited to, threats that may result from wandering. Continual supervision means supervision that is frequently repeated, but not necessarily uninterrupted.

Terminally ill means a medical condition that, with a reasonable degree of medical certainty, will result in your death within six *months* or less, as certified by a *physician*.

We, us, or our means Mutual of Omaha Insurance Company, Omaha, Nebraska.

You, your, or yourself means the person named as the insured on the policy schedule.

ELIGIBILITY FOR THE PAYMENT OF BENEFITS

To be eligible for the payment of benefits under all provisions of your policy, you must meet the following requirements:

- (a) You must be *chronically ill*; and
- (b) We must receive a written *plan of care* from a *licensed health care practitioner* prescribing *qualified long-term care services*.

Chronically ill means:

- (a) you are unable to perform at least two *activities of daily living* without *substantial assistance* from another person who is physically present with you, for a period that is expected to last at least 90 consecutive days due to a loss of functional capacity; or
- (b) you require *substantial supervision* to protect yourself from threats to health and safety due to a *severe cognitive impairment*.

You will only meet the definition of *chronically ill* if, within the preceding 12 *months*, a *licensed health care practitioner* has certified that you meet such requirements.

LIMITATIONS OR CONDITIONS ON ELIGIBILITY FOR BENEFITS

You must meet **ALL** of the following conditions to be eligible for benefits:

- (a) Your policy must be in force on the date for which you are claiming benefits.
- (b) Your *policy limit* has not been reduced to zero.
- (c) You have not exhausted any maximum benefit amount shown on the policy schedule that applies to the benefit you are claiming.
- (d) You must satisfy the *elimination period* if it applies to the benefit you are claiming. The *elimination period* does not apply to the Cash Benefit Rider, if part of your coverage, *respite care* benefits, *hospice care* benefits, stay-at-home benefits, and the *care coordinator* service.

One Benefit is Payable on a Single Day

If you are eligible for benefits under more than one provision on any single day, we will only pay benefits under the provision which pays the greatest amount. This limitation applies even if multiple benefits share the same maximum benefit amount. This limitation does not apply to your policy's stay-at-home benefits, which you may receive at the same time as other policy benefits. At your option, the monthly cash benefit may be paid in place of any other benefit if the Cash Benefit Rider is part of your coverage.

CARE COORDINATOR SERVICE

The *care coordinator* service is voluntary and available to you at no cost to assist you in managing and arranging your long-term care needs. The *care coordinator* offers knowledge, training, and experience,

and can help you to make the best use of your policy's benefits. You do not need to satisfy the *elimination period* in order to use the *care coordinator* service.

To request a *care coordinator*, call the toll-free telephone number shown on the face page of your policy.

If you wish to use this service, the *care coordinator* will contact you to:

- (a) evaluate your specific needs for care and services;
- (b) develop your initial and subsequent *plans of care*;
- (c) assist you in obtaining the services and facilities outlined in the *plan of care*; and
- (d) monitor your progress and the quality of the care you receive on an ongoing basis.

Stay-at-home benefits and the alternate care benefit are only available if you use a *care coordinator*. You do not need to use a *care coordinator* to receive any other benefits under your policy.

We do not require you to use the providers identified in the *plan of care* developed by a *care coordinator*. Once you have exhausted your policy's benefits, a *care coordinator* can recommend a transition plan. The transition plan will specify how your care needs may be met.

HOME HEALTH CARE BENEFITS

If you receive *home health care* from a *home health care agency* or an *independent provider*, we will pay the expense you incur for *covered services*, up to the Home Health Care Maximum Monthly Benefit shown on the policy schedule, for each *month* you receive such services. *Home health care* benefits begin after you have satisfied your policy's *elimination period*. *Covered services* for *home health care* consist of:

- (a) part-time or intermittent skilled services provided by a *nurse*;
- (b) services to help you comply with your medication/treatment regimen;
- (c) home health aide services;
- (d) physical therapy, respiratory therapy, occupational therapy, speech therapy, or audiology therapy;
- (e) services provided by a specialist in the field of nutrition or the administration of chemotherapy;
- (f) *homemaker services*; and
- (g) *maintenance or personal care services*.

Home health care benefits will end when you no longer meet the ELIGIBILITY FOR THE PAYMENT OF BENEFITS section requirements or the *policy limit* has been reduced to zero, whichever occurs first.

ADULT DAY CARE BENEFITS

If you receive *adult day care* from an *adult day care center*, we will pay the expense you incur for *covered services*, up to the Home Health Care Maximum Monthly Benefit shown on the policy schedule, for each *month* you receive such services. *Covered services* for *adult day care* consist of *adult day care center* services and fees charged for transportation to and from the *adult day care center*. *Adult day care* benefits begin after you have satisfied your policy's *elimination period*.

Adult day care benefits will end when you no longer meet the ELIGIBILITY FOR THE PAYMENT OF BENEFITS section requirements or the *policy limit* has been reduced to zero, whichever occurs first.

ASSISTED LIVING FACILITY BENEFITS

If you are *confined* in an *assisted living facility*, we will pay the expense you incur for *covered services*, up to the Assisted Living Facility Maximum Monthly Benefit shown on the policy schedule, for each *month* you are *confined*. *Assisted living facility* benefits begin after you have satisfied your policy's *elimination period*. *Covered services* for *assisted living facility confinement* consist of:

- (a) room and board for a one-bedroom unit;
- (b) *ancillary services*; and
- (c) patient supplies provided by the *assisted living facility* for care of its residents.

Assisted living facility benefits will end when you no longer meet the ELIGIBILITY FOR THE PAYMENT OF BENEFITS section requirements or the *policy limit* has been reduced to zero, whichever occurs first.

ASSISTED LIVING FACILITY BED RESERVATION BENEFIT

If you are absent for any reason (except discharge) during an *assisted living facility confinement*, and are charged by the *facility* to reserve your place there, we will pay an *assisted living facility* bed reservation benefit. This *assisted living facility* bed reservation benefit begins after you have satisfied your policy's *elimination period*. We will pay the *assisted living facility* bed reservation benefit up to the calendar year maximum shown on the policy schedule. Any unused days cannot be carried over into the next calendar year.

This *assisted living facility* bed reservation benefit will end when you no longer meet the ELIGIBILITY FOR THE PAYMENT OF BENEFITS section requirements or the *policy limit* has been reduced to zero, whichever occurs first.

NURSING HOME BENEFITS

If you are *confined* in a *nursing home*, we will pay the expense you incur for *covered services*, up to the Nursing Home Maximum Monthly Benefit shown on the policy schedule, for each *month* you are *confined*. *Nursing home* benefits begin after you have satisfied your policy's *elimination period*. *Covered services* for *nursing home confinement* consist of:

- (a) room and board;
- (b) *ancillary services*; and
- (c) patient supplies provided by the *nursing home* for care of its residents.

Nursing home benefits will end when you no longer meet the ELIGIBILITY FOR THE PAYMENT OF BENEFITS section requirements or the *policy limit* has been reduced to zero, whichever occurs first.

NURSING HOME BED RESERVATION BENEFIT

If you are absent for any reason (except discharge) during a *nursing home confinement*, and are charged by the *facility* to reserve your place there, we will pay a *nursing home* bed reservation benefit. This *nursing home* bed reservation benefit begins after you have satisfied your policy's *elimination period*. We will pay the *nursing home* bed reservation benefit up to the calendar year maximum shown on the policy schedule. Any unused days cannot be carried over into the next calendar year.

This *nursing home* bed reservation benefit will end when you no longer meet the ELIGIBILITY FOR THE PAYMENT OF BENEFITS section requirements or the *policy limit* has been reduced to zero, whichever occurs first.

RESPITE CARE BENEFITS

If your unpaid caregiver needs short-term relief from the duties of providing care to you, we will pay the expense you incur for *covered services* for *respite care* up to the Respite Care Benefit Limit shown on the policy schedule for that calendar year. You do not need to satisfy the *elimination period* in order to use *respite care* benefits. *Covered services* for *respite care* consist of:

- (a) *home health care*;
- (b) *adult day care*;
- (c) *confinement* in an *assisted living facility*; or
- (d) *confinement* in a *nursing home*.

If you are eligible to receive *respite care* benefits for less than an entire *month*, we will prorate benefits based on the actual number of days that you receive *respite care*. We will base the calculation on a 30 day *month* despite the actual number of days in the applicable *month*. We will pay *respite care* benefits up to the calendar year Respite Care Benefit Limit shown on the policy schedule. Any unused days cannot be carried over to the next calendar year.

Respite care benefits will end when you no longer meet the ELIGIBILITY FOR THE PAYMENT OF BENEFITS section requirements or the *policy limit* has been reduced to zero, whichever occurs first.

HOSPICE CARE BENEFITS

If you are *terminally ill* and receive *hospice care*, we will pay the expense you incur for *covered services* up to the applicable *maximum monthly benefit* for each *month* you receive such services. The *maximum monthly benefit* will depend on the location where you receive the *hospice care*.

You can receive *hospice care*:

- (a) at *home* as a *home health care* benefit;
- (b) at an *adult day care center* as an *adult day care* benefit;
- (c) while *confined* in an *assisted living facility* as an *assisted living facility* benefit;
- (d) while *confined* in a *nursing home* as a *nursing home* benefit; or
- (e) while *confined* in a *hospice care facility*.

During *confinement* in a stand-alone *hospice care facility*, *covered services* are paid as a *nursing home* benefit.

You do not need to satisfy the *elimination period* to use *hospice care* benefits.

Hospice care benefits will end when your *physician* ceases to certify you as *terminally ill*, you no longer meet the ELIGIBILITY FOR THE PAYMENT OF BENEFITS section requirements, or the *policy limit* has been reduced to zero, whichever occurs first.

INTERNATIONAL BENEFIT

If you meet the ELIGIBILITY FOR THE PAYMENT OF BENEFITS section requirements while outside of the United States, its possessions or territories, Canada, or the United Kingdom, we will pay a monthly international benefit for each *month* of:

- (a) *confinement* in a *nursing home*;
- (b) *confinement* in an *assisted living facility*;

- (c) *home health care*;
- (d) *adult day care*;
- (e) *respite care*; and
- (f) *hospice care*.

The international benefit is a fixed indemnity benefit equal to the *maximum monthly benefit* shown on the policy schedule up to the International Benefit Limit. We will pay the benefit regardless of the actual expenses you incur.

International benefits for *nursing home, assisted living facility, adult day care, or home health care* begin after you have satisfied your policy's *elimination period*. You do not need to satisfy the *elimination period* to receive *hospice care* or *respite care*.

We will pay the international benefit in place of any other policy or rider benefit. The following benefits are not available when you are receiving the international benefit: the Cash Benefit Rider, the care coordinator service, waiver of premium, and stay-at-home benefits.

We will pay the international benefit unless you receive the care or services while you are in a country where United States government sanctions prohibit payment, as specified by the United States Department of the Treasury's Office of Foreign Assets Control, or its successor. In addition, all care providers must meet the licensing or certification requirements, if any, of the jurisdiction in which you receive the care. We will make all benefit payments in U.S. dollars. Payment is subject to all of your policy's terms and conditions.

This benefit will end when we have paid the International Benefit Limit shown on the policy schedule, you no longer meet the ELIGIBILITY FOR THE PAYMENT OF BENEFITS section requirements, or the *policy limit* has been reduced to zero, whichever occurs first.

IMPORTANT NOTICE: The international benefit is a fixed amount indemnity benefit paid without regard to the actual expenses you incur. Total benefits paid under your policy in excess of the daily limit described in Section 7702B(d)(2) of the Internal Revenue Code of 1986 may be considered taxable income. For more information, we advise you to consult a tax advisor.

STAY-AT-HOME BENEFITS

Stay-at-home benefits are only available when you use the *care coordinator* service.

Stay-at-home benefits are provided to help you remain in your *home* or return *home* after a *confinement*. The *care coordinator* must determine that stay-at-home benefits are a cost-effective alternative to benefits otherwise provided by your policy. When you follow the *plan of care* developed by the *care coordinator*, we will pay the expense you incur for *covered services* for the following stay-at-home benefits:

- (a) caregiver training;
- (b) durable medical equipment;
- (c) home modification; and
- (d) medical alert system.

You do not need to satisfy the *elimination period* to receive stay-at-home benefits. However, you cannot use stay-at-home benefits to satisfy the *elimination period* for other policy benefits. All four stay-at-home benefits combined are subject to the single Stay-At-Home Benefit Limit shown on the policy schedule.

You can receive stay-at-home benefits at the same time you receive any other policy benefit, except for the Cash Benefit Rider, if part of your coverage. We will not pay stay-at-home benefits for expenses incurred prior to the date the *care coordinator* recommends them in a *plan of care*.

Stay-at-home benefits will end when we have paid the Stay-At-Home Benefit Limit shown on the policy schedule, you no longer meet the ELIGIBILITY FOR THE PAYMENT OF BENEFITS section requirements, or the *policy limit* has been reduced to zero, whichever occurs first.

CAREGIVER TRAINING

Caregiver training is the training of an *immediate family* member or friend to provide care for you in your *home*. *Covered services* consist of training for the proper use of a therapeutic device or a caregiving procedure. The person who provides the training must be licensed, certified, or otherwise qualified to provide training. Your *immediate family* member or friend can receive the training while you are *confined* in a hospital or a *facility* only if it is reasonably expected that such training will make it possible for you to return *home* where the caregiver can care for you. We will not pay to train someone who will be paid to care for you.

DURABLE MEDICAL EQUIPMENT

Durable medical equipment is equipment that primarily serves a medical purpose, rather than comfort or convenience, and can withstand repeated use. Examples include walkers, wheelchairs, infusion pumps, and hospital beds. *Covered services* consist of either the rental charge or the purchase price of such equipment. We will decide whether rental or purchase is more appropriate. Durable medical equipment does not include any device implanted in your body, a motorized scooter, or exercise equipment.

HOME MODIFICATION

Home modification means minor changes to your *home* to enhance your ability to perform *activities of daily living* and allow you to live there safely. *Covered services* consist of the charges for labor, equipment, and supplies for such modifications. Examples include installation of a ramp, grab bars or railings, and alterations to a room to accommodate a wheelchair. Home modification does not include hot tubs, swimming pools, home repair or maintenance, fees for building permits or inspections. This benefit may not be used solely to increase the value of your *home*.

MEDICAL ALERT SYSTEM

A medical alert system is a communication system installed in your *home* that is used solely to call for assistance in the event of a medical emergency. *Covered services* consist of shipping and installation fees for the device, the monthly monitoring fees, and the rental charge or purchase price of such system. We will decide whether rental or purchase is more appropriate. A medical alert system does not include charges for a normal telephone service, or for a home security system, or any other similar service or device.

ALTERNATE CARE BENEFIT

Alternate care benefits are only available when you use the *care coordinator* service.

When a *plan of care* developed by a *care coordinator* recommends treatment, services, or supplies not otherwise covered by your policy, we may pay benefits for such alternate types of care if:

- (a) they are *qualified long-term care services*;
- (b) they are a less-expensive alternative to your policy's other benefits for which you are then eligible; and
- (c) you, we, and a *licensed health care practitioner* agree to the alternate care services in writing.

Alternate care benefits include new types of *qualified long-term care services* that may be developed after the *policy effective date*. We will decide the amount of the benefit we will pay at the time we approve the alternate care. The written agreement will state whether you must satisfy your policy's *elimination period* to receive alternate care benefits. Any benefits paid under this provision will reduce your *policy limit* amount. We will not pay alternate care benefits for expenses incurred prior to the date the *care coordinator* recommends them in a *plan of care*.

We will not pay an alternate care benefit for any benefit that was available at the time of application and which you did not elect to purchase or was not included as part of your coverage.

Alternate care benefits will end when you no longer meet the ELIGIBILITY FOR THE PAYMENT OF BENEFITS section requirements or the *policy limit* has been reduced to zero, whichever occurs first. Upon written notice to you or your *representative*, we may discontinue alternate care benefits at any time without affecting your right to your policy's remaining benefits.

WAIVER OF PREMIUM BENEFIT

After you have satisfied the ELIGIBILITY FOR THE PAYMENT OF BENEFITS section requirements, you will not need to pay premiums for your policy effective on the date we begin paying:

- (a) *nursing home* benefits;
- (b) *assisted living facility* benefits;
- (c) at least eight days of *home health care* or *adult day care* benefits in any *month*; or
- (d) the monthly cash benefit, if the Cash Benefit Rider is attached to your policy.

The premium payment mode you selected does not affect the waiver of premium start date. However, we will not refund the portion of any premium you paid beyond the waiver of premium start date. Instead, we will credit such premium toward any future premium payments that become due when the waiver of premium ends.

If your coverage includes an optional rider that limits premium payments to a specified period of time (such as 10 years or 20 years), you will only be eligible for waiver of premium during the period in which premium payments are actually due.

Waiver of premium will end when the benefits listed in (a), (b), (c), or (d) of this section cease to be payable or you no longer meet the ELIGIBILITY FOR THE PAYMENT OF BENEFITS section requirements, whichever occurs first. Once waiver of premium ends, you must resume paying premiums to keep your policy in force.

CONTINGENT NONFORFEITURE BENEFIT

The contingent nonforfeiture benefit is effective on the *policy effective date*. This benefit is included only if you rejected our offer of the Nonforfeiture Benefit - Shortened Benefit Period Rider in writing at the time you applied for your policy.

The contingent nonforfeiture benefit is available to you only if there is a *substantial premium increase* for your coverage, as described under the **Substantial Premium Increase** provision. This benefit gives you the option to either choose a reduced benefit amount to prevent premium increases or to convert your policy to a paid-up status.

If there is a *substantial premium increase* for your coverage, we will send you written notice at least 60 days before the date your premium will change. The written notice will include the amount of the premium and inform you of your right to:

- (a) reduce your current level of coverage without evidence of insurability so that the required premium for your coverage is not increased; or
- (b) convert your coverage to a paid-up status with a reduced *policy limit* as described below. This option may be elected at any time during the 120-day period following the date of the *substantial premium increase*. If your policy lapses during the 120-day period following the date of the *substantial premium increase*, you will be deemed to have elected the offer to convert.

If you convert your coverage to paid-up status, you will not be required to make further premium payments. We will continue to pay benefits up to the applicable monthly maximums subject to all of the terms and conditions of your policy in effect at the time of lapse. However, your *policy limit* will be reduced, resulting in benefits being paid for a shorter length of time. The *policy limit* will be reduced to an amount equal to the greater of:

- (a) the *maximum monthly benefit* in effect on the date your policy lapsed; or
- (b) the total amount of premiums paid for your policy.

This reduced *policy limit* will not exceed the *policy limit* amount remaining in effect on the date your policy lapsed.

SUBSTANTIAL PREMIUM INCREASE

A *substantial premium increase* means a cumulative increase to your annual premium that is equal to or exceeds the percentage of your initial annual premium shown in the following table based on your *issue age*.

TABLE OF TRIGGERS FOR A SUBSTANTIAL PREMIUM INCREASE

Issue Age	Percentage of Increase Over Initial Annual Premium	Issue Age	Percentage of Increase Over Initial Annual Premium
29 and under	200%	72	36%
30 – 34	190%	73	34%
35 – 39	170%	74	32%
40 – 44	150%	75	30%
45 – 49	130%	76	28%
50 – 54	110%	77	26%
55 – 59	90%	78	24%
60	70%	79	22%
61	66%	80	20%

62	62%	81	19%
63	58%	82	18%
64	54%	83	17%
65	50%	84	16%
66	48%	85	15%
67	46%	86	14%
68	44%	87	13%
69	42%	88	12%
70	40%	89	11%
71	38%	90 and Older	10%

EXTENSION OF BENEFITS

If your policy terminates due to your failure to pay premium while you are *confined* in a *nursing home* or *assisted living facility*, we will pay either one of those benefits in the same manner as if your policy were still in force. Extension of benefits will begin after you have satisfied your policy's *elimination period*. Extension of benefits will end on the earliest of the date:

- (a) you no longer meet the ELIGIBILITY FOR THE PAYMENT OF BENEFITS section requirements;
- (b) you are no longer *confined* in a *nursing home* or *assisted living facility*; or
- (c) your *policy limit* has been reduced to zero.

RIGHT TO REDUCE COVERAGE AND LOWER PREMIUMS

You may elect to lower your policy's premium at any time by:

- (a) reducing your *policy limit*;
- (b) reducing your policy's *maximum monthly benefit* amount; or
- (c) exercising other options that are consistent with the policy design or our administrative processes.

We will base the premium for the reduced coverage on your *issue age*. We will not reduce benefits below the minimum amount of coverage we allow when issuing a new policy. To request a reduction in coverage, please contact us at the toll-free number shown on the face page of your policy.

If your policy is about to lapse due to non-payment of premium, we will notify you of your option to lower premium by reducing coverage. You will have 30 days to elect this option.

EXCLUSIONS

We will not pay benefits for:

- (a) services provided by an *immediate family* member, unless:
 1. he or she is a regular employee of the *facility* or agency providing the *covered services*;
 2. the *facility* or agency receives the payment for the *covered services*; and

3. he or she receives no compensation other than the normal compensation for employees in his or her job category;
- (b) services for which you are not charged in the absence of insurance;
- (c) services provided outside of the United States, its possessions or territories, Canada, or the United Kingdom (except as provided by the INTERNATIONAL BENEFIT section);
- (d) loss resulting from suicide, attempted suicide, or intentionally self-inflicted injury;
- (e) loss resulting from alcoholism or drug addiction (except for an addiction to a prescription medication when administered in accordance with the advice of your *physician*);
- (f) treatment provided in a government *facility* (unless otherwise required by law) except a Veterans Administration facility;
- (g) services received while your policy is not in force (except as provided by the EXTENSION OF BENEFITS section); or
- (h) loss resulting from war or act of war (declared or undeclared).

NON-DUPLICATION OF BENEFITS

We will not duplicate benefits for that portion of covered expense paid or payable:

- (a) by *Medicare*, including amounts that are reimbursable or would be reimbursable but for the application of a deductible or coinsurance amount;
- (b) by any other governmental program (except Medicaid), including the Veterans Administration; or
- (c) by any state or federal workers' compensation, employer liability, or occupational disease law, or any motor vehicle no-fault law.

TERMINATION

Your policy will end on the earliest of:

- (a) the date we receive your written request to cancel the policy (in which case the grace period will not apply);
- (b) the date of your death;
- (c) the date your *policy limit* is reduced to zero; or
- (d) the *policy renewal date*, if the renewal premium was not paid before the end of the grace period (except as provided for in the **Protection Against Unintentional Lapse** provision).

In the event of termination, we will refund any unearned premium according to the **Refund of Premium** provision. Termination will not affect any claim for *covered services* that you incurred while your policy was in force.

TERM OF COVERAGE

Your coverage starts on the *policy effective date* at 12:00 a.m. where you reside. It ends at 12:00 a.m. where you reside on the first *policy renewal date*. Each time you renew your policy by paying the premium within the grace period, a new term begins when the old term ends.

CLAIMS

If any part of this section conflicts with the applicable law of the state where your policy is issued, the claims process will be administered according to such applicable state law.

NOTICE OF CLAIM

If you think you may be *chronically ill*, you or your *representative* should notify us as soon as reasonably possible. The notice should include your name and policy number. You can mail notice to us at the address shown on the face page of your policy, or you may call us.

HOW WE DETERMINE YOUR ELIGIBILITY FOR BENEFITS

When we receive notice of claim, we will attempt to collect the information we need to determine whether you meet the requirements of the ELIGIBILITY FOR THE PAYMENT OF BENEFITS section. We may arrange for an *assessment* at no cost to you. We may need to contact your *physician* or other care provider. Also, we may need to review your medical records. We will not pay benefits until we determine your eligibility based on the information we obtain. If we determine you are eligible for benefits, we will arrange for a *licensed health care practitioner* or a *care coordinator* to develop a *plan of care*.

CLAIM FORMS

When we receive your notice of a 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 specified for filing in the **Proof of Loss** provision.

PROOF OF LOSS

Written proof of loss must be given to us within 90 days after the onset of such loss. If it is 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.

ASSISTANCE WITH COMPLETING CLAIM FORMS

If you would like assistance with completing claim forms, you may call us at the toll-free telephone number shown on the face page of your policy.

PHYSICAL EXAMINATIONS

We may have you examined, at our expense, when and as often as is reasonable while a claim is pending, but no more than once every 90 days.

TIME OF PAYMENT OF CLAIMS

After we receive written proof of loss, we will pay all benefits then due on a monthly basis.

PROMPT PAYMENT OF CLAIMS

Within 30 business days after we receive a claim for benefits under your policy, we will pay such claim or send a written notice informing you of the date we received the claim and:

- (a) the reasons for denial if we decline to pay all or part of the claim; or
- (b) the additional information we need to determine if we are required under your policy to pay all or part of the claim.

Within 30 business days after we receive all of the requested additional information, we will either pay the claim or send you a written notice of denial. The written notice will explain why we are declining to pay all or part of the claim.

If we have a reasonable basis, supported by specific information, to believe that a claim was fraudulently submitted, this provision will not apply.

PAYMENT OF CLAIMS

We will pay benefits to you, if you are living, unless you send us a written assignment 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.

APPEALING A BENEFIT TRIGGER DECISION

We will notify you in writing if we determine that you have not met the ELIGIBILITY FOR PAYMENT OF BENEFITS section, or "benefit trigger," requirements. The written notice will explain why we determined that you did not meet the benefit trigger and provide information about your right to an internal appeal and your right to submit new or additional information related to the denial. Also, we will inform you of your right to request an independent review after you have exhausted our internal appeal process. You may choose a *representative* to act for you during the appeal process.

Internal Appeal

If you disagree with our original benefit trigger decision, you may ask that we reconsider your claim. You must send your request in writing within 120 days of our decision. You should submit any additional information that you feel we need to review our decision.

The person or panel we choose to reconsider your claim will not be the same person or panel that made the original claim decision. Within 30 days after we receive all information we deem necessary, we will complete the internal appeal and send you written notice of the decision. The notice will inform you of your right to request an independent review if we uphold the original decision.

Independent Review

After you have exhausted the internal appeal process, you may request an independent review of our benefit trigger decision by an organization certified to perform such reviews. You may send us a written request for an independent review within 120 days after you receive our final written notice of the internal appeal decision.

You may choose an independent review organization from a list that we will provide when we notify you of our internal appeal decision. We will refer your written request to the organization within five business days after we receive your written request and notice of your choice. Independent review organizations must be certified or approved by the state to conduct such reviews, if state approval or certification is required. The independent review organization will only review benefit trigger decisions. The independent review organization will not review claim payment decisions.

The organization will review all of the information or documents provided to and considered by us in making our determination. The organization will provide both you and us written notice of its final decision. This decision will be final and binding on us. We will pay for the cost of the independent review.

You may submit, at any time, new or additional information not previously provided to us but relevant to the benefit trigger denial. The information will first be considered by us according to our internal appeal process.

ASSIGNMENT OF BENEFITS

You may ask us to pay policy benefits directly to a provider of *covered services* by submitting a written request. The provider must agree to this assignment of benefits. Unless you specify otherwise in the written request, the assignment will be effective on the date you sign the written request. We are not liable for any actions we take before we receive the written request.

We are not responsible for the validity of any assignment of benefits.

OVERPAYMENT OF BENEFITS

If we find that we paid more benefits than we should have under your policy, we have a right to recover the overpayment. We may request a refund of the overpayment from you or from any provider who received such overpayment. We may also deduct the overpayment from any future benefits payable under your policy.

PREMIUM AND REINSTATEMENT

PREMIUMS CAN CHANGE

The premium for your policy can change. We will not increase premium due to a change in your age or health or your use of the long-term care coverage. However, we can change premiums if we make the same change for all persons of the same *class*, but never more than once per year. We will notify you at least 60 days before we change premiums for your *class*. Your premium rates will also increase when you purchase additional coverage after the *policy effective date*, such as an increased level of inflation protection.

PAYMENT OF PREMIUMS

You must pay premiums to us to keep your policy in force. Premium is considered paid when we receive it. Your first premium is due on the *policy effective date*. Subsequent premiums are due on each *policy renewal date*.

The frequency of payment is called the premium mode. You chose your premium mode on your application and it is shown on the policy schedule. You may change your premium mode by giving us written or verbal notice at least 30 days before the next *policy renewal date*.

GRACE PERIOD

Your policy has a 65-day grace period. This means that if you do not pay the full amount of the renewal premium on or before the date it is due, you can pay it during the following 65 days. During the grace period, your policy will stay in force, as long as you pay the full amount of the premium due before the end of the grace period. The grace period operates as follows:

If you do not pay your premium within 30 days from the due date, we will send notice of lapse to you and the person you may have designated to receive notice of lapse due to non-payment of premium. We will send notice by United States first-class mail. You will have at least 35 days from the date of the notice of lapse to pay all premiums that are due. If you do not pay the premium during the grace period,

coverage will terminate as of the date the premium was due, and we will not pay claims incurred on or after that date. The grace period does not apply if you cancel your policy.

REINSTATEMENT

Your policy will lapse if you do not pay your premium before the end of the grace period. If your policy lapses, you may request that we reinstate your policy. We must receive your request within 180 days from the date of lapse. We may or may not reinstate your policy at our option. If we accept a late premium without refunding it or requiring you to complete an application for reinstatement, your policy will be reinstated.

We may require you to complete an application for reinstatement and meet our underwriting guidelines. If we approve the application and receive payment of all past due premium, we will reinstate your policy as of the last premium due date. If we do not approve your application within 45 days of the date that we receive the application and all past due premium, we will reinstate your policy unless we have previously given you written notice of our disapproval of your request for reinstatement.

Your reinstated policy will only cover loss that results from cognitive impairment or loss of functional capacity that occurs after the date of reinstatement. In all other respects, your rights and our rights will remain the same as before the policy lapsed, subject to any provisions noted on or attached to the reinstated policy.

In the event of reinstatement, we may charge interest up to 6% on the overdue premium.

PROTECTION AGAINST UNINTENTIONAL LAPSE

You have the right, at the time of application, to designate at least one person who is to receive notice of lapse due to non-payment of premium in addition to yourself. You may change this designation at any time. To do so, you must notify us in writing. We will remind you in writing every two years of this opportunity.

If your policy lapses due to non-payment of premium, we will reinstate your policy if we receive proof that you were *chronically ill* beginning on or before the date of lapse. The proof must be in the form of an *assessment* from a *licensed health care practitioner* certifying that you were *chronically ill*. We must receive your request for reinstatement within 180 days of the date of lapse and you must pay all past due premiums. We will reinstate your policy as of the date of lapse and your coverage will continue without interruption. We will not require evidence of insurability for such reinstatement.

REFUND OF PREMIUM

We will apply all refunds of premium due under your policy as a reduction in future premiums, except for any refund of premium due upon your death or cancellation of the policy.

If you die while covered under your policy, we will refund the pro-rata portion of any premium paid for the period after your death. We will make the refund within 30 days after we receive written notice and proof of your death. We will make the refund to your *partner*, if living, or to your estate.

If you cancel your policy, we will promptly return the unearned portion of any premium paid.

UNPAID PREMIUMS

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

POLICY PROVISIONS

ENTIRE CONTRACT AND CHANGES

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

- (a) your 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 the policy. No agent can change your policy or waive any of its provisions. Any rider, endorsement, or application added after the *policy effective date* which reduces or eliminates coverage under your policy will require your signed acceptance to be valid.

INCONTESTABILITY

In issuing your policy, we relied on the information on your application. If your policy has been in force for less than six *months* following the *policy effective date*, we may rescind your policy or deny a valid claim due to a misrepresentation on your application that is material to our acceptance of you for coverage.

If your policy has been in force for at least six *months* but less than two years, we may rescind your policy or deny a valid claim due to a misrepresentation on your application that is both material to our acceptance of you for coverage and pertains to the conditions for which benefits are sought.

After your policy has been in force for two years, we cannot use a misrepresentation on your application to rescind your policy or to deny a valid claim for benefits unless you knowingly and intentionally misrepresented any relevant facts relating to your health.

CLERICAL ERROR

If we discover a clerical, bookkeeping, or data entry error in our records, we will correct it. In the event of an error, we will adjust premium and benefits accordingly.

MISSTATEMENT OF AGE OR SEX

If you misstated your age or sex in the application, we will adjust all benefits payable to those which the premium paid would have purchased at the correct age or sex.

LEGAL ACTIONS

If this provision conflicts with the applicable law of the state where your policy is issued, this provision is amended to conform with such applicable state law.

You cannot bring a legal action to recover under your policy until at least 60 days after we receive satisfactory written proof of loss. You cannot bring a legal action more than three years from the date proof of loss is required.

CHANGE OF BENEFICIARY

Only you have the right to change the *beneficiary*. Unless your beneficiary designation is irrevocable, the *beneficiary's* consent is not required to change the *beneficiary* or to make any other change in your policy.

To change a *beneficiary*, please send us a written request. When we record and acknowledge that request, the change will be effective as of the date you signed the request unless otherwise specified. The change will not apply to any payments made or other action taken by us before recording.

CONFORMITY WITH INTERNAL REVENUE CODE

If on the *policy effective date*, your policy does not comply with the requirements of Section 7702B(b) of the Internal Revenue Code of 1986, as amended, it will be treated as if it had been changed to comply with those requirements. Because your policy is guaranteed renewable, we will inform you in writing of any required change in the provisions of your policy, and you will be given the choice of accepting the change, or retaining your policy without that change. If you reject the change, your policy may no longer be tax-qualified and you should consult a financial planning professional.

INTERSTATE INSURANCE PRODUCT REGULATION COMMISSION (IIPRC) POLICY PROVISIONS

CONFORMITY WITH IIPRC STANDARDS

Your policy was approved under the authority of the IIPRC and issued under its standards. Any provision of your policy that on the *policy effective date* is in conflict with IIPRC standards for this product type is amended as of that date to conform to such standards.

CROSS BORDER RULES

We will pay benefits for similar services obtained in a state other than your policy state of issue if we would have paid benefits for those services in the policy state of issue. We will pay such benefits regardless of any *facility* licensing, certification, or registration requirement (or similar requirement) differences between the states.

MUTUAL OF OMAHA INSURANCE COMPANY

MUTUAL OF OMAHA PLAZA, OMAHA, NE 68175

CASH BENEFIT RIDER

The premium you paid and the application you completed have put this rider in force as of the Rider Date. This rider is made a part of the policy to which it is attached. It is subject to all parts of your policy not in conflict with this rider. In the event of a conflict between this rider and any other provision of your policy, this rider will control.

Rider Date (same as the *policy effective date*)

NOTICE

This rider is only available at the time you applied for your policy. If this rider is included as part of your coverage, you cannot later choose to cancel it or to remove it from your policy.

CASH BENEFIT

If you meet your policy's ELIGIBILITY FOR THE PAYMENT OF BENEFITS section requirements, you may elect to receive the monthly cash benefit shown on the policy schedule in place of any other benefit for which you qualify under your policy. The cash benefit is a fixed indemnity benefit that we will pay in advance, at the start of each *month*, regardless of the actual expenses you incur.

You do not need to satisfy your policy's *elimination period* to receive the cash benefit. However, any days on which we waive the *elimination period* for the cash benefit cannot be used to satisfy the *elimination period* for other policy benefits. If you switch from the cash benefit to another policy benefit, you must still satisfy the *elimination period* applicable to the other policy benefit.

If you are eligible for the cash benefit for less than an entire *month*, we will pay a pro rata benefit for that *month* based on the actual number of days that you meet the ELIGIBILITY FOR THE PAYMENT OF BENEFITS section requirements. We will assume that a month consists of 30 days regardless of the actual number of days in a month. We reserve the right to require an *assessment* and a new *plan of care* at least once every 90 days while you are receiving the cash benefit.

We will not pay the cash benefit if you are located outside of the United States, its possessions or territories, Canada, or the United Kingdom at the time you are eligible for the cash benefit.

The cash benefit will end on the date the first of the following events occurs:

- (a) you no longer meet your policy's ELIGIBILITY FOR THE PAYMENT OF BENEFITS section requirements;
- (b) we receive notice from you that you elect to discontinue receiving the cash benefit;
- (c) we receive notice from you that you wish to switch to another policy benefit; or
- (d) your *policy limit* has been reduced to zero.

EFFECT ON OTHER BENEFITS

We will not pay the cash benefit if you are receiving any other policy benefits. You may elect to discontinue receiving the cash benefit in favor of receiving other benefits for which you may qualify by

sending us a written request. However, any cash benefit that we have paid in advance will be deducted from any future benefits payable under your policy.

TERMINATION

This rider will end on the date your policy ends.

IMPORTANT NOTICE: The cash benefit is a fixed amount indemnity benefit paid without regard to the actual expenses you incur. Total benefits paid under your policy in excess of the daily limit described in Section 7702B(d)(2) of the Internal Revenue Code of 1986 may be considered taxable income. For more information, we advise you to consult a tax advisor.

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COMPOUND INFLATION PROTECTION - LIFETIME BENEFIT RIDER

The premium you paid and the application you completed have put this rider in force as of the Rider Date. This rider is made a part of the policy to which it is attached. It is subject to all parts of your policy not in conflict with this rider. In the event of a conflict between this rider and any other provision of your policy, this rider will control.

Rider Date (the effective date for this rider is shown on the policy schedule)

Rider Premium (amount is shown on the policy schedule)

COMPOUND INFLATION PROTECTION - LIFETIME BENEFIT

This rider increases the benefit amounts of your policy each year. The percentage by which your benefits will increase is shown on the policy schedule. This compound inflation protection will increase your benefits as follows:

On each *policy anniversary date*, we will increase your then existing *maximum monthly benefit* by the increase percentage shown on the policy schedule.

On each *policy anniversary date*, we will increase your *policy limit* by the increase percentage shown on the policy schedule.

If you add this rider to your coverage after the *policy effective date*, increases in your *maximum monthly benefit* and *policy limit* will begin on the *policy anniversary date* that occurs on or next follows the Rider Date.

EFFECT ON BENEFITS

These benefit increases will:

- (a) continue regardless of your age, changes in health, claims status, or length of time you have been insured under your policy so long as this rider and your policy remain in effect;
- (b) be effective on each *policy anniversary date* even if you are receiving benefits; and
- (c) be rounded up or down to the nearest whole dollar.

These increases in benefits will not be determined by the actual amount of future inflation. The actual increases in benefits under your policy are a fixed amount which may be greater or less than the amount of inflation.

EFFECT ON PREMIUMS

Your premium will not change solely because of these annual benefit increases. However, premiums may still increase for all members of your *class* as described in the **Premiums Can Change** provision of your policy.

TERMINATION

VOLUNTARY TERMINATION

If you request that we remove this inflation protection benefit from your policy:

- (a) your benefit amounts will remain at the level they were as of the effective date of your request; and
- (b) your premium will change to equal the amount that would be charged for your coverage at the time you terminate this rider, based on your original *issue age*.

AUTOMATIC TERMINATION

This rider will end on the earliest of the date:

- (a) benefits continue under the EXTENSION OF BENEFITS section of your policy;
- (b) your policy continues in force under the terms of any nonforfeiture benefit; or
- (c) your policy ends.

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MUTUAL OF OMAHA PLAZA, OMAHA, NE 68175

COMPOUND INFLATION PROTECTION - LIMITED PERIOD BENEFIT RIDER

The premium you paid and the application you completed have put this rider in force as of the Rider Date. This rider is made a part of the policy to which it is attached. It is subject to all parts of your policy not in conflict with this rider. In the event of a conflict between this rider and any other provision of your policy, this rider will control.

Rider Date (same as the *policy effective date*)

Rider Premium (amount is shown on the policy schedule)

COMPOUND INFLATION PROTECTION - LIMITED PERIOD BENEFIT

This rider increases the benefit amounts of your policy each year for a limited period. The limited period is the maximum number of years shown in the policy schedule for which this rider increases benefits. The percentage by which your benefits will increase is also shown on the policy schedule. This compound inflation protection will increase your benefits for the limited period as follows:

On each *policy anniversary date* for the remainder of the limited period, we will increase your then existing *maximum monthly benefit* by the increase percentage shown on the policy schedule.

On each *policy anniversary date* for the remainder of the limited period, we will increase your *policy limit* by the increase percentage shown on the policy schedule.

EFFECT ON BENEFITS

These benefit increases will:

- (a) continue regardless of your age, changes in health, or claims status, so long as this rider and your policy remain in effect;
- (b) be effective on each *policy anniversary date* even if you are receiving benefits; and
- (c) be rounded up or down to the nearest whole dollar.

Benefit increases will stop accruing after the limited period has expired.

These increases in benefits will not be determined by the actual amount of future inflation. The actual increases in benefits under your policy are a fixed amount which may be greater or less than the amount of inflation.

EFFECT ON PREMIUMS

Your premium will not change solely because of these annual benefit increases. However, premiums may still increase for all members of your *class* as described in the **Premiums Can Change** provision of your policy.

TERMINATION

VOLUNTARY TERMINATION

You may request that we remove this inflation protection benefit from your policy if we receive your written request before the limited period has expired. When we receive your request to terminate this rider:

- (a) your benefit amounts will remain at the level they were as of the effective date of your request; and
- (b) your premium will change to equal the amount that would be charged for your coverage at the time you terminate this rider, based on your original *issue age*.

AUTOMATIC TERMINATION

This rider will end on the earliest of the date:

- (a) benefits continue under the EXTENSION OF BENEFITS section of your policy;
- (b) your policy continues in force under the terms of any nonforfeiture benefit; or
- (c) your policy ends.

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COMPOUND INFLATION PROTECTION BENEFIT WITH BUY-UP OPTION RIDER

The premium you paid and the application you completed have put this rider in force as of the Rider Date. This rider is made a part of the policy to which it is attached. It is subject to all parts of your policy not in conflict with this rider. In the event of a conflict between this rider and any other provision of your policy, this rider will control.

Rider Date (same as the *policy effective date*)

Rider Premium (amount is shown on the policy schedule)

COMPOUND INFLATION PROTECTION BENEFIT

This rider increases the benefit amounts of your policy each year. The percentage by which your benefits will increase is shown on the policy schedule. This compound inflation protection will increase your benefits as follows:

On each *policy anniversary date*, we will increase your then existing *maximum monthly benefit* by the increase percentage shown on the policy schedule.

On each *policy anniversary date*, we will increase your *policy limit* by the increase percentage shown on the policy schedule.

EFFECT ON BENEFITS

These benefit increases will:

- (a) continue regardless of your age, changes in health, claims status, or length of time you have been insured under your policy, so long as this rider and your policy remain in effect;
- (b) be effective on each *policy anniversary date* even if you are receiving benefits; and
- (c) be rounded up or down to the nearest whole dollar.

These increases in benefits will not be determined by the actual amount of future inflation. The actual increases in benefits under your policy are a fixed amount which may be greater or less than the amount of inflation.

EFFECT ON PREMIUMS

Your premium will not change solely because of these annual benefit increases. However, your premium will increase if you elect the buy-up option. Premiums may also increase for all members of your *class* as described in the **Premiums Can Change** provision of your policy.

BUY-UP OPTION

This rider allows you the option to increase the percentage of inflation protection applied to your policy benefits each year.

On or before each *policy anniversary date*, you may choose to increase your compound inflation percentage to any percentage we offer. The total level of inflation protection that you receive under this rider cannot exceed 5%. You may elect this option once a year, on or before each *policy anniversary date*, by sending us a written request.

You are eligible for the buy-up option unless, at any time during the two years preceding your request to exercise this option:

- (a) we waived premium under any provision of your policy;
- (b) your policy was paid-up; or
- (c) you were *chronically ill*.

The buy-up option is available up to and including the Final Buy-Up Date shown on the policy schedule for this benefit.

BUY-UP OPTION WILL INCREASE YOUR PREMIUM

The premium for your policy will increase each time you elect the buy-up option. This will occur on the *policy anniversary date* coinciding with or next following the date we receive your written request. This increase will be based on your age and the premium rate in effect for the new compound inflation percentage at that time.

Benefit increases will not occur until the second *policy anniversary date* coinciding with or next following the date your written request is received and accepted by us.

TERMINATION

VOLUNTARY TERMINATION

If you request that we remove this inflation protection benefit from your policy:

- (a) your benefit amounts will remain at the level they were as of the effective date of your request; and
- (b) your premium will change to equal the amount that would be charged for your coverage at the time you terminate this rider, based on your original *issue age*.

AUTOMATIC TERMINATION

This rider will end on the earliest of the date:

- (a) benefits continue under the EXTENSION OF BENEFITS section of your policy;
- (b) your policy continues in force under the terms of any nonforfeiture benefit; or
- (c) your policy ends.

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COMPOUND INFLATION PROTECTION - LIMITED PERIOD BENEFIT WITH BUY-UP OPTION RIDER

The premium you paid and the application you completed have put this rider in force as of the Rider Date. This rider is made a part of the policy to which it is attached. It is subject to all parts of your policy not in conflict with this rider. In the event of a conflict between this rider and any other provision of your policy, this rider will control.

Rider Date (same as the *policy effective date*)

Rider Premium (amount is shown on the policy schedule)

COMPOUND INFLATION PROTECTION - LIMITED PERIOD BENEFIT

This rider increases the benefit amounts of your policy each year for a limited period. The limited period is the maximum number of years shown in the policy schedule for which this rider increases benefits. The percentage by which your benefits will increase is also shown on the policy schedule. This compound inflation protection will increase your benefits for the limited period as follows:

On each *policy anniversary date* for the remainder of the limited period, we will increase your then existing *maximum monthly benefit* by the increase percentage shown on the policy schedule.

On each *policy anniversary date* for the remainder of the limited period, we will increase your *policy limit* by the increase percentage shown on the policy schedule.

EFFECT ON BENEFITS

These benefit increases will:

- (a) continue regardless of your age, changes in health, or claims status, so long as this rider and your policy remain in effect;
- (b) be effective on each *policy anniversary date* even if you are receiving benefits; and
- (c) be rounded up or down to the nearest whole dollar.

Benefit increases will stop accruing after the limited period has expired.

These increases in benefits will not be determined by the actual amount of future inflation. The actual increases in benefits under your policy are a fixed amount which may be greater or less than the amount of inflation.

EFFECT ON PREMIUMS

Your premium will not change solely because of these annual benefit increases. However, your premium will increase if you elect the buy-up option. Premiums may also increase for all members of your *class* as described in the **Premiums Can Change** provision of your policy.

BUY-UP OPTION

This rider allows you the option to increase the percentage of inflation protection applied to your policy benefits each year.

On or before each *policy anniversary date*, you may choose to increase your compound inflation percentage to any percentage we offer. The total level of inflation protection that you receive under this rider cannot exceed 5%. You may elect this option once a year, on or before each *policy anniversary date*, by sending us a written request.

You are eligible for the buy-up option unless, at any time during the two years preceding your request to exercise this option:

- (a) we waived premium under any provision of your policy;
- (b) your policy was paid-up; or
- (c) you were *chronically ill*.

The buy-up option is available up to and including the Final Buy-Up Date shown on the policy schedule for this benefit.

BUY-UP OPTION WILL INCREASE YOUR PREMIUM

The premium for your policy will increase each time you elect the buy-up option. This will occur on the *policy anniversary date* coinciding with or next following the date we receive your written request. This increase will be based on your age and the premium rate in effect for the new compound inflation percentage at that time.

Benefit increases will not occur until the second *policy anniversary date* coinciding with or next following the date your written request is received and accepted by us.

TERMINATION

VOLUNTARY TERMINATION

You may request that we remove this inflation protection benefit from your policy if we receive your written request before the limited period has expired. When we receive your request to terminate this rider:

- (a) your benefit amounts will remain at the level they were as of the effective date of your request; and
- (b) your premium will change to equal the amount that would be charged for your coverage at the time you terminate this rider, based on your original *issue age*.

AUTOMATIC TERMINATION

This rider will end on the earliest of the date:

- (a) benefits continue under the EXTENSION OF BENEFITS section of your policy;
- (b) your policy continues in force under the terms of any nonforfeiture benefit; or
- (c) your policy ends.

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NONFORFEITURE BENEFIT - SHORTENED BENEFIT PERIOD RIDER

The premium you paid and the application you completed have put this rider in force as of the Rider Date. This rider is made a part of the policy to which it is attached. It is subject to all parts of your policy not in conflict with this rider. In the event of a conflict between this rider and any other provision of your policy, this rider shall control.

Rider Date (same as the *policy effective date*)

Rider Premium (amount is shown on the policy schedule)

NONFORFEITURE BENEFIT - SHORTENED BENEFIT PERIOD

The CONTINGENT NONFORFEITURE BENEFIT section of your policy is removed and replaced by the following:

This nonforfeiture benefit provides a continuation of your coverage, but with a reduced *policy limit*, if your coverage lapses on or after the third *policy anniversary date*.

We will pay benefits for *covered services* you receive up to the applicable monthly maximums and subject to all of the terms and conditions of your policy in effect at the time of lapse. However, your *policy limit* will be reduced, resulting in benefits being paid for a shorter length of time. Your *policy limit* will be reduced to an amount equal to the greater of:

- (a) the *maximum monthly benefit* in effect on the date the policy lapsed; or
- (b) the total amount of premiums paid for your policy.

This reduced *policy limit* will not exceed the *policy limit* amount remaining in effect on the date your policy lapsed.

TERMINATION

This rider will end on the earliest of the date:

- (a) we receive your written request to terminate this rider; or
- (b) your policy ends.

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WAIVER OF ELIMINATION PERIOD FOR HOME HEALTH CARE BENEFITS RIDER

The premium you paid and the application you completed have put this rider in force as of the Rider Date. This rider is made a part of the policy to which it is attached. It is subject to all parts of your policy not in conflict with this rider. In the event of a conflict between this rider and any other provision of your policy, this rider will control.

Rider Date (same as the *policy effective date*)

Rider Premium (amount is shown on the policy schedule)

NOTICE

This rider is only available at the time you applied for your policy. If this rider is included as part of your coverage, you cannot later choose to cancel it or to remove it from your policy.

WAIVER OF ELIMINATION PERIOD FOR HOME HEALTH CARE BENEFITS

If you meet your policy's ELIGIBILITY FOR THE PAYMENT OF BENEFITS section requirements and you incur expenses for *covered services* for *home health care* or *adult day care*, we will waive the requirement that you satisfy the *elimination period* before we will pay *home health care* or *adult day care* benefits. Days on which we waive the *elimination period* for *home health care* or *adult day care* benefits will be used to satisfy the *elimination period* for other benefits available under your policy, including but not limited to *nursing home* benefits or *assisted living facility* benefits.

TERMINATION

This rider will end on the date your policy ends.

Mutual of Omaha Insurance Company



MUTUAL OF OMAHA INSURANCE COMPANY

MUTUAL OF OMAHA PLAZA, OMAHA, NE 68175

PROFESSIONAL HOME HEALTH CARE BENEFITS RIDER

The premium you paid and the application you completed have put this rider in force as of the Rider Date. This rider is made a part of the policy to which it is attached. It is subject to all parts of your policy not in conflict with this rider. In the event of a conflict between this rider and any other provision of your policy, this rider will control.

Rider Date (same as the *policy effective date*)

Rider Premium (amount is shown on the policy schedule)

NOTICE

This rider is only available at the time you applied for your policy. If this rider is included as part of your coverage, you cannot later choose to cancel it or to remove it from your policy.

DEFINITIONS

The definitions shown in your policy apply to this rider. In applying them, substitute "rider" for "policy." In addition, the following definition applies to this rider.

Professional home health care means *home health care covered services* provided by a *nurse* or a skilled professional who has received specialized training or state licensure in the field of physical therapy, respiratory therapy, occupational therapy, speech therapy, audiology, nutrition, or chemotherapy administration.

PROFESSIONAL HOME HEALTH CARE BENEFITS

This rider pays benefits for the expense you incur for *covered services* for *professional home health care* in conjunction with your policy's HOME HEALTH CARE BENEFITS section. We will first pay for such expenses under this rider. Any excess expense incurred will be considered under your policy's *home health care* benefits.

If you receive *professional home health care* from a *home health care agency* or an *independent provider*, we will pay the expense you incur for *covered services*, up to the Professional Home Health Care Maximum Monthly Benefit shown on the policy schedule, for each *month* you receive such services. If the expense you incur for *professional home health care* exceeds the Professional Home Health Care Maximum Monthly Benefit, we will pay for such expense under the terms of your policy's *home health care* benefits up to the Home Health Care Maximum Monthly Benefit shown on the policy schedule. *Professional home health care* benefits begin after you have satisfied your policy's *elimination period*. *Covered services* for *professional home health care* consist of:

- (a) part-time or intermittent skilled services provided by a *nurse* (for a maximum of 365 days of service while your policy is in force);
- (b) physical therapist services;
- (c) respiratory therapist services;
- (d) occupational therapist services;

- (e) speech therapist services;
- (f) audiologist services;
- (g) chemotherapy administration specialist services; and
- (h) nutritional specialist services.

Professional home health care benefits will end when you no longer meet your policy's ELIGIBILITY FOR THE PAYMENT OF BENEFITS section requirements or the *policy limit* has been reduced to zero, whichever occurs first.

TERMINATION

This rider ends on the date your policy ends.

Mutual of Omaha Insurance Company

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MUTUAL OF OMAHA INSURANCE COMPANY

MUTUAL OF OMAHA PLAZA, OMAHA, NE 68175

JOINT WAIVER OF PREMIUM RIDER

The premium you paid and the application you completed have put this rider in force as of the Rider Date. This rider is made a part of the policy to which it is attached. It is subject to all parts of your policy not in conflict with this rider. In the event of a conflict between this rider and any other provision of your policy, this rider will control.

Rider Date (same as the *policy effective date*)

Rider Premium (amount is shown on the policy schedule)

JOINT WAIVER OF PREMIUM

We will waive the payment of your premium when your *partner* qualifies for the waiver of premium benefit under his or her policy. We will waive your premium for as long as your *partner's* premium continues to be waived. This waiver of premium benefit is only available if both you and your *partner* are covered under separate, in force Mutual of Omaha Insurance Company long-term care policies, series LTC13, and each of you has this rider in force.

If we increase the premium for your policy because you purchase additional coverage after the *policy effective date*, such as an increased level of inflation protection, you must pay the amount of the premium increase until the 10th anniversary of the effective date of the increase. Afterwards, we will waive the increased amount.

For the purposes of this rider, your *partner* must have been your *partner* on the date you applied for your policy.

The premium payment mode you selected does not affect the waiver of premium start date. However, we will not refund the portion of any premium you paid after the waiver of premium start date. If a surplus of premium exists because it was paid after the waiver of premium start date, we will credit such premium towards future premium payments, if any, that become due when and if waiver ends.

Waiver of premium will end when your *partner's* waiver of premium ends or your *partner's policy limit* has been reduced to zero, whichever occurs first. Once waiver of premium ends, you must resume paying premiums to keep your policy in force.

TERMINATION

This rider will end on the earliest of the date:

- (a) we receive your written request to terminate this rider;
- (b) we receive your *partner's* written request to terminate the Waiver of Premium Rider attached to his or her policy;
- (c) you or your *partner* no longer meet the definition of a *partner*;
- (d) benefits are continued under the EXTENSION OF BENEFITS section of your policy;
- (e) your policy or your *partner's* policy continues in force under the terms of any nonforfeiture benefit; or
- (f) your policy or your *partner's* policy ends.

If you and your *partner* end your relationship as *partners*, you must notify us within 90 days of the date your relationship has ended.

Mutual of Omaha Insurance Company

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MUTUAL OF OMAHA INSURANCE COMPANY

MUTUAL OF OMAHA PLAZA, OMAHA, NE 68175

SURVIVORSHIP BENEFIT RIDER

The premium you paid and the application you completed have put this rider in force as of the Rider Date. This rider is made a part of the policy to which it is attached. It is subject to all parts of your policy not in conflict with this rider. In the event of a conflict between this rider and any other provision of your policy, this rider will control.

Rider Date (same as the *policy effective date*)

Rider Premium (amount is shown on the policy schedule)

SURVIVORSHIP BENEFIT

If your *partner* dies after the qualification period expires, your premium will be waived so that no further premium payments will be due for your policy, effective on the next *policy renewal date*. You must notify us in writing and furnish satisfactory proof that your *partner* has died. You must satisfy the qualification period set forth in the policy schedule to qualify for benefits under this rider.

This survivorship benefit is only available if both you and your *partner* are covered under separate, in force Mutual of Omaha Insurance Company long-term care policies, series LTC13, each of you has this rider in force, and each of you continue to live for the length of the qualification period. The qualification period for the survivorship benefit begins on the *policy effective date* and continues for the number of years shown on the policy schedule.

If we increase the premium for your policy because you purchase additional coverage after the *policy effective date*, such as an increased level of inflation protection, you must pay the amount of the premium increase until the 10th anniversary of the effective date of the increase. Afterwards, we will waive the increased amount.

For the purposes of this rider, your *partner* must have been your *partner* on the date you applied for your policy.

TERMINATION

This rider will end on the earliest of the date:

- (a) we receive your written request to terminate this rider;
- (b) we receive your *partner's* written request to terminate the Survivorship Benefit Rider attached to his or her policy;
- (c) you or your *partner* no longer meet the definition of a *partner*;
- (d) benefits are continued under the EXTENSION OF BENEFITS section of your policy;
- (e) your policy or your *partner's* policy continues in force under the terms of any nonforfeiture benefit; or
- (f) your policy or your *partner's* policy ends.

If you and your *partner* end your relationship as *partners*, you must notify us within 90 days of the date your relationship has ended.

Mutual of Omaha Insurance Company

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MUTUAL OF OMAHA INSURANCE COMPANY

MUTUAL OF OMAHA PLAZA, OMAHA, NE 68175

SHARED CARE BENEFIT RIDER

The premium you paid and the application you completed have put this rider in force as of the Rider Date. This rider is made a part of the policy to which it is attached. It is subject to all parts of your policy not in conflict with this rider. In the event of a conflict between this rider and any other provision of your policy, this rider will control.

Rider Date (same as the *policy effective date*)

Rider Premium (amount is shown on the policy schedule)

SHARED CARE BENEFIT

If your *policy limit* has been reduced to zero, this rider allows you to draw from your *partner's policy limit* to pay for benefits that you qualify for under your policy. The shared care benefit is only available if:

- (a) your *partner's policy limit* has not been reduced to an amount below 12 times the *maximum monthly benefit*; and
- (b) both you and your *partner* are covered under identical, separate, and in force Mutual of Omaha Insurance Company long-term care policies, series LTC13. The policies are identical if they contain the same *policy limits, elimination periods, maximum monthly benefit* amounts, and optional benefits, including the shared care benefit.

For the purposes of this rider, your *partner* must have been your *partner* on the date you applied for your policy.

You will reduce the *policy limit* under your *partner's* policy to the extent that you draw against it to pay for your policy benefits. Your *partner* may receive benefits under his or her policy at the same time that you are drawing on your *partner's policy limit*.

The shared care benefit will end when you no longer meet your policy's ELIGIBILITY FOR THE PAYMENT OF BENEFITS section requirements, or your *partner's policy limit* has been reduced to an amount less than or equal to twelve times the *maximum monthly benefit*, whichever occurs first.

EFFECT OF YOUR PARTNER DRAWING ON YOUR POLICY LIMIT

The amount of shared care benefits we pay under your policy to your *partner* will reduce your *policy limit*. This means that when you file a claim, the *policy limit* available to you may be less than the *policy limit* shown on the policy schedule.

DEATH OF A PARTNER

If your *partner* dies while his or her policy and this benefit are in force, the remaining amount of your *partner's policy limit* will be added to your *policy limit*. You must notify us in writing and furnish satisfactory proof that your *partner* has died. You must also certify that you were *partners* at the time of his or her death. Your premium will not change solely as a result of such increase in your *policy limit*. However, premiums may still increase for all members of your *class* as described in the **Premiums Can Change** provision of your policy.

TERMINATION

This rider will end on the earliest of the date:

- (a) we receive your written request to terminate this rider, if you have not received the shared care benefit;
- (b) you or your *partner* no longer meet the definition of a *partner*, if you have not received the shared care benefit;
- (c) the Shared Care Benefit Rider attached to your *partner's* policy ends;
- (d) you make a change to your policy or your *partner* makes a change to his or her policy that results in the policies no longer containing identical coverage;
- (e) benefits are continued under the EXTENSION OF BENEFITS section of your policy;
- (f) your policy or your *partner's* policy continues in force under the terms of any nonforfeiture benefit;
- (g) your policy ends; or
- (h) your *partner's* policy ends, unless your *partner* dies under the terms described in the **Death of a Partner** provision of this rider.

If you and your *partner* end your relationship as *partners*, you must notify us within 90 days of the date your relationship has ended.

Mutual of Omaha Insurance Company



MUTUAL OF OMAHA INSURANCE COMPANY

MUTUAL OF OMAHA PLAZA, OMAHA, NE 68175

SECURITY BENEFIT RIDER

The premium you paid and the application you completed have put this rider in force as of the Rider Date. This rider is made a part of the policy to which it is attached. It is subject to all parts of your policy not in conflict with this rider. In the event of a conflict between this rider and any other provision of your policy, this rider will control.

Rider Date (same as the *policy effective date*)

Rider Premium (amount is shown on the policy schedule)

SECURITY BENEFIT

If you are receiving benefits under your policy, and your *partner* is alive, we will pay you an additional cash benefit, without reducing your *policy limit*.

The additional benefit will equal the security benefit percentage shown on the policy schedule times the monthly benefit we pay you for *covered services* you receive. However, we will not pay the security benefit if you are receiving benefits under any Cash Benefit Rider that may be attached to your policy.

For the purposes of this rider, your *partner* must have been your *partner* on the date you applied for your policy.

The security benefit will end on the date this rider ends, the date you are no longer receiving benefits under your policy, or the date your *policy limit* has been reduced to zero, whichever occurs first.

TERMINATION

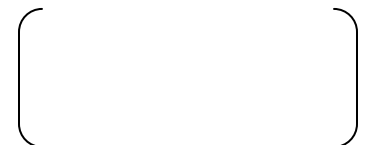
This rider will end on the earliest of the date:

- (a) we receive your written request to terminate this rider;
- (b) your policy continues in force under the terms of any nonforfeiture benefit;
- (c) your *partner* dies;
- (d) you or your *partner* no longer meet the definition of a *partner*; or
- (e) your policy terminates.

If you and your *partner* end your relationship as *partners*, you must notify us within 90 days of the date your relationship has ended.

IMPORTANT NOTICE: The security benefit is a fixed amount indemnity benefit paid without regard to the actual expenses you incur. Total benefits paid under your policy in excess of the daily limit described in Section 7702B(d)(2) of the Internal Revenue Code of 1986 may be considered taxable income. For more information, we advise you to consult a tax advisor.

Mutual of Omaha Insurance Company



MUTUAL OF OMAHA INSURANCE COMPANY

MUTUAL OF OMAHA PLAZA, OMAHA, NE 68175

THREE TIMES THE MAXIMUM MONTHLY BENEFIT RETURN OF PREMIUM AT DEATH (MINUS CLAIMS PAID) BENEFIT RIDER

The premium you paid and the application you completed have put this rider in force as of the Rider Date. This rider is made a part of the policy to which it is attached. It is subject to all parts of your policy not in conflict with this rider. In the event of a conflict between this rider and any other provision of your policy, this rider will control.

Rider Date (same as the *policy effective date*)

Rider Premium (amount is shown on the policy schedule)

NOTICE

This rider is only available at the time you applied for your policy. If this rider is included as part of your coverage, you cannot later choose to cancel it or to remove it from your policy.

THREE TIMES THE MAXIMUM MONTHLY BENEFIT RETURN OF PREMIUM AT DEATH (MINUS CLAIMS PAID) BENEFIT

If we receive satisfactory proof that you died while your policy was in force, we will refund the total amount of premium paid for your policy, but no more than three times your *maximum monthly benefit*, minus all benefits paid, from the effective date of this benefit up to the date of your death. Your policy must remain in force for the length of the qualification period specified in the policy schedule in order for you to receive benefits under this rider.

For the purposes of this rider, the *maximum monthly benefit* is the lesser of:

- (a) your initial *maximum monthly benefit*; or
- (b) your most recent *maximum monthly benefit* excluding, for the purposes of this rider, the whole amount of any inflation protection increases that you may have received.

Payment will not include interest, any benefits paid under your policy, any waived premiums, or any premium that we return under the **Refund of Premium** provision in your policy. We will pay this benefit in one lump sum to your *beneficiary*. If your *beneficiary* is dead, or cannot be located, we will pay this benefit to your estate.

We will return premium after we have processed all claims for benefits under your policy. If a claim is filed after we have returned premiums, we will reduce any benefits payable by the amount of premium returned.

We will not pay this benefit if your death occurs while either this rider or your policy is not in force.

TERMINATION

This rider will end on the earlier of the date:

- (a) your policy continues in force under the terms of any nonforfeiture benefit; or
- (b) your policy ends.

IMPORTANT NOTICE: Payment of this benefit may be considered taxable income for your *beneficiary* or estate. For more information, we advise you to consult a tax advisor.

Mutual of Omaha Insurance Company



MUTUAL OF OMAHA INSURANCE COMPANY

MUTUAL OF OMAHA PLAZA, OMAHA, NE 68175

RETURN OF PREMIUM (MINUS CLAIMS PAID) IF DEATH OCCURS BEFORE AGE 65 BENEFIT RIDER

The premium you paid and the application you completed have put this rider in force as of the Rider Date. This rider is made a part of the policy to which it is attached. It is subject to all parts of your policy not in conflict with this rider. In the event of a conflict between this rider and any other provision of your policy, this rider will control.

Rider Date (same as the *policy effective date*)

Rider Premium (amount is shown on the policy schedule)

NOTICE

This rider is only available at the time you applied for your policy. If this rider is included as part of your coverage, you cannot later choose to cancel it or to remove it from your policy.

RETURN OF PREMIUM (MINUS CLAIMS PAID) IF DEATH OCCURS BEFORE AGE 65 BENEFIT

If we receive satisfactory proof that you died before the *policy anniversary date* which coincides with or next follows your 65th birthday and while your policy was in force, we will refund the total amount of premiums paid for your policy, minus all benefits paid, from the *policy effective date* up to the date of your death.

Payment will not include interest, any benefits paid under your policy, any waived premiums, or any premium that we return under the **Refund of Premium** provision in your policy. We will pay this benefit in one lump sum to your *beneficiary*. If your *beneficiary* is dead, or cannot be located, we will pay this benefit to your estate.

We will return premium after we have processed all claims for benefits under your policy. If a claim is filed after we have returned premiums, we will reduce any benefits payable by the amount of premium returned.

We will not pay this benefit if:

- (a) you die on or after the first *policy anniversary date* which coincides with or next follows your 65th birthday; or
- (b) you die while either this rider or your policy is not in force.

TERMINATION

This rider will end on the earlier of the date:

- (a) your policy continues in force under the terms of any nonforfeiture benefit; or
- (b) your policy ends.

IMPORTANT NOTICE: Payment of this benefit may be considered taxable income for your *beneficiary* or estate. For more information, we advise you to consult a tax advisor.

Mutual of Omaha Insurance Company



MUTUAL OF OMAHA INSURANCE COMPANY

MUTUAL OF OMAHA PLAZA, OMAHA, NE 68175

RETURN OF PREMIUM AT DEATH (MINUS CLAIMS PAID) BENEFIT RIDER

The premium you paid and the application you completed have put this rider in force as of the Rider Date. This rider is made a part of the policy to which it is attached. It is subject to all parts of your policy not in conflict with this rider. In the event of a conflict between this rider and any other provision of your policy, this rider will control.

Rider Date (same as the *policy effective date*)

Rider Premium (amount is shown on the policy schedule)

NOTICE

This rider is only available at the time you applied for your policy. If this rider is included as part of your coverage, you cannot later choose to cancel it or to remove it from your policy.

RETURN OF PREMIUM AT DEATH (MINUS CLAIMS PAID) BENEFIT

If we receive satisfactory proof that you died while your policy was in force, we will refund the total amount of premiums paid for your policy, minus all benefits paid, from the *policy effective date* up to the date of your death.

Payment will not include interest, any benefits paid under your policy, any waived premiums, or any premium that we return under the **Refund of Premium** provision in your policy. We will pay this benefit in one lump sum to your *beneficiary*. If your *beneficiary* is dead, or cannot be located, we will pay this benefit to your estate.

We will return premium after we have processed all claims for benefits under your policy. If a claim is filed after we have returned premiums, we will reduce any benefits payable by the amount of premium returned.

We will not pay this benefit if you die while either this rider or your policy is not in force.

TERMINATION

This rider will end on the earlier of the date:

- (a) your policy continues in force under the terms of any nonforfeiture benefit; or
- (b) your policy ends.

IMPORTANT NOTICE: Payment of this benefit may be considered taxable income for your *beneficiary* or estate. For more information, we advise you to consult a tax advisor.

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