YOUR GROUP
TERM LIFE BENEFITS

FOR EMPLOYEES OF:

Hoover City Schools

CLASS(ES):

All Eligible Employees

EFFECTIVE DATE:

October 1, 2019

PUBLICATION DATE:

July 12, 2019

NOTICE(S)

THIS CERTIFICATE DESCRIBES THE BENEFITS THAT ARE AVAILABLE TO YOU. PLEASE READ YOUR CERTIFICATE CAREFULLY. BENEFITS ARE PROVIDED THROUGH A GROUP POLICY ISSUED IN THE STATE OF ALABAMA.

FRAUD WARNING

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Group Number: G000BJXW

If You have any questions about or concerns with this insurance, please first contact the Policyholder or Your benefits administrator. If, after doing so, You still have a question or concern, You may contact Us at:

United of Omaha Life Insurance Company
Mutual of Omaha Plaza
Omaha, Nebraska 68175
Call Toll-Free: 1-800-775-8805
www.mutualofomaha.com

When contacting Us, please have Your Policy number available.

IF YOU ARE NOT SATISFIED WITH YOUR CERTIFICATE, YOU MAY RETURN IT TO US WITHIN 30 DAYS AFTER YOU RECEIVE IT, UNLESS A CLAIM HAS PREVIOUSLY BEEN RECEIVED BY US UNDER YOUR CERTIFICATE. WE WILL REFUND WITHIN 30 DAYS OF OUR RECEIPT OF THE RETURNED CERTIFICATE ANY PREMIUM THAT HAS BEEN PAID AND THE CERTIFICATE WILL THEN BE CONSIDERED TO HAVE NEVER BEEN ISSUED. YOU SHOULD BE AWARE THAT IF YOU ELECT TO RETURN THE CERTIFICATE FOR A REFUND OF PREMIUMS, LOSSES WHICH OTHERWISE WOULD HAVE BEEN COVERED UNDER YOUR CERTIFICATE WILL NOT BE COVERED.

ABOUT LIVING BENEFITS (ACCELERATED BENEFIT)

LIFE INSURANCE BENEFITS (BENEFITS PAYABLE BY REASON OF THE DEATH OF YOU) WILL BE REDUCED IF BENEFITS ARE PAID UNDER THE LIVING BENEFITS (ACCELERATED BENEFIT) PROVISION.

This disclosure is a brief summary of the Living Benefits (Accelerated Benefit) provision and its effect on life insurance benefits.

An eligible Insured Person may receive payment of part of the amount of life insurance in effect for the Insured Person while living if the Insured Person has been diagnosed with a terminal condition. A terminal condition means an injury or sickness that is expected to result in death within the number of months stated in the Certificate, as certified by a Physician. Please refer to the Living Benefits (Accelerated Benefit) provision of this Certificate for information regarding who is eligible for this benefit and the complete definition of Terminal Condition.

This benefit is included in the premium paid for life insurance. There is no separate premium charge for this benefit. The premium for life insurance does not change if benefits are paid under the Living Benefits (Accelerated Benefit) provision.

The Living Benefits offered under this contract **may or may not** qualify for favorable tax treatment under the Internal Revenue Code of 1986 (as amended). Whether such benefits qualify depends on factors such as the life expectancy of You at the time benefits are accelerated or whether You use the benefits to pay for necessary long-term care expenses, such as nursing home care. If the Living Benefits qualify for favorable tax treatment, the benefits will be excludable from Your income and not subject to federal taxation. Tax laws relating to Living Benefits are complex. You are advised to consult with a qualified tax advisor about circumstances under which You could receive Living Benefits excludable from income under federal law.

Receipt of Living Benefits may affect Your, Your Spouse's or Your family's eligibility for public assistance programs such as medical assistance (Medicaid), Aid to Families with Dependent Children (AFDC), supplementary social security income (SSI), and drug assistance programs. You are advised to consult with a qualified tax advisor and with social service agencies concerning how receipt of such a payment will affect Your, Your Spouse's or Your family's eligibility for public assistance.

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TABLE OF CONTENTS

PAGE

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CERTIFICATE OF INSURANCE

UNITED OF OMAHA LIFE INSURANCE COMPANY

Home Office:
Mutual of Omaha Plaza
Omaha, Nebraska 68175

United of Omaha Life Insurance Company certifies that Group Policy Number GLUG-BJXW (the Policy) has been issued to Hoover City Schools (the Policyholder).

Insurance is provided for Employees of the Policyholder subject to the terms and conditions of the Policy.

Please read this Certificate carefully. The benefits described in this Certificate are effective only if You are eligible for the insurance, become insured and remain insured as described in this Certificate and according to the terms and conditions of the Policy.

If the provisions of this Certificate and those of the Policy do not agree, the provisions of the Policy will apply. The Policy is part of a contract between United of Omaha Life Insurance Company and the Policyholder, and may be amended, changed or terminated without Your consent or notice to You.

This Certificate replaces any certificate previously issued under the Policy.

James T. Blackledge
Chief Executive Officer

David A. Vanheat
Corporate Secretary

SCHEDULE

Capitalized terms used in this section have the meanings assigned to them in this section or in other sections of the Policy.

CLASS(ES)

All Eligible Employees

LIFE INSURANCE FOR YOU (THE EMPLOYEE)

Your amount of life insurance is an amount equal to 2.5 times Your Annual Earnings, but in no event less than $10,000 or more than $500,000. Your amount of life insurance will be rounded to the nearest multiple of $1,000.

Your amount of life insurance is subject to any reductions indicated in the Benefit Reductions provision in this Schedule. If You have questions regarding the amount of Your life insurance, You may contact the Policyholder.

ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE FOR YOU

Your amount of accidental death and dismemberment (AD&D) insurance is equal to Your amount of life insurance.

Your amount of AD&D insurance is also referred to as the Principal Sum. Your amount of AD&D insurance is subject to any reductions indicated in the Benefit Reductions provision of this Schedule. If You have questions regarding the amount of Your AD&D insurance, You may contact the Policyholder.

EVIDENCE OF INSURABILITY

Evidence of Insurability is not required for any amount of insurance under the Policy, unless otherwise stated in this Certificate.

BENEFIT REDUCTIONS

As You grow older, the amount of life and AD&D insurance for You will be reduced according to the following schedule:

At the Age of:	The Original Amount of Insurance Will Reduce to:
70	50%
75	35%
80	27%

Reductions become effective on the first day of the Policy month that coincides with or follows the day You reach the specified age. Any reduced amount of insurance will round to the nearest dollar.

If You are age 70 or older on the date insurance becomes effective, the amount of life and AD&D insurance for You will be reduced as shown above. Thereafter, the amount of life and AD&D insurance will continue to reduce in accord with the schedule above.

ELIGIBILITY

Capitalized terms used in this section have the meanings assigned to them in this section or in other sections of the Policy.

DEFINITIONS

Actively Working, *Active Work* means an Employee is performing the normal duties of his or her regular job for the Policyholder on a regular and continuous basis 20 or more hours each week. An Employee will be considered to be actively working on any day that is a regular paid holiday or day of vacation, or regular or scheduled non-working day, provided the Employee was actively working on the last preceding regular work day.

Disability Elimination Period means the period of time that must be satisfied before You are eligible to continue benefits, beginning on the date Your Injury or Sickness occurred. The length of the disability elimination period is shown in the Continuation of Insurance for Total Disability with Waiver of Premium provision.

Partial Disability, Partially Disabled means that, because of an Injury or Sickness lasting longer than 12 months, You are unable to perform the normal duties of Your regular job for the Policyholder on a regular or continuous basis, but are able to satisfy all other requirements of the Active Work definition.

Recurrent Disability means a Total Disability which is related to or due to the same cause(s) of a prior Total Disability for which You were approved for coverage under the Continuation of Insurance for Total Disability with Waiver of Premium provision of the Policy.

Total Disability, Totally Disabled means that because of an Injury or Sickness You are completely and continuously unable to perform any work or engage in any occupation.

WHEN AN EMPLOYEE BECOMES ELIGIBLE FOR INSURANCE

An Employee who is Actively Working on the Policy Effective Date becomes eligible for insurance under the Policy on the Policy Effective Date.

An Employee who is hired after the Policy Effective Date becomes eligible for insurance under the Policy on the day the Employee begins Active Work.

The day on which an Employee becomes eligible for insurance under the Policy may not be the same as the day on which insurance begins. The When Insurance Begins provision describes the day on which insurance begins.

CONTINUITY OF INSURANCE UPON TRANSFER OF INSURANCE CARRIER

If there is a conflict between this provision and any other provision of the Policy, this provision shall control.

If the Policy replaces a Prior Plan, the Policy will provide insurance for an Employee who:

a) was insured under the Prior Plan on the day before the Policy Effective Date;
b) is otherwise eligible under the Policy, but is not Actively Working on the Policy Effective Date due to:
    1. Injury or Sickness; or
    2. a leave of absence protected under:
        a. the federal Family and Medical Leave Act (FMLA) or Uniformed Services Employment and Reemployment Rights Act (USERRA) and any amendments thereto; or
        b. any other applicable federal or state law that allows for continuation of insurance in certain instances;
c) is not eligible for benefits or continuation of insurance under any provision of the Prior Plan;
d) is not a retired Employee; and
e) is not Totally Disabled on the Policy Effective Date.

Insurance under this provision is subject to the following conditions:

a) insurance under the Policy may not exceed Your amount of insurance under the Prior Plan on the day before the Policy Effective Date;

b) the benefit payable under the Policy will be the amount which would have been paid by the Prior Plan had insurance remained in-force under the Prior Plan, less the amount of any benefit payable under the Prior Plan;
c) the Policyholder must notify Us in writing prior to the Policy Effective Date of the amount of Your insurance under the Prior Plan on the day before the Policy Effective Date;
d) insurance is subject to uninterrupted payment of premium to Us when due; and
e) insurance is subject to any reductions shown in the Schedule and all other terms and conditions of the Policy.

We reserve the right to request any information We need from the Policyholder to determine whether the conditions necessary to be eligible for insurance under this provision have been satisfied.

Insurance under this provision will end on the earliest of:
a) the day the Employee returns to Active Work for the Policyholder or begins employment with any other employer;
b) the last day the Employee would have been insured under the Prior Plan, if the Prior Plan had not ended or terminated;
c) the day the Employee's insurance under the Policy ends for any reason shown in the When Insurance Ends provision; or
d) the last day of the twelfth month following the Policy Effective Date.

If an Employee is eligible for insurance under this provision, the Employee will not be eligible for insurance under any continuation provision or the Portability provision in this Certificate.

If Your insurance under this provision ends and You have not returned to Active Work, You may be able to obtain insurance under the Conversion provision.

Persons who are not eligible for insurance under this provision may be eligible to apply for conversion of insurance under the Prior Plan and should contact the Policyholder for additional information.

WHEN INSURANCE BEGINS

An eligible Employee will become insured on the first day of the month that coincides with or follows the latest of the day:
a) the Employee begins Active Work; or
b) the Employee submits a Written Request to enroll for insurance, if applicable.

If the Employee is not Actively Working on the day insurance would otherwise begin, insurance will begin on the day the Employee returns to Active Work.

EXCEPTIONS TO WHEN INSURANCE BEGINS

This provision does not apply if the Employee is eligible for coverage under the Continuity of Insurance Upon Transfer of Insurance Carrier provision.

Insurance for an Employee who is:
a) Totally Disabled;
b) confined in a Hospital as an inpatient;
c) confined in any institution or facility other than a Hospital; or
d) confined at home and under the care or supervision of a Physician;
on the day insurance is to begin will not take effect until the day after the Employee has completed one full day of Active Work.

Insurance for an Employee who is not Actively Working on the Policy Effective Date due to Injury or Sickness will not take effect until the day after the Employee has completed one full day of Active Work.

CHANGES TO INSURANCE BENEFITS

Any allowable change in Your class or amount of insurance, whether requested by You or the Policyholder, or as a result of the terms of the Policy, will take effect on the first day of the month that follows the date of the request or the change.

For any increase in insurance, We will use the Policyholder's records and/or the premium We have received to verify that the amount of insurance being requested is the appropriate insurance amount for which the Insured Person is eligible under the terms of the Policy.

If You are not Actively Working on the day any increase in insurance would otherwise take effect, the increase will become effective the first day of the month that follows the day after You return to Active Work.

REINSTATEMENT OF INSURANCE

You may be eligible to reinstate insurance that has ended in accordance with this provision.

Reinstated insurance will take effect on the first day of the month that coincides with or follows the date You become eligible for insurance. If You are not Actively Working on the day the reinstated insurance would otherwise take effect, insurance will become effective on the day after You return to Active Work.

The following reinstatement option(s) is/are available:

Transfer From Portability or Conversion

If insurance was obtained under the Portability or Conversion provision while an Employee was not Actively Working, insurance may be reinstated up to the amount of insurance that was in effect on the last day of Active Work. Any insurance provided through the Portability provision will terminate upon reinstatement of insurance as an Actively Working Employee.

WHEN INSURANCE ENDS

Insurance will end on the last day of the month in which the earliest of the following events occurs:

a) an Insured Person is no longer eligible for insurance under the Policy; or
b) an Insured Person begins active duty in the Armed Forces, National Guard or Reserves of any state or country (except for temporary active duty of 31 days or less).

Insurance will also end:

a) on the day the Policy terminates; or
b) in accordance with the Grace Period provision.

NOTICE TO YOU WHEN INSURANCE ENDS

The Policyholder is required to notify You when insurance under the Policy ends if:

a) You cease to be eligible for insurance under the Policy; or
b) the Policy is discontinued and is not replaced by another policy or plan with no interruption in coverage.

Notice shall be provided within 15 days from the date insurance ends for You, and shall include information about any options available to continue or obtain insurance.

EXCEPTIONS TO WHEN INSURANCE ENDS

If insurance for You would otherwise end, You may be able to continue or obtain insurance under one of the following provisions:

a) Continuation of Insurance for Layoff or Leave
b) Continuation of Insurance for Injury or Sickness
c) Continuation of Insurance for Partial Disability
d) Continuation of Insurance for Total Disability with Waiver of Premium
e) Portability
f) Conversion

CONTINUATION OF INSURANCE FOR LAYOFF OR LEAVE

If there is a conflict between this provision and any other provision of the Policy, this provision shall control.

You may be able to continue insurance from the day You cease to be Actively Working in the event of:

a) a temporary involuntary layoff; or
b) a leave of absence approved by the Policyholder due to any personal reason.

In addition, the federal Family Medical Leave Act (FMLA) and Uniformed Services Employment and Reemployment Rights Act (USERRA) and any amendments thereto, as well as other applicable federal or state laws, may allow continuation of insurance in certain instances for leaves of absence, layoff or termination. Contact the Policyholder for additional information regarding any other continuation options that may be available.

Any insurance continued under this provision will be subject to the following conditions:

a) insurance may not be continued beyond the earliest of:
    1. 12 weeks for Your temporary involuntary layoff;
    2. 12 weeks for Your leave of absence; or
    3. the time period allowed by FMLA, USERRA or applicable federal or state law that allows for continuation;
b) the amount of insurance may not be increased while insurance is continued under this provision; and
c) We continue to receive premium payment when due (premiums must be paid by You or on Your behalf).

Insurance under this provision will end on the last day of the month which coincides with or follows the earliest of the day:

a) the time period in a) in the preceding paragraph has been satisfied;
b) Your temporary involuntary layoff becomes permanent, if insurance is continued under this provision due to Your temporary involuntary layoff;
c) You return to Active Work;
d) You begin full-time employment with an employer other than the Policyholder; or
e) the Policy terminates.

Insurance under this provision will also end in accordance with the Grace Period provision.

If continued insurance under this provision ends and You have not returned to Active Work, You may be able to continue or obtain insurance under the Continuation of Insurance for Injury or Sickness provision, Portability provision or Conversion provision.

If Your leave is due to an Injury or Sickness which may result in Your Total Disability, We must receive notification of Your potential Total Disability on Our total disability claim form within 6 months of the date Your Injury or Sickness occurred, or as soon as reasonably possible.

See the Options for Payment of Premium for Continued Insurance provision for premium payment options.

CONTINUATION OF INSURANCE FOR INJURY OR SICKNESS

If there is a conflict between this provision and any other provision of the Policy, this provision shall control.

When Your insurance would otherwise end due to Your Injury or Sickness, You may be able to continue insurance under this provision. In such circumstances, the total continuation period under this provision and the Continuation of Insurance for Layoff or Leave provision, if You were previously insured under this provision, shall not exceed 12 months.

Insurance may be continued under this provision if We continue to receive timely premium payment when due (premiums must be paid by You or on Your behalf).

The amount of insurance may not be increased while insured under this provision.

Insurance under this provision will end on the earliest of the last day of the month which coincides with or follows the day:

a) that is 12 months from the day You cease Active Work;
b) You return to Active Work;
c) You begin full-time employment with an employer other than the Policyholder; or
d) the Policy terminates.

Insurance under this provision will also end in accordance with the Grace Period provision.

If continued insurance under this provision ends and You have not returned to Active Work, You may be able to continue or obtain insurance under the Continuation of Insurance for Partial Disability provision, Continuation of Insurance for Total Disability with Waiver of Premium provision, Portability provision or Conversion provision.

If Your leave is due to an Injury or Sickness which may result in Your Total Disability, We must receive notification of Your potential Total Disability on Our total disability claim form within 6 months of the date Your Injury or Sickness occurred, or as soon as reasonably possible.

See the Options for Payment of Premium for Continued Insurance provision of this Certificate for premium payment options.

CONTINUATION OF INSURANCE FOR PARTIAL DISABILITY

If there is a conflict between this provision and any other provision of the Policy, this provision shall control.

When You are no longer eligible to continue insurance under the Continuation of Insurance for Injury or Sickness provision, You may be able to continue insurance under this provision due to Your Partial Disability.

Insurance may be continued under this provision if the following conditions are satisfied:

a) You are Partially Disabled, but not Totally Disabled; and
b) We continue to receive timely premium payment when due (premiums must be paid by You or on Your behalf).

The amount of insurance may not be increased while insured under this provision.

Insurance under this provision will end on the earliest of the last day of the month which coincides with or follows the day:

a) You return to Active Work;
b) Your Injury or Sickness results in Your Total Disability and You are eligible to continue insurance under the Continuation of Insurance for Total Disability with Waiver of Premium provision;
c) You begin full-time employment with an employer other than the Policyholder; or
d) the Policy terminates.

Insurance under this provision will also end in accordance with the Grace Period provision.

If Your insurance under this provision ends and You have not returned to Active Work, You may be able to obtain insurance under the Continuation of Insurance for Total Disability with Waiver of Premium provision, Portability provision or Conversion provision.

If Your Partial Disability may result in Your Total Disability, We must receive notification of Your potential Total Disability on Our total disability claim form within 6 months of the date Your Injury or Sickness occurred, or as soon as reasonably possible.

See the Options for Payment of Premium for Continued Insurance provision of this Certificate for premium payment options.

CONTINUATION OF INSURANCE FOR TOTAL DISABILITY WITH WAIVER OF PREMIUM

If there is a conflict between this provision and any other provision of the Policy, this provision shall control.

This provision only allows for continuation of life insurance under the Policy. Accidental death and dismemberment insurance may not be continued under this provision.

When Your insurance ends under the Continuation of Insurance for Injury or Sickness provision or Continuation of Insurance for Partial Disability provision, You may be able to continue insurance under this provision due to Your Total Disability. After satisfaction of the Disability Elimination Period, and upon submission of proof of Total Disability acceptable to Us, Your insurance may be continued without payment of premium until insurance ends in accordance with this provision.

We must receive notification of Your potential Total Disability on Our total disability claim form within 6 months of the date Your Injury or Sickness occurred, or as soon as reasonably possible.

Insurance may be continued under this provision if the following conditions are satisfied:

a) You are Totally Disabled;
b) You were under age 60 at the time You became Totally Disabled;
c) the Disability Elimination Period is satisfied; and
d) proof of Total Disability is provided to Us (as described below in this provision).

The amount of insurance may not be increased while insured under this provision.

If You are age 60 or older and become Totally Disabled, You may be able to obtain insurance under the Portability or Conversion provision.

About the Disability Elimination Period

The Disability Elimination Period is a period of 6 consecutive months. Any period of time in which You are insured under the Continuation of Insurance for Injury or Sickness provision will apply toward satisfaction of the Disability Elimination Period.

Proof of Total Disability

You must submit to Us acceptable proof of Total Disability approved by Our authorized representative in Our home office before the end of the Disability Elimination Period or as soon as reasonably possible thereafter.

In order to confirm that You are Totally Disabled, We have the right to have You examined by a Physician of Our choice at Our expense.

If You are approved for continuation of insurance under this provision, We will periodically require proof of continuing Total Disability. We may have You examined by a Physician of Our choice at any time during the first two years of Total Disability and once a year thereafter at Our expense. If an additional examination is required due to questionable or disputed results of an examination, any additional examination may be at Your expense.

When Continuation of Insurance for Total Disability is Approved

We will notify You in writing if Your proof of Total Disability is approved by Us. Any premium paid for Your insurance from the day You ceased to be Actively Working will be refunded in a lump sum within 31 days of Your approval.

Once You are approved for insurance under this provision, a Recurrent Disability will be treated as part of Your prior claim and You will not be required to satisfy another Disability Elimination Period if:

a) You were continuously insured under the Policy for the period between Your prior claim and Your Recurrent Disability; and
b) Your Recurrent Disability occurs within 6 months of the end of Your prior claim.

When Continuation of Insurance for Total Disability is Not Approved

We will notify You in writing if Your proof of Total Disability is not approved by Us. If at any time while You are insured under this provision We determine that You are no longer Totally Disabled, We will notify You in writing that You are no longer eligible to continue insurance under this provision.

If You are ineligible for insurance under this provision or Your insurance under this provision ends, You will have 31 days from the date of Our notice to submit a Written Request for insurance under the Portability or Conversion provision, if You have not returned to Active Work or You are not eligible for insurance under the Continuation of Insurance for Partial Disability provision.

When Insurance Under this Provision Ends

Insurance under this provision will end on the last day of the month which coincides with or follows the day:

a) You are eligible to continue insurance under the Continuation of Insurance for Partial Disability provision; or
b) You return to Active Work.

Insurance under this provision will also end on the earliest of the day:

a) You are no longer Totally Disabled;
b) that is 90 days after the date of Our request to You for proof of Total Disability if such proof has not been received by Us;
c) You fail to obtain an examination from a Physician of Our choice as described in the Proof of Total Disability provision by a date established by Us;
d) You reach age 65; or

e) You begin full-time employment with an employer other than the Policyholder.

Insurance under this provision will also end in accordance with the Grace Period provision.

PORTABILITY

You have the right to continue receiving group life and accidental death and dismemberment insurance under this provision if You are under age 70 when insurance would otherwise end for any of the following reasons:

a) You cease to be Actively Working and are not eligible for insurance under any other continuation provision in this Certificate (if applicable);
b) Your employment with the Policyholder ends;
c) You retire; or
d) the Policy terminates and the Policyholder does not obtain group life coverage within 31 days.

If an Insured Person requests to continue to receive group insurance under this provision, the amount of insurance shall not exceed the lesser of:

a) the amount in effect under the Policy on the day insurance ended; or
b) $500,000.

The amount of insurance may not be increased after insurance continues under this provision.

If You continue to receive group insurance under this provision, You can not continue insurance under any other continuation provision of the Policy (if applicable).

The Group Term Life Insurance Portability Policy

Group insurance continued under this provision is available under another group term life insurance policy (the "Portability Policy") issued by Us, as available at the time insurance under this provision is requested. If You become insured under the Portability Policy, You will receive a certificate of insurance that describes the terms and conditions of coverage under the Portability Policy.

The Portability Policy may not provide all the same benefits or have all the same terms and conditions that are included in the Policy. In addition, the premium rates charged for insurance under the Portability Policy may not be the same as the premium rates charged for insurance under the Policy. The benefits and premium rates of Our Portability Policy are described on Our portability request form. You may contact the Policyholder or Us to obtain Our portability request form.

The continued group insurance coverage under the Portability Policy is available as a result of portability rights that arise solely from the Policy, as arranged for You as an employee welfare benefit subject to the Employee Retirement Income Security Act of 1974, as amended.

Notice of the Right to Continue Group Insurance Under this Provision

The portability period is the period of time that is 31 days from the date insurance under the Policy ends ("Portability Period"). When insurance under the Policy ends, notice of the right to continue receiving insurance under this provision may be given. If notice is not given at least 15 days after the start of the Portability Period, an extension of the period of time in which to apply for a Portability Policy will be allowed. Any extension of the Portability Period will expire on the earlier of:

a) 15 days after notice has been received; or
b) 60 days after the end of the Portability Period, even if notice is not received.

How to Continue Group Insurance Under this Provision

You must submit a Written Request for insurance under the Portability Policy. The Written Request and the initial premium due must be submitted within the Portability Period.

CONVERSION

This provision allows for conversion of life insurance. Conversion insurance is not available for accidental death and dismemberment insurance.

When Employment or Class Membership Ends or the Amount of Insurance Reduces

If group life insurance ends because Your employment or membership in a class (as shown under Class(es) on the Schedule) ends or Your benefit amount reduces, You may apply for an individual policy of life insurance other than term insurance ("Conversion Policy").

The Conversion Policy issued under this provision will be:

a) any type of individual policy of life insurance then customarily issued by Us for purposes of conversion, except term insurance; and
b) issued without any supplemental benefits.

Premium shall be based on the standard premium rate for the Conversion Policy according to the amount of insurance, class of risk, gender and age of the applicant on the date the Conversion Policy takes effect.

The Conversion Policy will become effective on the later of the date of issue or 31 days after the date insurance under the Policy ended or was reduced.

When the Policy or a Class Terminates

You may apply for a Conversion Policy if insurance under the Policy ends due to termination of the Policy or termination of Your class (as shown under Class(es) on the Schedule), provided You have been insured under the Policy or any Prior Plan for at least 5 consecutive years.

The Conversion Policy issued under this provision will be:

a) any type of individual policy of life insurance then customarily issued by Us for purposes of conversion, except term insurance;
b) issued without any supplemental benefits;
c) for an amount of life insurance that does not exceed the lesser of:
    1. $10,000; or
    2. the amount of insurance that ended under the Policy less the amount of any other group life insurance for which the applicant becomes eligible within 31 days after insurance under the Policy ended.

Premium shall be based on the standard premium rate for the Conversion Policy according to the amount of insurance, class of risk, gender and age of the applicant on the date the Conversion Policy takes effect.

The Conversion Policy will become effective on the later of the date of issue or 31 days after the date insurance under the Policy ended or was reduced.

Notice of the Right to Obtain Insurance Under this Provision

The conversion period is the period of time that is 31 days from the date insurance under the Policy ends or reduces ("Conversion Period"). When insurance ends under the Policy, notice of the right to convert may be given. If notice is not given at least 15 days after the start of the Conversion Period, an extension of the period of time in which to apply for a Conversion Policy will be allowed. Any extension will expire on the earlier of:

a) 15 days after notice has been received; or
b) 60 days after the end of the Conversion Period, even if notice is not received.

If You are entitled to obtain a Conversion Policy and die within 31 days after insurance under the Policy ends or reduces, We will pay the amount of life insurance which could have been converted, even if You did not apply for a Conversion Policy.

How to Request Insurance Under this Provision

Insurance is available without providing Evidence of Insurability. You must submit a Written Request for a Conversion Policy. The Written Request and the initial premium due must be submitted to Us within the Conversion Period.

Conversion Insurance and Your Return to Active Work

If You are issued a Conversion Policy and again become eligible for insurance under the Policy, insurance under the Policy will become effective (subject to all eligibility requirements) only if any Conversion Policy(ies) is/are surrendered to Us.

PREMIUM PAYMENTS

Capitalized terms used in this section have the meanings assigned to them in this section or in other sections of the Policy.

OPTIONS FOR PAYMENT OF PREMIUM FOR CONTINUED INSURANCE

When insurance is continued We must receive premium payment when due for insurance to remain effective, unless otherwise stated or allowed in the Policy. Premium payment may be made in the following ways:

a) the Policyholder may pay the premiums; or
b) You may pay premium to the Policyholder who will then submit premium to Us.

Contact the Policyholder to determine which option is available to You.

Payment of premium does not guarantee eligibility for coverage.

GRACE PERIOD

All premiums must be paid within the grace period. There is a grace period of 60 days for payment of premiums. This means that, except for the initial premium, if premium is not paid on or before the date it is due, the premium must be paid in the 60-day period that follows. We will consider premium to be paid on the date We receive it.

Insurance will stay in force during the grace period, unless You or the Policyholder provides Us with written notice that insurance will terminate during the grace period. If We receive such notice, insurance will terminate on the date requested.

If any premium due is not paid during the grace period, insurance will end on the last day of the grace period. If insurance ends, it may be reinstated as described in the Reinstatement of Insurance provision.

PREMIUM CHANGES

If You request a change in the amount of insurance, the Policyholder will provide You with notice of Your new premium amount upon request if You are responsible for the payment of premiums for insurance.

If there is a change in the amount of the premium for insurance in accordance with the terms of the Policy, or a change in the amount of insurance as the result of a request of the Policyholder, the Policyholder will provide You with notice of the change at least 15 days prior to the date of the change if You are responsible for the payment of premiums for insurance.

Premium amounts will change if:

a) You reach an age at which benefits are reduced as described in the Benefit Reductions provision in the Schedule; or
b) premium rates under the Policy are changed.

LIFE INSURANCE BENEFITS

Capitalized terms used in this section have the meanings assigned to them in this section or in other sections of the Policy.

BENEFITS

In the event of death while insured under the Policy, We will pay the amount of life insurance in effect at the time of death for You. Benefits payable by reason of Your death will be paid to Your beneficiary.

BENEFICIARY DESIGNATION

At the time You elect(ed) insurance under the Policy or any Prior Plan, a beneficiary should be designated. Beneficiary records will be kept by the Policyholder, Plan Administrator or the office where beneficiary records for the Policy are kept. The most current beneficiary designation in effect under a Prior Plan will be accepted as a beneficiary designation under the Policy.

If You have not designated a beneficiary, or no beneficiary survives You, in the event of Your death, benefits will be paid to:

a) Your surviving Spouse; if none, then to
b) Your surviving natural and/or adopted child(ren), in equal shares; if none, then to
c) Your surviving parent(s), in equal shares; if none, then to
d) Your estate.

Certain states are community property states. If You live in a community property state and You designate someone other than Your Spouse as a beneficiary, state law may require that Your Spouse consent to such designation. If You do not obtain Your Spouse's consent to the designation, then such designation may not be effective. Community property states as of the Policy Effective Date include: Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington and Wisconsin.

BENEFICIARY CHANGE

Your beneficiary may be changed, subject to any restrictions or limitations in the Policy. To make a change, a Written Request should be provided to the Policyholder, Plan Administrator or to the office where beneficiary records for the Policy are kept. If You do not know where the records are kept, then You may send the Written Request to Us. When received by the Policyholder, the change will take effect as of the date the Written Request is signed. The change will not apply to any payments or other action taken by Us before the Written Request was received.

FACILITY OF PAYMENT

We may pay an amount of up to $500 to any person or entity that has incurred expenses related to Your death and subsequent burial. An amount, if paid, will be deducted from the amount of life insurance benefits payable.

LIVING BENEFITS (ACCELERATED BENEFIT)

Capitalized terms used in this section have the meanings assigned to them in this section or in other sections of the Policy.

This section only applies to the life insurance offered by the Policy. Accidental death and dismemberment (AD&D) insurance is not included under this section.

The benefits received under this section may be taxable. Receipt of Living Benefits may adversely affect eligibility for Medicaid or other government benefits or entitlements. You should consult Your personal tax advisor or the Social Security Administration before requesting Living Benefits.

DEFINITIONS

Living Benefits means an advance payment of part of Your life insurance death benefit.

Terminal Condition means an Injury or Sickness that is expected to result in Your death within a specified number months as certified by an attending Physician's written statement, as follows:

a) for Living Benefits of less than $250,000, death is expected to occur within 12 months; or
b) for Living Benefits of $250,000 or more, death is expected to occur within 6 months.

ABOUT LIVING BENEFITS

If You incur a Terminal Condition while insured under the Policy, You, Your Spouse or Your legal representative may submit a Written Request for Living Benefits.

The maximum amount of Living Benefits available is 75% of the amount of life insurance for You in effect at the time of the request or $375,000, whichever is less. The minimum amount is 10% of the amount of life insurance in effect for You at the time of the request or $1,000, whichever is greater.

We will pay Living Benefits to You in a lump sum, provided You are living at the time payment is made.

The amount of life insurance benefits payable for You in the event of death will be reduced by the amount of Living Benefits paid for You. Payment of Living Benefits has no effect on accidental death and dismemberment (AD&D) insurance benefits.

APPLYING FOR LIVING BENEFITS

To apply for Living Benefits, You, Your Spouse or Your legal representative must provide Us:

a) a Written Request for Living Benefits;
b) satisfactory proof of Your Terminal Condition, including an attending Physician's written statement; and
c) a statement of consent from any beneficiary(ies) or assignee(s).

You, Your Spouse or Your legal representative will receive information at the time of benefit payment about the amount of life insurance remaining in force after payment of Living Benefits.

CONDITIONS OF LIVING BENEFITS

Living Benefits are subject to the following conditions:

a) Living Benefits are payable for You only once under the Policy;
b) You can request Living Benefits in any $1,000 increment, subject to the limits specified in this section;
c) Premium must continue to be paid on the full amount of life insurance, unless subject to waiver of premium under the Continuation of Insurance for Total Disability with Waiver of Premium provision;
d) The amount of insurance You may obtain under the Conversion provision will be reduced by the amount of Living Benefits paid for You; and
e) The Portability provision is not available for You after payment of Living Benefits.

WHEN LIVING BENEFITS ARE NOT AVAILABLE

Living Benefits are not available:

a) when You have irrevocably assigned life insurance under the Policy;
b) if such benefits were paid under a Prior Plan;
c) when all or a portion of the life insurance benefits under the Policy are to be paid to a former Spouse as part of a divorce agreement or pursuant to a court order;
d) for any Terminal Condition caused by a suicide attempt or an intentionally self-inflicted Injury;
e) during any Conversion or Portability Period;
f) if the required premium is due and unpaid on the date the Written Request for Living Benefits is made;
g) if requested after insurance under the Policy ends; or
h) if requested after the Policy terminates.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS RIDER

This rider is made a part of group Policy GLUG-BJXW. It is subject to all of the Policy provisions which are not inconsistent with the provisions of this rider.

This rider is effective the later of the Policy Effective Date or the day You become insured under the Policy.

Capitalized terms used in this rider have the meanings assigned to them in this rider or in the other sections of the Policy.

DEFINITIONS

Accident means an external, sudden, unexpected, unforeseeable and unintended event, independent of Sickness and all other causes. Accident does not include Sickness, disease, bodily or mental infirmity or medical or surgical treatment thereof, or bacterial or viral infection, regardless of how contracted. Accident does include bacterial infection that is the natural and foreseeable result of an accidental external bodily Injury or accidental food poisoning.

Airbag means any factory-installed, inflatable, supplemental restraint device which meets published federal safety standards.

Automobile means a licensed private passenger motor vehicle for use on public roadways.

Childcare means care provided for children on a regular basis for daily periods of less than 24 hours, whether the care is for daytime or nighttime hours. This care must be provided by an adult other than a person who is part of the Insured Person's Family.

Coma, Comatose means the Insured Person is in a profound stupor or state of complete and total unconsciousness with a Glasgow Coma Score of eight (8) points or less, as a result of an Injury.

Family means Spouse, former Spouse, children, parents, grandparents, grandchildren, brothers, sisters and the spouses of such individuals.

Intoxicated means having a blood alcohol level, at the time of the Accident, which equals or exceeds the legal limit for operating a motor vehicle in the jurisdiction in which the loss occurs.

Loss of a Hand or Foot means Severance of at least four whole fingers from one hand or Severance of the foot above the ankle joint.

Loss of Hearing means total and permanent loss of hearing in both ears which cannot be corrected by any means.

Loss of Sight means total and permanent loss of sight of the eye which cannot be corrected by any means.

Loss of Speech means total and permanent loss of audible communication which cannot be corrected by any means.

Loss of a Thumb and Index Finger means Severance at or proximal to the metacarpophalangeal joints (the joints that connect the fingers and the hand).

Paralysis means total and permanent loss of use of a limb without Severance. This loss must be determined by a Physician to be complete and irreversible.

Participation in a Riot means actively participating in a tumultuous disturbance of the peace by three or more persons assembling together of their own authority with intent to mutually assist one another in an illegal or legal act.

Seat Belt means a factory-installed lap and shoulder seat belt or other restraint device which meets published federal safety standards.

Severance means the complete separation and dismemberment of the part from the body.

Traveling on Business of the Policyholder means any trip made by You on assignment by or with authorization of the Policyholder for the purpose of furthering the business of the Policyholder. If this trip is made on a private aircraft, then the aircraft must:

a) have a current and valid Federal Aviation Administration of the United States (FAA) standard airworthiness certificate; and
b) be operated by a person holding a current and valid FAA pilot's certificate authorizing him or her to operate the aircraft.

EXPOSURE AND DISAPPEARANCE

An Insured Person will be presumed to have died, for the purposes of accidental death and dismemberment insurance, if after the forced landing, stranding, sinking or wrecking of a vehicle:
a) the Insured Person disappears;
b) the Insured Person's body is not found; and
c) a valid death certificate is issued by a court of appropriate jurisdiction.

BENEFITS

Basic Benefits

In the event of a loss while insured under the Policy, We will pay accidental death and dismemberment benefits based upon the amount of the Principal Sum in effect at the time of the loss for You. Benefits for Your insurance will be payable to You or to the beneficiary for life insurance under the Policy, unless otherwise indicated in a benefit provision included in this section.

If an Insured Person is Injured or dies as a result of an Accident, We will pay the benefit shown in the following Table. If an Accident causes more than one loss shown in the Table, We will pay only the largest benefit.

Accidental Death and Dismemberment Benefits Table (the "Table")

Loss	Benefit
Loss of Life	Principal Sum
Loss of Both Hands	Principal Sum
Loss of Both Feet	Principal Sum
Loss of Entire Sight of Both Eyes	Principal Sum
Loss of One Hand and One Foot	Principal Sum
Loss of One Hand and Entire Sight of One Eye	Principal Sum
Loss of One Foot and Entire Sight of One Eye	Principal Sum
Loss of Speech and Hearing (both ears)	Principal Sum
Loss of Entire Sight of One Eye	One-half Principal Sum
Loss of Speech or Hearing (both ears)	One-half Principal Sum
Loss of One Hand or One Foot	One-half Principal Sum
Loss of Thumb and Index Finger of same Hand	One-fourth Principal Sum
Quadriplegia (Paralysis of both upper and lower limbs)	Principal Sum
Triplegia (Paralysis of three limbs)	Three-quarters Principal Sum
Paraplegia (Paralysis of both lower limbs)	One-half Principal Sum
Hemiplegia (Paralysis of an upper and a lower limb)	One-half Principal Sum
Uniplegia (Paralysis of a limb)	One-fourth Principal Sum

Airbag Benefit

We will pay a benefit amount of 10% of the Principal Sum, up to a maximum of $25,000 if:
a) an Insured Person was Injured in an Accident while driving or riding in the front seat of an Automobile directly behind an Airbag;
b) the Insured Person's death resulted from such Injury; and
c) a copy of the police accident report is submitted with the claim.

We will not pay this benefit if the Accident occurs when the:
a) Automobile was being used for racing, stunting, or exhibition work;
b) Airbag was disengaged; or
c) Insured Person was breaking any laws of the jurisdiction in which the Accident occurred.

This benefit amount is payable in addition to any other applicable benefits under the Policy.

Common Carrier Benefit
We will pay a benefit amount of 100% of the Principal Sum, up to a maximum of $1,000,000 if:

a) an Insured Person was Injured in an Accident while riding as a fare-paying passenger in any public air, land or water conveyance provided by a common carrier primarily for passenger service; and
b) the Insured Person's death resulted from such Injury.

We will not pay this benefit if the Insured Person was an operator or member of the crew on the common carrier conveyance at the time of the Injury. This benefit amount is payable in addition to any other applicable benefits under the Policy.

Seat Belt Benefit
We will pay a benefit amount of 10% of the Principal Sum, up to a maximum of $25,000 if:

a) an Insured Person was Injured in an Accident while driving or riding in an Automobile and wearing a Seat Belt;
b) the Insured Person's death resulted from such Injury; and
c) a copy of the police accident report is submitted with the claim.

We will not pay this benefit if the Accident occurs when the:

a) Automobile was being used for racing, stunting, or exhibition work;
b) Seat Belt was used to restrain more than one person;
c) Automobile is equipped with an automatic Seat Belt and the lap belt is not fastened; or
d) Insured Person is breaking any laws of the jurisdiction in which the Accident occurred.

This benefit amount is payable in addition to any other applicable benefits under the Policy.

Childcare Benefit
We will pay a monthly benefit amount of 5% of the Principal Sum, up to a maximum of $5,000 a year. The benefit is payable for each Dependent child under the age of 12, and may be paid to You, Your Spouse or the Dependent child's legally appointed guardian, as applicable. The benefit amount will be paid at the end of the month for up to 2 year(s) if:

a) You are Injured in an Accident and that Injury results in death;
b) You, Your Spouse or the Dependent child's legally appointed guardian incurs expenses for Childcare services within 365 days of Your death as a result of employment, education or training; and
c) We receive satisfactory proof of the Childcare expense incurred by You, Your Spouse or the Dependent child's legally appointed guardian.

If both parents of a Dependent child are insured under the Policy, benefits under this provision will be limited to payment under only one parent. This benefit amount is payable in addition to any other applicable benefits under the Policy.

Child Education Benefit
We will pay a benefit amount of 5% of the Principal Sum, up to a maximum of $5,000 a year. This benefit will be paid at the end of each school term for each Student for up to 4 consecutive year(s). This benefit may be paid to the Student or, if a minor child, to the Student's legally appointed guardian, if:

a) You are Injured in an Accident and that Injury results in death;
b) a Dependent child is or becomes a Student within 1 year(s) after Your death;
c) the Student continues to be enrolled for each consecutive term; and
d) a copy of the Student's most recent grade report and tuition statement is submitted with the claim.

If both parents of a Student are insured under the Policy, benefits under this provision will be limited to payment under only one parent. This benefit amount is payable in addition to any other applicable benefits under the Policy.

For purposes of this benefit, the term Student does not include a Dependent child attending high school.

Continuation of Coverage for Your Dependent(s)
We will continue accidental death and dismemberment insurance under the Policy without payment of premium if:

a) You are Injured in an Accident and that Injury results in death; and
b) at the time of Your death, Your Spouse and/or Dependent child(ren) were insured under the Policy.

Insurance continued under this provision ends on the earliest of the day:

a) the Policy terminates;
b) that is 12 months after the day that insurance would otherwise end for Your Spouse and/or Dependent child(ren) under the Policy; or

c) Your Spouse and/or Dependent child(ren) becomes insured for accidental death and dismemberment insurance under the Continuation of Insurance Under Portability provision.

Spouse Education Benefit

We will pay a benefit amount of up to $3,000 a year to Your Spouse for education at an accredited trade school, college, university or other institution of higher learning. This benefit will be payable at the end of each school term for up to 4 consecutive year(s) if:

a) You are Injured in an Accident and that Injury results in Your death;
b) Your Spouse is enrolled or becomes enrolled at an accredited institution for the purpose of attaining or refreshing the skills needed for employment within 1 year(s) after Your death;
c) Your Spouse is enrolled full-time as indicated by evidence acceptable to Us.
d) Your Spouse continues to be enrolled for each consecutive term; and
e) a copy of Your Spouse's most recent grade report and tuition statement is submitted with the claim.

This benefit amount is payable in addition to any other applicable benefits under the Policy.

Coma Benefit

We will pay a monthly benefit amount of 5% of the Principal Sum. Benefits will be payable to the Insured Person's legal representative or legally appointed guardian at the end of the month for up to 20 months if:

a) the Insured Person was Injured in an Accident and, as a result, becomes Comatose within 31 consecutive days of the Injury; and
b) the Insured Person remains Comatose for 31 consecutive days.

If the Insured Person's Glasgow Coma Score temporarily becomes nine (9) points or higher and then reverts to eight (8) points or less, this will not cause a discontinuance in the benefit payment if the lapses and subsequent Coma recurrences are due to the same Injury.

Benefits will be payable until the earlier of:

a) the end of the month in which the Insured Person is no longer Comatose; or
b) the end of the month in which the Insured Person dies.

EXCLUSIONS

We will not pay for any loss which:

a) results, whether the Insured Person is sane or insane, from:
    1. an intentionally self-inflicted Injury or Sickness; or
    2. suicide or attempted suicide;
b) results from the Insured Person's Participation in a Riot or in the commission of a felony;
c) results from an act of declared or undeclared war or armed aggression;
d) is incurred while the Insured Person is on active duty or training in the Armed Forces, National Guard or Reserves of any state or country and for which any governmental body or its agencies are liable;
e) is not permanent, unless specifically provided;
f) occurs more than 365 days after the Injury, except that this 365 day limit will not apply if the Insured Person is Comatose or being kept alive by an artificial support system at the end of the 365 days;
g) does not result from an Accident;
h) is caused by intentional, self-infliction of carbon monoxide poisoning emanating from a motor vehicle;
i) results from Injuries the Insured Person receives in any aircraft while operating, riding as a passenger, boarding or leaving, unless riding as a passenger in a commercial aircraft on a regularly-scheduled flight or while You are Traveling on Business of the Policyholder;
j) results from an Injury received while riding in any aircraft engaged in:
    1. racing;
    2. endurance tests;
    3. acrobatic or stunt flying;
k) is caused by the Insured Person, and is a result of Injuries received while under the influence of any controlled drug, unless administered on the advice of a Physician;
l) is caused by the Insured Person and is a result of Injuries the Insured Person receives while voluntarily Intoxicated.

Corporate Secretary

PAYMENT OF CLAIMS

Capitalized terms used in this section have the meanings assigned to them in this section or in other sections of the Policy.

CLAIM FORMS

Before benefits are paid, We must be given written proof of loss as described in this section.

HOW TO OBTAIN PLAN BENEFITS

Forward the completed claim form to:
Benefits Administrator
Hoover City Schools
2810 Metropolitan Way
Hoover, Alabama 35243

CLAIM ASSISTANCE

For assistance with filing a claim or an explanation of how a claim was paid, contact:
United of Omaha Life Insurance Company
Mutual of Omaha Plaza
Omaha, Nebraska 68175
Call Toll-Free: 1-800-775-8805

PROOF OF LOSS

The Insured Person or the beneficiary has 90 days from the date of loss to furnish Us with a completed claim form and other information needed to prove loss. Failure to furnish such proof within this time period shall not invalidate nor reduce any claim if:

a) it was not reasonably possible to give proof within that 90-day period; and
b) proof is furnished as soon as reasonably possible, but not later than one year after the date of loss, unless the Insured Person or the beneficiary is not legally capable.

We may occasionally require an Insured Person to be examined by a Physician of Our choice to assist in determining whether benefits are payable. We will pay for these examinations. We will not require more than a reasonable number of examinations. Where not prohibited by law, We may also require an autopsy. We will pay for this autopsy.

PAYMENT OF CLAIMS

Benefits will be paid after We receive acceptable written proof of loss. Benefits will be paid only if We determine that the claimant is entitled to benefits under the terms of the Policy. We may require supporting information which may include, but which is not limited to, the following:

a) clinical records;
b) charts;
c) x-rays; and
d) other diagnostic aids.

Benefits will be paid to the Insured Person or the beneficiary in accord with the Life Insurance Benefits section and/or Accidental Death and Dismemberment Benefits Rider.

MODE OF PAYMENT

Life insurance benefits will be available in one lump sum. Accidental death and dismemberment benefits will be available in one lump sum unless otherwise indicated in the Accidental Death and Dismemberment Benefits Rider.

REFUND TO US

If it is found that We paid more benefits than We should have paid under the Policy, We will have the right to a refund from You or the recipient of benefits.

We also have a right to recover any payments due to:

a) fraud or misrepresentation; or
b) any error We make in processing a claim.

You or the recipient of benefits must reimburse Us in full. We will determine the method by which the repayment is to be made.

AUTHORITY TO INTERPRET POLICY

By purchasing the Policy, the Policyholder grants Us the discretion and the final authority to construe and interpret the Policy. This means that We have the authority to decide all questions of eligibility and all questions regarding the amount and payment of any Policy benefits within the terms of the Policy as interpreted by Us. Benefits under the Policy will be paid only if We decide, in Our discretion, that a person is entitled to them. In making any decision, We may rely on the accuracy and completeness of any information furnished by the Policyholder, an Insured Person or any other third party.

The Policyholder further grants Us the authority to delegate to third parties, including, without limitation, United of Omaha Life Insurance Company and any third party administrator with whom We have contracted to provide claims administration and other administrative services, the discretionary authority granted in the Policy. The Policyholder expressly grants such third party the full discretionary authority granted to Us under this Policy.

The Insured Person or beneficiary has the right to request a review of Our decision. If, after exercising the Policy's review procedures, the Insured Person or beneficiary's claim for benefits is denied or ignored, in whole or in part, the Insured Person or beneficiary may file suit and a court will review the Insured Person or beneficiary's eligibility or entitlement to benefits under the Policy.

The Policyholder, as Plan sponsor, agrees that the Policyholder retains full responsibility for the legal and tax status of its benefits program and releases Us from all responsibility for the reporting and the employment-based design of the program and from all other responsibilities not accepted in writing by Our authorized representative in Our home office.

CLAIM REVIEW AND APPEAL PROCEDURES FOR LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Capitalized terms used in this section have the meanings assigned to them in this section or in other sections of the Policy.

IMPORTANT NOTICE: In addition to the requirements described in this document, applicable state laws may contain requirements for claims review and appeal procedures. To the extent that any requirement in this document is inconsistent with any state law requirement, the requirement that is most favorable to the person insured under the Policy shall prevail. If you have any questions, please contact Us.

DEFINITIONS

The definitions set forth below shall apply to both the singular and plural versions of the defined term.

Adverse Benefit Determination means a denial, reduction, or termination of a benefit or a failure to provide or make payment (in whole or in part) for a benefit. This includes, without limitation, any such denial, reduction or termination of a benefit, or failure to provide or make payment, that is based upon ineligibility for insurance under the Policy.

Claimant means the person who submits a claim for benefits under the Policy, including the authorized representative of such person.

CLAIM REVIEW PROCEDURES

Once We receive information necessary to evaluate the claim, We will make a decision within the time periods set forth below. In the event an extension is necessary due to matters beyond Our control, We will notify the Claimant of the extension and the circumstances requiring the extension.

Except where the Claimant voluntarily agrees to provide Us with additional time, extensions are limited as set forth below. If an extension is necessary due to the Claimant's failure to submit complete information, We will notify the Claimant of the additional information required. Such notice of incomplete information will be sent within the time periods set forth below

In order for Us to continue processing the claim, the missing information must be provided to Us within the time periods set forth below. The Claimant may contact Us at any time for additional details about the processing of the claim.

INITIAL CLAIM DECISION

The period of time within which a claim decision will be made begins at the time the claim is filed, without regard to whether all the information necessary to make a claim decision accompanies the filing. The applicable time periods are shown below:

a) Initial claim decision period: 90 days
b) Extension period: 90 days

If additional information is needed, We will notify the Claimant within 15 days of Our receipt of the claim. Once the Claimant receives Our request for additional information, the Claimant will be given no less than 30 days to submit the additional information to Us. We will make Our determination within 60 days of Our receipt of the additional information. If We do not receive the additional information within the specified time period, We will make Our determination based upon the available information.

CLAIM DENIALS

If a request for a claim is denied, in whole or in part, the Claimant will receive notice of the denial, which will include:

a) the specific reason(s) for the denial;
b) reference to the specific Policy provisions on which the denial is based;
c) a description of the appeal procedures and time limits applicable to such procedures, including the right to request an appeal within 60 days and the right to bring a civil action following the appeal process; and
d) any other information which may be required under state or federal laws and regulations.

Additionally, if an internal rule, guideline, protocol or other similar criterion was relied upon in making the Adverse Benefit Determination, the Claimant has the right to request information about such internal rule, guideline, protocol or other similar criterion that was used in making the Adverse Benefit Determination, free of charge.

OPPORTUNITY TO REQUEST AN APPEAL

The Claimant shall have a reasonable opportunity to appeal a claim review decision. As part of the appeal, there will be a full and fair review of the claim review decision.

The Claimant will have no later than 60 days from the Claimant's receipt of notification of Our claim review decision to submit a request for an appeal. The request for an appeal should include:

a) the Insured Person's name;
b) the name of the person filing the appeal if different from the Claimant;
c) the Policy number; and
d) the nature of the appeal.

The request for an appeal can be submitted in any manner and should include any additional information that may have been omitted from Our review or that should be considered by Us. The notification regarding Our claim review decision will include instructions on how and where to submit an appeal.

By requesting an appeal, the Claimant has authorized Us, or anyone designated by Us, to review any and all records (including, but not limited to, medical records) which We determine may be relevant to the appeal.

RESPONSE TO APPEALS

We will respond no later than 60 days from Our receipt of the request for an appeal. However, if We determine that an extension is required, We will notify the Claimant in writing of the extension prior to the termination of the initial appeal period. In no event will the extension exceed 60 days from the end of the initial appeal period. The extension notice will indicate the special circumstances requiring the extension and the date by which We expect to render the appeal decision.

When We make Our determination, the Claimant will be provided with:

a) information regarding the decision; and
b) information regarding other internal or external appeal or dispute resolution alternatives, including any required state mandated appeal rights.

The period of time within which an appeal decision is required to be made will begin at the time an appeal is filed, without regard to whether all the information necessary to make an appeal decision accompanies the filing. If a period of time is extended as described above due to the Claimant's failure to submit information necessary to decide a claim, the period for making the appeal decision shall be "tolled" or suspended from the date on which the extension notice is sent until the earlier of (1) the date on which We receive the response; or (2) the date established by Us in the notice of extension for the furnishing of the requested information.

CLAIM REVIEW AND APPEAL PROCEDURES FOR CONTINUATION OF INSURANCE FOR TOTAL DISABILITY BENEFITS

Capitalized terms used in this section have the meanings assigned to them in this section or in other sections of this Certificate.

DEFINITIONS

The definitions set forth below shall apply to both the singular and plural versions of the defined term.

Adverse Benefit Determination means a denial, reduction, or termination of a benefit or a failure to provide or make payment (in whole or in part) for a benefit. This includes, without limitation, and such denial, reduction or termination of a benefit, or failure to provide or make payment, that is based upon ineligibility for insurance under the Policy.

Claimant means the person who submits a claim for benefits under the Policy, including the authorized representative of such person.

CLAIM REVIEW PROCEDURES

Once We receive information necessary to evaluate the claim, We will make a decision within the time periods set forth below. In the event an extension is necessary due to matters beyond Our control, We will notify the Claimant of the extension and the circumstances requiring the extension.

Except when the Claimant voluntarily agrees to provide Us with additional time, extensions are limited as set forth below. If an extension is necessary due to the Claimant's failure to submit complete information, We will notify the Claimant of the additional information required. Such notice of incomplete information will be sent within the time periods set forth below.

In order for Us to continue processing the claim, the missing information must be provided to Us within the time periods set forth below. The Claimant may contact Us at any time for additional details about the processing of the claim.

INITIAL CLAIM DECISION

The period of time within which a claim decision will be made begins at the time the claim is filed, without regard to whether all the information necessary to make a claim decision accompanies the filing. The applicable time periods are shown below:

a) initial claim decision period: 45 days unless additional information is requested as set forth below;
b) extension period: 30 days; and
c) maximum number of extensions: two.

If additional information is needed, We will notify the Claimant within 10 days of Our receipt of the claim. Once the Claimant receives Our request for additional information, the Claimant will be given no less than 45 days to submit the additional information to Us. We will make Our determination within 15 days of Our receipt of the additional information. If We do not receive the additional information within the specified time period, We will make Our determination based upon the available information.

CLAIM DENIALS

If a request for a claim is denied, in whole or in part, the Claimant will receive notice of the denial, which will include:

a) the specific reason(s) for the denial;
b) reference to the specific Policy provisions on which the denial is based;
c) a description of the appeal procedures and time limits applicable to such procedures, including the right to request an appeal within 180 days and the right to bring a civil action following the appeal process; and
d) any other information which may be required under state or federal laws and regulations.

Additionally, if an internal rule, guideline, protocol or other similar criterion was relied upon in making the Adverse Benefit Determination, the Claimant has the right to request information about such internal rule, guideline, protocol or other similar criterion that was used in making the Adverse Benefit Determination, free of charge.

OPPORTUNITY TO REQUEST AN APPEAL

The Claimant shall have a reasonable opportunity to appeal a claim review decision. As part of the appeal, there will be a full and fair review of the claim review decision.

The Claimant will have no later than 180 days from the Claimant's receipt of notification of Our claim review decision to submit a request for an appeal. The request for an appeal should include:

a) the Claimant's name;
b) the name of the person filing the appeal if different from the Claimant;
c) the Policy number; and
d) the nature of the appeal.

The request for an appeal can be submitted in any manner and should include any additional information that may have been omitted from Our review or that should be considered by Us. The notification regarding Our claim review decision will include instructions on how and where to submit an appeal.

By requesting an appeal, the Claimant has authorized Us, or anyone designated by Us, to review any and all records (including, but not limited to, medical records) which We determine may be relevant to the appeal.

A document, record, or other information will be considered relevant to a claim if it:

a) was relied upon in making the claim decision;
b) was submitted, considered, or generated in the course of making the claim decision, without regard to whether it was relied upon in making the claim decision; or
c) demonstrates compliance with administrative processes and safeguards designed to ensure and verify that claim decisions are made in accordance with the Policy and that, where appropriate, Policy provisions have been applied consistently with respect to similarly situated claimants.

RESPONSE TO APPEALS

We will respond no later than 45 days from Our receipt of the request for an appeal. However, if We determine that an extension is required, We will notify the Claimant in writing of the extension prior to the termination of the initial appeal period. In no event will the extension exceed 45 days from the end of the initial appeal period. The extension notice will indicate the special circumstances requiring the extension and the date by which We expect to render the appeal decision.

When We make Our determination, the Claimant will be provided with:

a) information regarding the decision; and
b) information regarding other internal or external appeal or dispute resolution alternatives, including any required state mandated appeal rights.

The period of time within which an appeal decision is required to be made will begin at the time an appeal is filed, without regard to whether all the information necessary to make an appeal decision accompanies the filing. If a period of time is extended as described above due to the Claimant's failure to submit information necessary to decide a claim, the period for making the appeal decision shall be "tolled" or suspended from the date on which the extension notice is sent until the earlier of (1) the date on which We receive the response; or (2) the date established by Us in the notice of extension for the furnishing of the requested information.

STANDARD PROVISIONS

Capitalized terms used in this section have the meanings assigned to them in this section or in other sections of the Policy.

INSURANCE CONTRACT

The insurance contract consists of:

a) the Policy;
b) the Policyholder's signed application attached to the Policy; and
c) any signed application for You.

Statements in an application are considered representations and not warranties. We will not use any statements in an Insured Person's application to deny a claim or to contest the validity of this insurance unless We provide You or Your beneficiary with a copy of that application.

CHANGES IN THE INSURANCE CONTRACT

The insurance contract may be changed (including reducing or terminating benefits or increasing premium costs) any time We and the Policyholder both agree to a change. No one else has the authority to change the insurance contract. A change in the insurance contract:

a) does not require the consent of any Insured Person or beneficiary; and
b) must be:
    1. in writing;
    2. made a part of the Policy; and
    3. signed by Our authorized representative in Our home office.

A change may affect any class of Insured Persons included in the Policy.

INCONTESTABILITY

We will not use any statements in an Insured Person's application to contest the validity of this insurance after it has been in-force during the lifetime of the Insured Person for two years.

LEGAL ACTIONS

No legal action can be brought until at least 60 days after We have been given written proof of loss. No legal action can be brought more than six years after the date written proof of loss is required, unless otherwise required by state law in Your state of residence.

GENERAL DEFINITIONS

The following capitalized terms have the meanings assigned in this section. These terms are used throughout the Policy.

Annual Earnings means Your gross annual earnings received from the Policyholder and in effect immediately prior to the date of loss, as determined by the Policyholder and verified by the premium received by Us.

Your annual earnings include Your contributions to deferred compensation plans.

Your annual earnings do not include commissions, bonuses, overtime pay, other extra compensation, shift differential, or the Policyholder's contributions to deferred compensation plans.

Certificate means this document that describes the benefits, terms, conditions, exclusions and limitations of the insurance provided under the Policy.

Dependent means a citizen, permanent resident or lawful resident of the United States who, as indicated by evidence acceptable to Us, is:

a) Your Spouse;
b) Your natural born or legally adopted child;
c) Your stepchild; or
d) any other child who lives with You in a regular parent/child relationship and who qualifies as Your "dependent" as defined in the United States Internal Revenue Code.

A dependent does not include:

a) anyone insured under the Policy as an Employee;
b) anyone who is a member of the Armed Forces, National Guard or Reserves of any state or country on active duty (except for temporary duty of 31 days or less);
c) Your divorced, legally separated or former Spouse;
d) a child who has reached the age of 26 unless the child is Incapacitated;
e) Your married child(ren);
f) Your child if the child has been legally adopted by another person; or
g) a child placed in Your home by a social service agency which retains control over the child.

Employee means a person who is:

a) a citizen or permanent resident of the United States; or
b) lawfully and legally able to work in the United States pursuant to applicable federal and state laws; and
c) receiving compensation from the Policyholder for work performed for the Policyholder at:
    1. the Policyholder's usual place of business;
    2. an alternative work site at the direction of the Policyholder; or
    3. a location to which the employee must travel to perform the job.

An employee does not include a person:

a) who resides outside the United States for a period in excess of 12 consecutive months unless written approval has been received from Our authorized representative in Our home office;
b) working on a seasonal or temporary basis; or
c) performing services for the Policyholder as an independent contractor, including persons reporting income on a 1099 form or subject to the terms of a leasing agreement between the Policyholder and a leasing organization.

Evidence of Insurability means proof of good health acceptable to Us. This proof may be obtained through questionnaires, physical exams or written documentation, as required by Us.

Hospital means an accredited facility licensed by the proper authority of the area in which it is located to provide care and treatment for the condition causing confinement. A hospital does not include a facility or institution or part of a facility or institution which is licensed or used principally as a clinic, convalescent home, rest home, nursing home or home for the aged, halfway house or board and care facilities.

Incapacitated means that a Dependent child is continuously incapable of self-sustaining employment by reason of intellectual disability, developmental disability, mental illness or physical handicap.

Injured means the occurrence of an Injury.

Injury, Injuries means an accidental bodily injury that requires treatment by a Physician. It must result in loss independently of Sickness and other causes.

Our, We, Us means United of Omaha Life Insurance Company.

Physician means any of the following licensed practitioners:

a) a doctor of medicine (MD), osteopathy (DO), podiatry (DPM) or chiropractic (DC);
b) a licensed doctoral clinical psychologist;
c) a Master's level counselor and licensed or certified social worker who is acting under the supervision of a doctor of medicine or a licensed doctoral clinical psychologist;
d) a licensed physician's assistant (PA) or nurse practitioner (NP); or
e) where required by law, any other licensed practitioner of a healing art who is acting within the scope of his/her license.

A physician does not include:

a) a naturopathic doctor;
b) an acupuncturist;
c) a physician in training; or
d) You, Your Spouse or a child, brother, sister or parent of You or Your Spouse or any person who lives with You.

Plan Administrator means the person or entity designated as the plan administrator for the Policyholder's group life insurance plan.

Policy means the group policy issued to the Policyholder by Us, including this Certificate.

Policy Anniversary means October 1 of each Policy Year.

Policy Effective Date means October 1, 2019.

Policy Year means the period commencing on the Policy Effective Date and ending on the next succeeding Policy Anniversary and, thereafter, each 12-month period commencing on the Policy Anniversary.

Prior Plan means any policy or plan of benefits:

a) replaced by insurance under part or all of the Policy; and
b) in effect and maintained or sponsored by the Policyholder on the day before the Policy Effective Date.

Schedule means the section of the Certificate identified as the "Schedule".

Sickness means a disease, disorder or condition that requires treatment by a Physician.

Spouse means the person to whom You are legally married, or Your domestic partner, civil union partner or equivalent, as recognized and allowed by applicable federal law, state law, or law of the county, city or local government in Your jurisdiction of residence. A spouse may include Your same sex or opposite sex domestic or civil union partner or equivalent if:

a) You submit to the Policyholder a written declaration of partnership signed by You and Your partner in a form acceptable to Us; or
b) You submit evidence acceptable to Us that all applicable requirements of the jurisdiction in which you reside regarding the establishment of a domestic or civil union partnership have been met; or
c) You and Your partner satisfy the Policyholder's requirements for such partnerships.

Student means Your Dependent child who attends an accredited high school, trade school, college, university or other institution of higher learning and is enrolled full-time as indicated by evidence acceptable to Us. Student includes a Dependent child who would otherwise qualify as a student but cannot maintain full-time enrollment due to Sickness or Injury.

Written Request means a request that is signed, dated and submitted to the Policyholder or Us. The request must be on a form We supply or be in a form and content acceptable to Us.

You, Your, Insured Person means the Employee who is insured under the Policy.

Group Term Life Benefits

Hoover City Schools

Group Number: G000BJXW

United of Omaha Life Insurance Company

Home Office:
Mutual of Omaha Plaza
Omaha, Nebraska 68175

YOUR GROUP VOLUNTARY TERM LIFE BENEFITS

FOR EMPLOYEES OF:

Hoover City Schools

CLASS(ES):

All Eligible Employees

REVISION EFFECTIVE DATE:

October 1, 2019

PUBLICATION DATE:

February 19, 2020

NOTICE(S)

THIS CERTIFICATE DESCRIBES THE BENEFITS THAT ARE AVAILABLE TO YOU. PLEASE READ YOUR CERTIFICATE CAREFULLY. BENEFITS ARE PROVIDED THROUGH A GROUP POLICY ISSUED IN THE STATE OF ALABAMA.

FRAUD WARNING

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Group Number: G000BJXW

If You have any questions about or concerns with this insurance, please first contact the Policyholder or Your benefits administrator. If, after doing so, You still have a question or concern, You may contact Us at:

United of Omaha Life Insurance Company
Mutual of Omaha Plaza
Omaha, Nebraska 68175
Call Toll-Free: 1-800-775-8805
www.mutualofomaha.com

When contacting Us, please have Your Policy number available.

IF YOU ARE NOT SATISFIED WITH YOUR CERTIFICATE, YOU MAY RETURN IT TO US WITHIN 30 DAYS AFTER YOU RECEIVE IT, UNLESS A CLAIM HAS PREVIOUSLY BEEN RECEIVED BY US UNDER YOUR CERTIFICATE. WE WILL REFUND WITHIN 30 DAYS OF OUR RECEIPT OF THE RETURNED CERTIFICATE ANY PREMIUM THAT HAS BEEN PAID AND THE CERTIFICATE WILL THEN BE CONSIDERED TO HAVE NEVER BEEN ISSUED. YOU SHOULD BE AWARE THAT IF YOU ELECT TO RETURN THE CERTIFICATE FOR A REFUND OF PREMIUMS, LOSSES WHICH OTHERWISE WOULD HAVE BEEN COVERED UNDER YOUR CERTIFICATE WILL NOT BE COVERED.

ABOUT LIVING BENEFITS (ACCELERATED BENEFIT)

LIFE INSURANCE BENEFITS (BENEFITS PAYABLE BY REASON OF THE DEATH OF YOU) WILL BE REDUCED IF BENEFITS ARE PAID UNDER THE LIVING BENEFITS (ACCELERATED BENEFIT) PROVISION.

This disclosure is a brief summary of the Living Benefits (Accelerated Benefit) provision and its effect on life insurance benefits.

An eligible Insured Person may receive payment of part of the amount of life insurance in effect for the Insured Person while living if the Insured Person has been diagnosed with a terminal condition. A terminal condition means an injury or sickness that is expected to result in death within the number of months stated in the Certificate, as certified by a Physician. Please refer to the Living Benefits (Accelerated Benefit) provision of this Certificate for information regarding who is eligible for this benefit and the complete definition of Terminal Condition.

This benefit is included in the premium paid for life insurance. There is no separate premium charge for this benefit. The premium for life insurance does not change if benefits are paid under the Living Benefits (Accelerated Benefit) provision.

The Living Benefits offered under this contract **may or may not** qualify for favorable tax treatment under the Internal Revenue Code of 1986 (as amended). Whether such benefits qualify depends on factors such as the life expectancy of You at the time benefits are accelerated or whether You use the benefits to pay for necessary long-term care expenses, such as nursing home care. If the Living Benefits qualify for favorable tax treatment, the benefits will be excludable from Your income and not subject to federal taxation. Tax laws relating to Living Benefits are complex. You are advised to consult with a qualified tax advisor about circumstances under which You could receive Living Benefits excludable from income under federal law.

Receipt of Living Benefits may affect Your, Your Spouse's or Your family's eligibility for public assistance programs such as medical assistance (Medicaid), Aid to Families with Dependent Children (AFDC), supplementary social security income (SSI), and drug assistance programs. You are advised to consult with a qualified tax advisor and with social service agencies concerning how receipt of such a payment will affect Your, Your Spouse's or Your family's eligibility for public assistance.

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TABLE OF CONTENTS

PAGE

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CERTIFICATE OF INSURANCE

UNITED OF OMAHA LIFE INSURANCE COMPANY

Home Office:
Mutual of Omaha Plaza
Omaha, Nebraska 68175

United of Omaha Life Insurance Company certifies that Group Policy Number GVTL-BJXW (the Policy) has been issued to Hoover City Schools (the Policyholder).

Insurance is provided for Employees of the Policyholder subject to the terms and conditions of the Policy.

Please read this Certificate carefully. The benefits described in this Certificate are effective only if You and Your Dependent(s), if applicable, are eligible for the insurance, become insured and remain insured as described in this Certificate and according to the terms and conditions of the Policy.

If the provisions of this Certificate and those of the Policy do not agree, the provisions of the Policy will apply. The Policy is part of a contract between United of Omaha Life Insurance Company and the Policyholder, and may be amended, changed or terminated without Your consent or notice to You.

This Certificate replaces any certificate previously issued under the Policy.

James T. Blackledge
Chief Executive Officer

Jay A. Vanhoat
Corporate Secretary

SCHEDULE

Capitalized terms used in this section have the meanings assigned to them in this section or in other sections of the Policy.

CLASS(ES)

All Eligible Employees

LIFE INSURANCE FOR YOU (THE EMPLOYEE)

You may elect to be insured for an amount of life insurance from $10,000 to $300,000, in increments of $10,000.

If You are eligible for and elect insurance under the Policy as both an Employee and Spouse, Your maximum amount of life insurance under the Policy is $300,000.

Your amount of life insurance is subject to any reductions indicated in the Benefit Reductions provision in this Schedule. If You have questions regarding the amount of Your life insurance, You may contact the Policyholder.

LIFE INSURANCE FOR YOUR DEPENDENT(S)

You may elect to have Your Spouse insured for an amount of life insurance from $5,000 to $30,000, in increments of $5,000, provided the amount elected does not exceed 100% of Your amount of life insurance.

Your Spouse's amount of life insurance is subject to any reductions indicated in the Benefit Reductions provision in this Schedule.

You may elect to have Your eligible Dependent child(ren) insured for an amount of life insurance from $1,000 to $10,000, in increments of $1,000, provided the amount elected does not exceed 100% of Your amount of life insurance. Each eligible Dependent child must have the same amount of insurance.

If You have questions regarding the amount of life insurance for Your Dependent(s), You may contact the Policyholder.

ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE FOR YOU

Provided You have elected some amount of life insurance, You may elect to be insured for an amount of accidental death and dismemberment (AD&D) insurance that is equal to Your amount of life insurance.

If You are eligible for and elect insurance under the Policy as both an Employee and Spouse, Your maximum amount of AD&D insurance under the Policy is $300,000.

Your amount of AD&D insurance is also referred to as the Principal Sum. Your amount of AD&D insurance is subject to any reductions indicated in the Benefit Reductions provision of this Schedule. If You have questions regarding the amount of Your AD&D insurance, You may contact the Policyholder.

ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE FOR YOUR DEPENDENT(S)

Provided You have elected some amount of life insurance for Your Spouse, You may elect to have Your Spouse insured for an amount of accidental death and dismemberment (AD&D) insurance that is equal to Your Spouse's amount of life insurance.

Your Spouse's amount of AD&D insurance is subject to any reductions indicated in the Benefit Reductions provision of this Schedule.

Provided You have elected some amount of life insurance for Your Dependent child(ren), You may elect to have Your eligible Dependent child(ren) insured for an amount of accidental death and dismemberment (AD&D) insurance equal to the amount of life insurance for Your Dependent child(ren).

The amount of AD&D insurance is also referred to as the Principal Sum. If You have questions regarding the amount of AD&D insurance for Your Dependent(s), You may contact the Policyholder.

GUARANTEE ISSUE AMOUNT(S) AND EVIDENCE OF INSURABILITY

Guarantee Issue Amount(s) is/are subject to any reductions indicated in the Benefit Reductions provision of this Schedule. In addition, guarantee issue is only available if the total number of Employees insured under the Policy attains or remains above 10 Employees or 25% of the eligible Employees, whichever is greater. If the total number falls below the required level, the Guarantee Issue Amount(s) may be reduced or rescinded.

Guarantee Issue Amount For You (The Employee)

Your Guarantee Issue Amount is $300,000, unless You were insured under a Prior Plan. If You were insured under a Prior Plan, Your Guarantee Issue Amount is equal to the amount of insurance that was in-force for You under a Prior Plan the day before the Policy Effective Date, but in no event more than the maximum amount of insurance stated in the Life Insurance for You (the Employee) section of this Schedule.

If You are eligible for and elect insurance under the Policy as both an Employee and Spouse, the Guarantee Issue Amount available to You under the Policy is $330,000.

Guarantee Issue Amount For Your Spouse

The Guarantee Issue Amount for Your Spouse is 100% of Your elected amount of life insurance or $30,000, whichever is less, unless Your Spouse was insured under a Prior Plan. If Your Spouse was insured under a Prior Plan, the Guarantee Issue Amount for Your Spouse is equal to the amount of insurance that was in-force for Your Spouse under a Prior Plan the day before the Policy Effective Date, but in no event more than the maximum amount of insurance for Your Spouse stated in the Life Insurance for Your Dependent(s) section of this Schedule.

Guarantee Issue Amount For Your Dependent Child(ren)

The Guarantee Issue Amount for Your Dependent child(ren) is 100% of Your elected amount of life insurance, unless Your Dependent child(ren) were insured under a Prior Plan. If Your Dependent child(ren) were insured under a Prior Plan, the Guarantee Issue Amount for Your Dependent child(ren) is equal to the amount of insurance that was in-force for Your Dependent child(ren) under a Prior Plan the day before the Policy Effective Date, but in no event more than the maximum amount of insurance for Your Dependent child(ren) stated in the Life Insurance for Your Dependent(s) section of this Schedule.

Insurance for You and Your Dependent(s), if applicable, is only available on a guarantee issue basis:

a) during Your First Enrollment Period;
b) during a Subsequent Enrollment Period; or
c) as otherwise stated or allowed in the Policy.

Evidence of Insurability

Evidence of Insurability is required for:

a) insurance elected more than 31 days after the date the Employee or Spouse becomes eligible;
b) any amount of insurance elected in excess of a Guarantee Issue Amount for the Employee or Spouse;
c) any increase in the amount of insurance after the initial election of insurance for the Employee or Spouse, unless during a Subsequent Enrollment Period or as otherwise stated or allowed in the Policy;
d) an Employee or Spouse who was eligible for insurance under a Prior Plan but did not elect such insurance; or
e) an Employee or Spouse whose amount of insurance elected under the Policy is in excess of the amount of insurance that was in-force under a Prior Plan the day before the Policy Effective Date, unless during a Subsequent Enrollment Period or as otherwise stated or allowed in the Policy.

If Evidence of Insurability is required for items a), d) or e) above, We may require that such evidence be provided at Your expense.

BENEFIT REDUCTIONS

As You grow older, the amount of life and AD&D insurance for You and Your Spouse will be reduced according to the following schedule:

At the Age of:	The Original Amount of Insurance Will Reduce to:
70	50%
75	35%
80	28%

Reductions become effective on the first day of the Policy month that coincides with or follows the day You reach the specified age. Any reduced amount of insurance will round to the nearest dollar.

If You are age 70 or older on the date insurance becomes effective, the amount of life and AD&D insurance for You and Your Spouse will be reduced as shown above. Thereafter, the amount of life and AD&D insurance will continue to reduce in accord with the schedule above.

If a reduction to Your amount of insurance causes an amount of insurance for one or more of Your Dependents to exceed the maximum amount of insurance described previously in this Schedule, the amount of insurance for the Dependent will be adjusted to comply with the maximum available.

ELIGIBILITY

Capitalized terms used in this section have the meanings assigned to them in this section or in other sections of the Policy.

DEFINITIONS

Actively Working, *Active Work* means an Employee is performing the normal duties of his or her regular job for the Policyholder on a regular and continuous basis 20 or more hours each week. An Employee will be considered to be actively working on any day that is a regular paid holiday or day of vacation, or regular or scheduled non-working day, provided the Employee was actively working on the last preceding regular work day.

Activities of Daily Living means the basic activities of daily living consisting of the following self-care tasks:

a) personal hygiene (bathing, grooming, shaving and oral care);
b) dressing and undressing (putting on and taking off all items of clothing and any necessary braces or artificial limbs);
c) eating (the ability to feed oneself);
d) transferring (from bed to chair, and back; from sitting to standing, and back);
e) continence (controlling bladder and bowel function);
f) toileting (the ability to use a restroom); and
g) moving around (as opposed to being bedridden).

Disability Elimination Period means the period of time that must be satisfied before You are eligible to continue benefits, beginning on the date Your Injury or Sickness occurred. The length of the disability elimination period is shown in the Continuation of Insurance for Total Disability with Waiver of Premium provision.

Life Event means:

a) a change in Your legal marital status or domestic partnership (or equivalent);
b) a change in the number of Your Dependents; or
c) a significant cost or coverage change under any other employer or group sponsored life plan under which You or Your Dependent(s) are covered.

Partial Disability, Partially Disabled means that, because of an Injury or Sickness lasting longer than 12 months, You are unable to perform the normal duties of Your regular job for the Policyholder on a regular or continuous basis, but are able to satisfy all other requirements of the Active Work definition.

Recurrent Disability means a Total Disability which is related to or due to the same cause(s) of a prior Total Disability for which You were approved for coverage under the Continuation of Insurance for Total Disability with Waiver of Premium provision of the Policy.

Total Disability, Totally Disabled means that because of an Injury or Sickness You are completely and continuously unable to perform any work or engage in any occupation.

WHEN AN EMPLOYEE BECOMES ELIGIBLE FOR INSURANCE

An Employee who is Actively Working on the Policy Effective Date becomes eligible for insurance under the Policy on the Policy Effective Date.

An Employee who is hired after the Policy Effective Date becomes eligible for insurance under the Policy on the day the Employee begins Active Work.

The day on which an Employee becomes eligible for insurance under the Policy may not be the same as the day on which insurance begins. The When Insurance Begins provision describes the day on which insurance begins.

WHEN A DEPENDENT BECOMES ELIGIBLE FOR INSURANCE

A Dependent becomes eligible for insurance under the Policy on the later of:

a) the day You become eligible for insurance under the Policy; or
b) the day You acquire the Dependent;

provided You elect insurance for yourself under the Policy.

If both You and Your Spouse are eligible for insurance under the Policy as Employees of the Policyholder, You or Your Spouse may also elect insurance as a Dependent of the other person.

If both You and Your Spouse are eligible for insurance under the Policy as Employees of the Policyholder, both You and Your Spouse may elect insurance for Your Dependent child(ren) under the Policy.

In order to insure an eligible Dependent child, You must insure all of Your eligible Dependent child(ren).

The day on which a Dependent becomes eligible for insurance under the Policy may not be the same as the day on which insurance begins. The When Insurance Begins provision describes the day on which insurance begins.

CONTINUITY OF INSURANCE UPON TRANSFER OF INSURANCE CARRIER

If there is a conflict between this provision and any other provision of the Policy, this provision shall control.

If the Policy replaces a Prior Plan, the Policy will provide insurance for an Employee who:
a) was insured under the Prior Plan on the day before the Policy Effective Date;
b) is otherwise eligible under the Policy, but is not Actively Working on the Policy Effective Date due to:
    1. Injury or Sickness; or
    2. a leave of absence protected under:
        a. the federal Family and Medical Leave Act (FMLA) or Uniformed Services Employment and Reemployment Rights Act (USERRA) and any amendments thereto; or
        b. any other applicable federal or state law that allows for continuation of insurance in certain instances;
c) is not eligible for benefits or continuation of insurance under any provision of the Prior Plan;
d) is not a retired Employee; and
e) is not Totally Disabled on the Policy Effective Date.

Insurance under this provision is subject to the following conditions:
a) insurance under the Policy may not exceed Your amount of insurance under the Prior Plan on the day before the Policy Effective Date;
b) the benefit payable under the Policy will be the amount which would have been paid by the Prior Plan had insurance remained in-force under the Prior Plan, less the amount of any benefit payable under the Prior Plan;
c) the Policyholder must notify Us in writing prior to the Policy Effective Date of the amount of Your insurance under the Prior Plan on the day before the Policy Effective Date;
d) insurance is subject to uninterrupted payment of premium to Us when due; and
e) insurance is subject to any reductions shown in the Schedule and all other terms and conditions of the Policy.

If insurance is provided for the Employee, insurance may also be provided for any eligible Dependent(s).

We reserve the right to request any information We need from the Policyholder to determine whether the conditions necessary to be eligible for insurance under this provision have been satisfied.

Insurance under this provision will end on the earliest of:
a) the day the Employee returns to Active Work for the Policyholder or begins employment with any other employer;
b) the last day the Employee would have been insured under the Prior Plan, if the Prior Plan had not ended or terminated;
c) the day the Employee's insurance under the Policy ends for any reason shown in the When Insurance Ends provision; or
d) the last day of the twelfth month following the Policy Effective Date.

If an Employee is eligible for insurance under this provision, the Employee will not be eligible for insurance under any continuation provision or the Portability provision in this Certificate.

If Your insurance under this provision ends and You have not returned to Active Work, You and Your Dependent(s) may be able to obtain insurance under the Conversion provision.

Persons who are not eligible for insurance under this provision may be eligible to apply for conversion of insurance under the Prior Plan and should contact the Policyholder for additional information.

WHEN INSURANCE BEGINS

An eligible Employee must enroll for insurance by submitting a Written Request for insurance for the Employee and any Dependent(s). The Written Request must be submitted to the Policyholder within 31 days following the day the Employee or Dependent(s) become(s) eligible. If the Written Request for insurance is not submitted within 31 days following the day the Employee or Dependent(s) become(s) eligible for insurance, the Employee and/or Dependent(s) must provide Evidence of Insurability.

An eligible Employee will become insured for any amount that does not require Evidence of Insurability on the first day of the month that coincides with or follows the latest of the day:

a) the Employee begins Active Work; or
b) the Employee submits a Written Request to enroll for insurance, if applicable.

If the Employee is not Actively Working on the day insurance would otherwise begin, insurance will begin on the day the Employee returns to Active Work.

An eligible Dependent will become insured for any amount that does not require Evidence of Insurability on the latest of the day:

a) the Employee becomes insured, unless otherwise agreed to by Our authorized representative in Our home office;
b) the Employee acquires the eligible Dependent; or
c) the Employee submits a Written Request to enroll the Dependent for insurance, if applicable.

An eligible Employee or Dependent must provide Evidence of Insurability if it is required. An eligible Employee or Dependent will become insured for any amount of insurance that requires Evidence of Insurability, including any amount of insurance in excess of the Guarantee Issue Amount (if applicable) for the Employee and any Dependent(s) on the later of:

a) the first day of the month that follows the day We approve Evidence of Insurability; and
b) the October 1st that follows the day We approve Evidence of Insurability if Evidence of Insurability is properly completed, signed and received by Us due to the Policyholder's annual enrollment period.

EXCEPTIONS TO WHEN INSURANCE BEGINS

This provision does not apply if the Employee is eligible for coverage under the Continuity of Insurance Upon Transfer of Insurance Carrier provision.

Insurance for an Employee or Dependent who is:

a) Totally Disabled (with respect to the Employee);
b) confined in a Hospital as an inpatient;
c) confined in any institution or facility other than a Hospital; or
d) confined at home and under the care or supervision of a Physician;

on the day insurance is to begin will not take effect until the day after the Employee has completed one full day of Active Work or Dependent is no longer confined.

Insurance for an Employee who is not Actively Working on the Policy Effective Date due to Injury or Sickness will not take effect until the day after the Employee has completed one full day of Active Work.

In addition, insurance for a Dependent who is unable to perform two or more Activities of Daily Living (ADLs), whether or not confined, will not take effect until the day the Dependent has performed all ADLs for at least 15 consecutive days.

Insurance for a Dependent child who became Incapacitated prior to reaching the age of 26 will begin in accordance with the When Insurance Begins provision, provided the child otherwise meets the definition of Dependent.

Insurance for a newborn Dependent child, regardless of confinement, will begin in accordance with the When Insurance Begins provision, provided the child otherwise meets the definition of Dependent.

THE FIRST ENROLLMENT PERIOD

An Employee may elect insurance for him/herself and any Dependent(s) during the First Enrollment Period.

If an Employee does not elect insurance during the Employee's or Dependent's First Enrollment Period, future elections may only be made in accordance with the Subsequent Enrollment Periods provision, or as otherwise provided under the When Election Changes Are Permitted provision.

SUBSEQUENT ENROLLMENT PERIODS

An Employee may elect, drop, increase, decrease or change insurance for the Employee and any Dependent(s) during a Subsequent Enrollment Period.

WHEN ELECTION CHANGES ARE PERMITTED

An Employee may elect, drop, increase, decrease or change insurance as allowed by the Policyholder. Any election of or increase in insurance for an Employee or Dependent will require Evidence of Insurability unless otherwise stated or allowed in the Policy.

Life Events

Within 31 days of a Life Event, You may submit a Written Request to change insurance.

If You experience a Life Event and You are currently insured under the Policy, insurance for You and any Dependent(s) may be issued up to the Guarantee Issue Amount without Evidence of Insurability. For any amount of insurance over the Guarantee Issue Amount, or if the Written Request is submitted more than 31 days after the date of a Life Event, We will require Evidence of Insurability.

An Employee who experiences a Life Event who previously declined insurance under the Policy must submit Evidence of Insurability for any change of insurance to be considered by Us.

Annual Increase Option

You may submit a Written Request to increase the amount of insurance once a year, provided the new amount of insurance does not exceed the maximum benefit amount shown in the Schedule. You may increase Your amount of insurance by up to $50,000, in increments as shown in the Schedule.

If the amount of insurance requested exceeds the Guarantee Issue Amount, Evidence of Insurability will be required. If Evidence of Insurability is required for this provision, such evidence will only be required once and will serve as acceptable proof for any future requests to increase the amount of insurance under this provision. This election may be made once a year within a time period designated by the Policyholder and approved by Our authorized representative in Our home office.

CHANGES TO INSURANCE BENEFITS

Any allowable change in Your or Your Dependent's class or amount of insurance, whether requested by You or the Policyholder, or as a result of the terms of the Policy, will take effect on the first day of the month that follows the date of the request or the change, or the first day of the month that follows the day We approve Evidence of Insurability (if required by Us), whichever is later.

For any increase in insurance, We will use the Policyholder's records and/or the premium We have received to verify that the amount of insurance being requested is the appropriate insurance amount for which the Insured Person is eligible under the terms of the Policy.

If You are not Actively Working on the day any increase in insurance would otherwise take effect, the increase will become effective the first day of the month that follows the day after You return to Active Work.

REINSTATEMENT OF INSURANCE

You may be eligible to reinstate insurance that has ended for You and/or Your Dependent(s) in accordance with this provision. You must submit a Written Request to reinstate insurance within 31 days of Your return to Active Work. We will require Evidence of Insurability if the amount of insurance being requested exceeds the amount of insurance in effect on the Employee's last day of Active Work.

Reinstated insurance will take effect on the first day of the month that coincides with or follows the date of the Written Request, or the first day of the month that follows the day We approve Evidence of Insurability (if required by Us), whichever is later. If You are not Actively Working on the day the reinstated insurance would otherwise take effect, insurance will become effective on the day after You return to Active Work.

The following reinstatement option(s) is/are available:

Non-Payment of Premium or Voluntary Termination of Insurance

If insurance ended due to Your non-payment of premium or voluntary termination of insurance, We will require Evidence of Insurability to reinstate insurance.

Transfer From Portability or Conversion

If insurance was obtained under the Portability or Conversion provision while an Employee was not Actively Working, insurance may be reinstated up to the amount of insurance that was in effect on the last day of Active Work. Any insurance provided through the Portability provision will terminate upon reinstatement of insurance as an Actively Working Employee.

WHEN INSURANCE ENDS

Insurance will end on the last day of the month in which the earliest of the following events occurs:

a) an Insured Person is no longer eligible for insurance under the Policy; or
b) an Insured Person begins active duty in the Armed Forces, National Guard or Reserves of any state or country (except for temporary active duty of 31 days or less).

Insurance will also end:

a) on the day the Policy terminates; or
b) in accordance with the Grace Period provision.

NOTICE TO YOU WHEN INSURANCE ENDS

The Policyholder is required to notify You when insurance under the Policy ends if:

a) You or any of Your Dependent(s) cease to be eligible for insurance under the Policy; or
b) the Policy is discontinued and is not replaced by another policy or plan with no interruption in coverage.

Notice shall be provided within 15 days from the date insurance ends for You or any of Your Dependent(s), and shall include information about any options available to continue or obtain insurance.

EXCEPTIONS TO WHEN INSURANCE ENDS

If insurance for You and/or Your Dependent(s) would otherwise end, You and/or Your Dependent(s) may be able to continue or obtain insurance under one of the following provisions:

a) Continuation of Insurance for Layoff or Leave
b) Continuation of Insurance for Injury or Sickness
c) Continuation of Insurance for Partial Disability
d) Continuation of Insurance for Total Disability with Waiver of Premium
e) Portability

f) Conversion

CONTINUATION OF INSURANCE FOR LAYOFF OR LEAVE

If there is a conflict between this provision and any other provision of the Policy, this provision shall control.

You may be able to continue insurance for You and Your Dependent(s) from the day You cease to be Actively Working in the event of:

a) a temporary involuntary layoff; or
b) a leave of absence approved by the Policyholder due to any personal reason.

In addition, the federal Family Medical Leave Act (FMLA) and Uniformed Services Employment and Reemployment Rights Act (USERRA) and any amendments thereto, as well as other applicable federal or state laws, may allow continuation of insurance in certain instances for leaves of absence, layoff or termination. Contact the Policyholder for additional information regarding any other continuation options that may be available.

Any insurance continued under this provision will be subject to the following conditions:

a) insurance may not be continued beyond the earliest of:
    1. 12 weeks for Your temporary involuntary layoff;
    2. 12 weeks for Your leave of absence; or
    3. the time period allowed by FMLA, USERRA or applicable federal or state law that allows for continuation;
b) the amount of insurance may not be increased while insurance is continued under this provision; and
c) We continue to receive premium payment when due (premiums must be paid by You or on Your behalf).

Insurance under this provision will end on the last day of the month which coincides with or follows the earliest of the day:

a) the time period in a) in the preceding paragraph has been satisfied;
b) Your temporary involuntary layoff becomes permanent, if insurance is continued under this provision due to Your temporary involuntary layoff;
c) You return to Active Work;
d) You begin full-time employment with an employer other than the Policyholder; or
e) the Policy terminates.

Insurance under this provision will also end in accordance with the Grace Period provision.

If continued insurance under this provision ends and You have not returned to Active Work, You and Your Dependent(s) may be able to continue or obtain insurance under the Continuation of Insurance for Injury or Sickness provision, Portability provision or Conversion provision.

If Your leave is due to an Injury or Sickness which may result in Your Total Disability, We must receive notification of Your potential Total Disability on Our total disability claim form within 6 months of the date Your Injury or Sickness occurred, or as soon as reasonably possible.

See the Options for Payment of Premium for Continued Insurance provision for premium payment options.

CONTINUATION OF INSURANCE FOR INJURY OR SICKNESS

If there is a conflict between this provision and any other provision of the Policy, this provision shall control.

When Your insurance would otherwise end due to Your Injury or Sickness, You may be able to continue insurance under this provision. In such circumstances, the total continuation period under this provision and the Continuation of Insurance for Layoff or Leave provision, if You were previously insured under this provision, shall not exceed 12 months. Insurance may be continued for You and Your Dependent(s).

Insurance may be continued under this provision if We continue to receive timely premium payment when due (premiums must be paid by You or on Your behalf).

The amount of insurance may not be increased while insured under this provision.

Insurance under this provision will end on the earliest of the last day of the month which coincides with or follows the day:

a) that is 12 months from the day You cease Active Work;
b) You return to Active Work;
c) You begin full-time employment with an employer other than the Policyholder; or
d) the Policy terminates.

Insurance under this provision will also end in accordance with the Grace Period provision.

If continued insurance under this provision ends and You have not returned to Active Work, You and Your Dependent(s) may be able to continue or obtain insurance under the Continuation of Insurance for Partial Disability provision, Continuation of Insurance for Total Disability with Waiver of Premium provision, Portability provision or Conversion provision.

If Your leave is due to an Injury or Sickness which may result in Your Total Disability, We must receive notification of Your potential Total Disability on Our total disability claim form within 6 months of the date Your Injury or Sickness occurred, or as soon as reasonably possible.

See the Options for Payment of Premium for Continued Insurance provision of this Certificate for premium payment options.

CONTINUATION OF INSURANCE FOR PARTIAL DISABILITY

If there is a conflict between this provision and any other provision of the Policy, this provision shall control.

When You are no longer eligible to continue insurance under the Continuation of Insurance for Injury or Sickness provision, You may be able to continue insurance under this provision due to Your Partial Disability. Insurance may be continued for You and Your Dependent(s).

Insurance may be continued under this provision if the following conditions are satisfied:

a) You are Partially Disabled, but not Totally Disabled; and
b) We continue to receive timely premium payment when due (premiums must be paid by You or on Your behalf).

The amount of insurance may not be increased while insured under this provision.

Insurance under this provision will end on the earliest of the last day of the month which coincides with or follows the day:

a) You return to Active Work;
b) Your Injury or Sickness results in Your Total Disability and You are eligible to continue insurance under the Continuation of Insurance for Total Disability with Waiver of Premium provision;
c) You begin full-time employment with an employer other than the Policyholder; or
d) the Policy terminates.

Insurance under this provision will also end in accordance with the Grace Period provision.

If Your insurance under this provision ends and You have not returned to Active Work, You and Your Dependent(s) may be able to obtain insurance under the Continuation of Insurance for Total Disability with Waiver of Premium provision, Portability provision or Conversion provision.

If Your Partial Disability may result in Your Total Disability, We must receive notification of Your potential Total Disability on Our total disability claim form within 6 months of the date Your Injury or Sickness occurred, or as soon as reasonably possible.

See the Options for Payment of Premium for Continued Insurance provision of this Certificate for premium payment options.

CONTINUATION OF INSURANCE FOR TOTAL DISABILITY WITH WAIVER OF PREMIUM

If there is a conflict between this provision and any other provision of the Policy, this provision shall control.

This provision only allows for continuation of life insurance under the Policy. Accidental death and dismemberment insurance may not be continued under this provision.

When Your insurance ends under the Continuation of Insurance for Injury or Sickness provision or Continuation of Insurance for Partial Disability provision, You may be able to continue insurance under this provision due to Your Total Disability. After satisfaction of the Disability Elimination Period, and upon submission of proof of Total Disability acceptable to Us, Your insurance may be continued without payment of premium until insurance ends in accordance with this provision.

We must receive notification of Your potential Total Disability on Our total disability claim form within 6 months of the date Your Injury or Sickness occurred, or as soon as reasonably possible.

Insurance may be continued under this provision if the following conditions are satisfied:

a) You are Totally Disabled;
b) You were under age 60 at the time You became Totally Disabled;
c) the Disability Elimination Period is satisfied; and
d) proof of Total Disability is provided to Us (as described below in this provision).

The amount of insurance may not be increased while insured under this provision.

Insurance may only be continued for You. If You are able to continue insurance under this provision, Your Dependent(s) may be able to obtain insurance under the Portability or Conversion provision.

If You are age 60 or older and become Totally Disabled, You and Your Dependent(s) may be able to obtain insurance under the Portability or Conversion provision.

About the Disability Elimination Period

The Disability Elimination Period is a period of 6 consecutive months. Any period of time in which You are insured under the Continuation of Insurance for Injury or Sickness provision will apply toward satisfaction of the Disability Elimination Period.

Proof of Total Disability

You must submit to Us acceptable proof of Total Disability approved by Our authorized representative in Our home office before the end of the Disability Elimination Period or as soon as reasonably possible thereafter.

In order to confirm that You are Totally Disabled, We have the right to have You examined by a Physician of Our choice at Our expense.

If You are approved for continuation of insurance under this provision, We will periodically require proof of continuing Total Disability. We may have You examined by a Physician of Our choice at any time during the first two years of Total Disability and once a year thereafter at Our expense. If an additional examination is required due to questionable or disputed results of an examination, any additional examination may be at Your expense.

When Continuation of Insurance for Total Disability is Approved

We will notify You in writing if Your proof of Total Disability is approved by Us. Any premium paid for Your insurance from the day You ceased to be Actively Working will be refunded in a lump sum within 31 days of Your approval.

Once You are approved for insurance under this provision, a Recurrent Disability will be treated as part of Your prior claim and You will not be required to satisfy another Disability Elimination Period if:

a) You were continuously insured under the Policy for the period between Your prior claim and Your Recurrent Disability; and
b) Your Recurrent Disability occurs within 6 months of the end of Your prior claim.

When Continuation of Insurance for Total Disability is Not Approved

We will notify You in writing if Your proof of Total Disability is not approved by Us. If at any time while You are insured under this provision We determine that You are no longer Totally Disabled, We will notify You in writing that You are no longer eligible to continue insurance under this provision.

If You are ineligible for insurance under this provision or Your insurance under this provision ends, You and Your Dependent(s) will have 31 days from the date of Our notice to submit a Written Request for insurance under the Portability or

Conversion provision, if You have not returned to Active Work or You are not eligible for insurance under the Continuation of Insurance for Partial Disability provision.

When Insurance Under this Provision Ends

Insurance under this provision will end on the last day of the month which coincides with or follows the day:

a) You are eligible to continue insurance under the Continuation of Insurance for Partial Disability provision; or
b) You return to Active Work.

Insurance under this provision will also end on the earliest of the day:

a) You are no longer Totally Disabled;
b) that is 90 days after the date of Our request to You for proof of Total Disability if such proof has not been received by Us;
c) You fail to obtain an examination from a Physician of Our choice as described in the Proof of Total Disability provision by a date established by Us;
d) You reach age 65; or
e) You begin full-time employment with an employer other than the Policyholder.

Insurance under this provision will also end in accordance with the Grace Period provision.

PORTABILITY

You have the right to continue receiving group life and accidental death and dismemberment insurance under this provision if You are under age 70 when insurance would otherwise end for any of the following reasons:

a) You cease to be Actively Working and are not eligible for insurance under any other continuation provision in this Certificate (if applicable);
b) Your employment with the Policyholder ends;
c) You retire; or
d) the Policy terminates and the Policyholder does not obtain group life coverage within 31 days.

In addition to the above reasons, Your Spouse has the right to continue receiving group insurance, including insurance for Dependent child(ren), under this provision if Your Spouse is under age 70 when insurance would otherwise end for any of the following reasons:

a) You reach the Attained Age of 70, but Your Spouse is under age 70;
b) You continue insurance under the Continuation of Insurance for Total Disability with Waiver of Premium provision;
c) You enter active duty in the Armed Forces, National Guard or Reserves of any state or country for a period of more than 31 days;
d) divorce or legal separation of You and Your Spouse; or
e) Your death.

If Your Spouse continues to receive insurance under this provision, Dependent child(ren) may be insured under You or Your Spouse, but not both.

If You are eligible for insurance under this provision and You are not eligible for insurance under any other continuation provision of the Policy (if applicable), You must continue insurance under this provision in order for Your Dependent(s) to be eligible.

If an Insured Person requests to continue to receive group insurance under this provision, the amount of insurance for each Insured Person shall not exceed the lesser of:

a) the amount in effect under the Policy on the day insurance ended; or
b) $500,000 for You and $250,000 for Your Dependents.

The amount of insurance may not be increased after insurance continues under this provision.

If You continue to receive group insurance under this provision, You and Your Dependent(s) can not continue insurance under any other continuation provision of the Policy (if applicable).

The Group Term Life Insurance Portability Policy

Group insurance continued under this provision is available under another group term life insurance policy (the "Portability Policy") issued by Us, as available at the time insurance under this provision is requested. If You or Your Spouse become insured under the Portability Policy, You or Your Spouse will receive a certificate of insurance that describes the terms and conditions of coverage under the Portability Policy.

The Portability Policy may not provide all the same benefits or have all the same terms and conditions that are included in the Policy. In addition, the premium rates charged for insurance under the Portability Policy may not be the same as the premium rates charged for insurance under the Policy. The benefits and premium rates of Our Portability Policy are described on Our portability request form. You may contact the Policyholder or Us to obtain Our portability request form.

The continued group insurance coverage under the Portability Policy is available as a result of portability rights that arise solely from the Policy, as arranged for You as an employee welfare benefit subject to the Employee Retirement Income Security Act of 1974, as amended.

Notice of the Right to Continue Group Insurance Under this Provision

The portability period is the period of time that is 31 days from the date insurance under the Policy ends ("Portability Period"). When insurance under the Policy ends, notice of the right to continue receiving insurance under this provision may be given. If notice is not given at least 15 days after the start of the Portability Period, an extension of the period of time in which to apply for a Portability Policy will be allowed. Any extension of the Portability Period will expire on the earlier of:

a) 15 days after notice has been received; or
b) 60 days after the end of the Portability Period, even if notice is not received.

How to Continue Group Insurance Under this Provision

You or Your Spouse must submit a Written Request for insurance under the Portability Policy. The Written Request and the initial premium due must be submitted within the Portability Period.

CONVERSION

This provision allows for conversion of life insurance. Conversion insurance is not available for accidental death and dismemberment insurance.

When Employment or Class Membership Ends or the Amount of Insurance Reduces

If group life insurance ends because Your employment or membership in a class (as shown under Class(es) on the Schedule) ends or Your benefit amount reduces, You may apply for an individual policy of life insurance other than term insurance ("Conversion Policy"). If group life insurance for any of Your Dependent(s) ends or reduces due to Your death, divorce, legal separation or failure to satisfy any other eligibility condition, Your Dependent(s) may also apply for a Conversion Policy.

The Conversion Policy issued under this provision will be:

a) any type of individual policy of life insurance then customarily issued by Us for purposes of conversion, except term insurance; and
b) issued without any supplemental benefits.

Premium shall be based on the standard premium rate for the Conversion Policy according to the amount of insurance, class of risk, gender and age of the applicant on the date the Conversion Policy takes effect.

The Conversion Policy will become effective on the later of the date of issue or 31 days after the date insurance under the Policy ended or was reduced.

When the Policy or a Class Terminates

You and/or Your Dependent(s) may apply for a Conversion Policy if insurance under the Policy ends due to termination of the Policy or termination of Your class (as shown under Class(es) on the Schedule), provided You have been insured under the Policy or any Prior Plan for at least 5 consecutive years.

The Conversion Policy issued under this provision will be:

a) any type of individual policy of life insurance then customarily issued by Us for purposes of conversion, except term insurance;
b) issued without any supplemental benefits;

c) for an amount of life insurance that does not exceed the lesser of:
    1. $10,000; or
    2. the amount of insurance that ended under the Policy less the amount of any other group life insurance for which the applicant becomes eligible within 31 days after insurance under the Policy ended.

Premium shall be based on the standard premium rate for the Conversion Policy according to the amount of insurance, class of risk, gender and age of the applicant on the date the Conversion Policy takes effect.

The Conversion Policy will become effective on the later of the date of issue or 31 days after the date insurance under the Policy ended or was reduced.

Notice of the Right to Obtain Insurance Under this Provision

The conversion period is the period of time that is 31 days from the date insurance under the Policy ends or reduces ("Conversion Period"). When insurance ends under the Policy, notice of the right to convert may be given. If notice is not given at least 15 days after the start of the Conversion Period, an extension of the period of time in which to apply for a Conversion Policy will be allowed. Any extension will expire on the earlier of:

a) 15 days after notice has been received; or
b) 60 days after the end of the Conversion Period, even if notice is not received.

If You or any of Your Dependent(s) are entitled to obtain a Conversion Policy and die within 31 days after insurance under the Policy ends or reduces, We will pay the amount of life insurance which could have been converted, even if You or Your Dependent(s) did not apply for a Conversion Policy.

How to Request Insurance Under this Provision

Insurance is available without providing Evidence of Insurability. You or Your Dependent(s) must submit a Written Request for a Conversion Policy. The Written Request and the initial premium due must be submitted to Us within the Conversion Period.

Conversion Insurance and Your Return to Active Work

If You or any of Your Dependent(s) are issued a Conversion Policy and again become eligible for insurance under the Policy, insurance under the Policy will become effective (subject to all eligibility requirements) only if any Conversion Policy(ies) is/are surrendered to Us.

PREMIUM PAYMENTS

Capitalized terms used in this section have the meanings assigned to them in this section or in other sections of the Policy.

PAYMENT OF PREMIUMS THROUGH PAYROLL DEDUCTION

You are responsible for the payment of premiums for insurance for You and/or Your Dependent(s) under the Policy. The premium owed by You equals the total premium for all Insured Person(s).

Premiums will be automatically deducted from Your paychecks by the Policyholder, then remitted to Us, as authorized by You during the enrollment process. Please contact the Policyholder for information regarding Your paycheck deductions.

Payment of premium does not guarantee eligibility for coverage.

OPTIONS FOR PAYMENT OF PREMIUM FOR CONTINUED INSURANCE

When insurance is continued We must receive premium payment when due for insurance to remain effective, unless otherwise stated or allowed in the Policy. Premium payment may be made in the following ways:

a) the Policyholder may pay the premiums; or
b) You may pay premium to the Policyholder who will then submit premium to Us.

Contact the Policyholder to determine which option is available to You.

Payment of premium does not guarantee eligibility for coverage.

GRACE PERIOD

All premiums must be paid within the grace period. There is a grace period of 60 days for payment of premiums. This means that, except for the initial premium, if premium is not paid on or before the date it is due, the premium must be paid in the 60-day period that follows. We will consider premium to be paid on the date We receive it.

Insurance for You and/or Your Dependent(s) will stay in force during the grace period, unless You or the Policyholder provides Us with written notice that insurance for You and/or Your Dependent(s) will terminate during the grace period. If We receive such notice, insurance will terminate for You and/or Your Dependent(s) on the date requested.

If any premium due is not paid during the grace period, insurance for You and/or Your Dependent(s) will end on the last day of the grace period. If insurance ends, it may be reinstated as described in the Reinstatement of Insurance provision.

PREMIUM CHANGES

If You request a change in the amount of insurance for You and/or Your Dependent(s), the Policyholder will provide You with notice of Your new premium amount upon request if You are responsible for the payment of premiums for insurance.

If there is a change in the amount of the premium for insurance for You and/or Your Dependent(s) in accordance with the terms of the Policy, or a change in the amount of insurance for You and/or Your Dependent(s) as the result of a request of the Policyholder, the Policyholder will provide You with notice of the change at least 15 days prior to the date of the change if You are responsible for the payment of premiums for insurance.

Premium amounts will change if:

a) You reach the Attained Age of the next higher age band in the premium rate structure for the Policy; or
b) You reach an Attained Age at which benefits are reduced as described in the Benefit Reductions provision in the Schedule; or
c) premium rates under the Policy are changed.

LIFE INSURANCE BENEFITS

Capitalized terms used in this section have the meanings assigned to them in this section or in other sections of the Policy.

BENEFITS

In the event of death while insured under the Policy, We will pay the amount of life insurance in effect at the time of death for You or any of Your Dependent(s), if applicable. Benefits payable by reason of Your death will be paid to Your beneficiary. Benefits payable by reason of the death of Your Dependent(s), if applicable, will be paid to You.

BENEFICIARY DESIGNATION

At the time You elect(ed) insurance under the Policy or any Prior Plan, a beneficiary should be designated. Beneficiary records will be kept by the Policyholder, Plan Administrator or the office where beneficiary records for the Policy are kept. The most current beneficiary designation in effect under a Prior Plan will be accepted as a beneficiary designation under the Policy.

If You have not designated a beneficiary, or no beneficiary survives You, in the event of Your death, benefits will be paid to:

a) Your surviving Spouse; if none, then to
b) Your surviving natural and/or adopted child(ren), in equal shares; if none, then to
c) Your surviving parent(s), in equal shares; if none, then to
d) Your estate.

Certain states are community property states. If You live in a community property state and You designate someone other than Your Spouse as a beneficiary, state law may require that Your Spouse consent to such designation. If You do not obtain Your Spouse's consent to the designation, then such designation may not be effective. Community property states as of the Policy Effective Date include: Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington and Wisconsin.

You are the beneficiary of Your Dependent(s) benefits. If You are not living at the time of the death of any of Your Dependent(s), the following will apply:

a) In the event of the death of Your Spouse, benefits will be paid to Your Spouse's estate.
b) In the event of the death of any of Your Dependent child(ren), benefits will be paid to Your Spouse, if Your Spouse is living. If Your Spouse is not living, benefits will be paid in equal shares to the deceased child's living siblings. If there are no living siblings, benefits will be paid to the estate of the deceased child.

Any benefits paid to a minor may be paid to the legally appointed guardian of the minor.

BENEFICIARY CHANGE

Your beneficiary may be changed, subject to any restrictions or limitations in the Policy. To make a change, a Written Request should be provided to the Policyholder, Plan Administrator or to the office where beneficiary records for the Policy are kept. If You do not know where the records are kept, then You may send the Written Request to Us. When received by the Policyholder, the change will take effect as of the date the Written Request is signed. The change will not apply to any payments or other action taken by Us before the Written Request was received.

FACILITY OF PAYMENT

We may pay an amount of up to $500 to any person or entity that has incurred expenses related to Your death and subsequent burial, or to the death and subsequent burial of any of Your Dependent(s), if applicable. An amount, if paid, will be deducted from the amount of life insurance benefits payable.

LIFE INSURANCE BENEFITS EXCLUSION

We will not pay benefits for a death which results from suicide, while sane or insane, within two years from the date insurance begins (under the Policy or any Prior Plan). Instead, We will refund the total of the premiums paid for insurance under the Policy to the beneficiary.

If death results from suicide, while sane or insane, within two years from the effective date of any increase in the amount of insurance under the Policy, benefits in the amount of the increase will not be paid. Instead, We will refund the total of the premiums paid under the Policy for said increase in insurance to the beneficiary.

LIVING BENEFITS (ACCELERATED BENEFIT)

Capitalized terms used in this section have the meanings assigned to them in this section or in other sections of the Policy.

This section only applies to the life insurance offered by the Policy. Accidental death and dismemberment (AD&D) insurance is not included under this section.

The benefits received under this section may be taxable. Receipt of Living Benefits may adversely affect eligibility for Medicaid or other government benefits or entitlements. You should consult Your personal tax advisor or the Social Security Administration before requesting Living Benefits.

DEFINITIONS

Living Benefits means an advance payment of part of Your life insurance death benefit.

Terminal Condition means an Injury or Sickness that is expected to result in Your death within the next 12 months as certified by an attending Physician's written statement.

ABOUT LIVING BENEFITS

If You incur a Terminal Condition while insured under the Policy, You, Your Spouse or Your legal representative may submit a Written Request for Living Benefits.

The maximum amount of Living Benefits available is 75% of the amount of life insurance for You in effect at the time of the request or $225,000, whichever is less. The minimum amount is 10% of the amount of life insurance in effect for You at the time of the request or $1,000, whichever is greater.

We will pay Living Benefits to You in a lump sum, provided You are living at the time payment is made.

The amount of life insurance benefits payable for You in the event of death will be reduced by the amount of Living Benefits paid for You. Life insurance on other Insured Persons, if any, is not affected by payment of Living Benefits for You. Payment of Living Benefits has no effect on accidental death and dismemberment (AD&D) insurance benefits.

APPLYING FOR LIVING BENEFITS

To apply for Living Benefits, You, Your Spouse or Your legal representative must provide Us:

a) a Written Request for Living Benefits;
b) satisfactory proof of Your Terminal Condition, including an attending Physician's written statement; and
c) a statement of consent from any beneficiary(ies) or assignee(s).

You, Your Spouse or Your legal representative will receive information at the time of benefit payment about the amount of life insurance remaining in force after payment of Living Benefits.

CONDITIONS OF LIVING BENEFITS

Living Benefits are subject to the following conditions:

a) Living Benefits are payable for You only once under the Policy;
b) You can request Living Benefits in any $1,000 increment, subject to the limits specified in this section;
c) Premium must continue to be paid on the full amount of life insurance, unless subject to waiver of premium under the Continuation of Insurance for Total Disability with Waiver of Premium provision;
d) The amount of insurance You may obtain under the Conversion provision will be reduced by the amount of Living Benefits paid for You; and
e) The Portability provision is not available for You after payment of Living Benefits.

WHEN LIVING BENEFITS ARE NOT AVAILABLE

Living Benefits are not available:

a) when You have irrevocably assigned life insurance under the Policy;
b) if such benefits were paid under a Prior Plan;
c) when all or a portion of the life insurance benefits under the Policy are to be paid to a former Spouse as part of a divorce agreement or pursuant to a court order;
d) for any Terminal Condition caused by a suicide attempt or an intentionally self-inflicted Injury;
e) during any Conversion or Portability Period;
f) if the required premium is due and unpaid on the date the Written Request for Living Benefits is made;
g) if requested after insurance under the Policy ends; or
h) if requested after the Policy terminates.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS RIDER

This rider is made a part of group Policy GVTL-BJXW. It is subject to all of the Policy provisions which are not inconsistent with the provisions of this rider.

This rider is effective the later of October 1, 2019 or the day You become insured under the Policy.

Capitalized terms used in this rider have the meanings assigned to them in this rider or in the other sections of the Policy.

DEFINITIONS

Accident means an external, sudden, unexpected, unforeseeable and unintended event, independent of Sickness and all other causes. Accident does not include Sickness, disease, bodily or mental infirmity or medical or surgical treatment thereof, or bacterial or viral infection, regardless of how contracted. Accident does include bacterial infection that is the natural and foreseeable result of an accidental external bodily Injury or accidental food poisoning.

Airbag means any factory-installed, inflatable, supplemental restraint device which meets published federal safety standards.

Automobile means a licensed private passenger motor vehicle for use on public roadways.

Childcare means care provided for children on a regular basis for daily periods of less than 24 hours, whether the care is for daytime or nighttime hours. This care must be provided by an adult other than a person who is part of the Insured Person's Family.

Coma, Comatose means the Insured Person is in a profound stupor or state of complete and total unconsciousness with a Glasgow Coma Score of eight (8) points or less, as a result of an Injury.

Family means Spouse, former Spouse, children, parents, grandparents, grandchildren, brothers, sisters and the spouses of such individuals.

Intoxicated means having a blood alcohol level, at the time of the Accident, which equals or exceeds the legal limit for operating a motor vehicle in the jurisdiction in which the loss occurs.

Loss of a Hand or Foot means Severance of at least four whole fingers from one hand or Severance of the foot above the ankle joint.

Loss of Hearing means total and permanent loss of hearing in both ears which cannot be corrected by any means.

Loss of Sight means total and permanent loss of sight of the eye which cannot be corrected by any means.

Loss of Speech means total and permanent loss of audible communication which cannot be corrected by any means.

Loss of a Thumb and Index Finger means Severance at or proximal to the metacarpophalangeal joints (the joints that connect the fingers and the hand).

Paralysis means total and permanent loss of use of a limb without Severance. This loss must be determined by a Physician to be complete and irreversible.

Participation in a Riot means actively participating in a tumultuous disturbance of the peace by three or more persons assembling together of their own authority with intent to mutually assist one another in an illegal or legal act.

Seat Belt means a factory-installed lap and shoulder seat belt or other restraint device which meets published federal safety standards.

Severance means the complete separation and dismemberment of the part from the body.

Traveling on Business of the Policyholder means any trip made by You on assignment by or with authorization of the Policyholder for the purpose of furthering the business of the Policyholder. If this trip is made on a private aircraft, then the aircraft must:

a) have a current and valid Federal Aviation Administration of the United States (FAA) standard airworthiness certificate; and
b) be operated by a person holding a current and valid FAA pilot's certificate authorizing him or her to operate the aircraft.

EXPOSURE AND DISAPPEARANCE

An Insured Person will be presumed to have died, for the purposes of accidental death and dismemberment insurance, if after the forced landing, stranding, sinking or wrecking of a vehicle:

a) the Insured Person disappears;
b) the Insured Person's body is not found; and
c) a valid death certificate is issued by a court of appropriate jurisdiction.

BENEFITS

Basic Benefits

In the event of a loss while insured under the Policy, We will pay accidental death and dismemberment benefits based upon the amount of the Principal Sum in effect at the time of the loss for You or any of Your Dependent(s), if applicable. Benefits for Your insurance will be payable to You or to the beneficiary for life insurance under the Policy, unless otherwise indicated in a benefit provision included in this section. Benefits for Your Dependent(s), if applicable, will be payable to You unless otherwise indicated in a benefit provision in this section.

If an Insured Person is Injured or dies as a result of an Accident, We will pay the benefit shown in the following Table. If an Accident causes more than one loss shown in the Table, We will pay only the largest benefit.

Accidental Death and Dismemberment Benefits Table (the "Table")

Loss	Benefit
Loss of Life	Principal Sum
Loss of Both Hands	Principal Sum
Loss of Both Feet	Principal Sum
Loss of Entire Sight of Both Eyes	Principal Sum
Loss of One Hand and One Foot	Principal Sum
Loss of One Hand and Entire Sight of One Eye	Principal Sum
Loss of One Foot and Entire Sight of One Eye	Principal Sum
Loss of Speech and Hearing (both ears)	Principal Sum
Loss of Entire Sight of One Eye	One-half Principal Sum
Loss of Speech or Hearing (both ears)	One-half Principal Sum
Loss of One Hand or One Foot	One-half Principal Sum
Loss of Thumb and Index Finger of same Hand	One-fourth Principal Sum
Quadriplegia (Paralysis of both upper and lower limbs)	Principal Sum
Triplegia (Paralysis of three limbs)	Three-quarters Principal Sum
Paraplegia (Paralysis of both lower limbs)	One-half Principal Sum
Hemiplegia (Paralysis of an upper and a lower limb)	One-half Principal Sum
Uniplegia (Paralysis of a limb)	One-fourth Principal Sum

Airbag Benefit

We will pay a benefit amount of 10% of the Principal Sum, up to a maximum of $25,000 if:

a) an Insured Person was Injured in an Accident while driving or riding in the front seat of an Automobile directly behind an Airbag;
b) the Insured Person's death resulted from such Injury; and
c) a copy of the police accident report is submitted with the claim.

We will not pay this benefit if the Accident occurs when the:

a) Automobile was being used for racing, stunting, or exhibition work;
b) Airbag was disengaged; or
c) Insured Person was breaking any laws of the jurisdiction in which the Accident occurred.

This benefit amount is payable in addition to any other applicable benefits under the Policy.

Common Carrier Benefit

We will pay a benefit amount of 100% of the Principal Sum, up to a maximum of $1,000,000 if:

a) an Insured Person was Injured in an Accident while riding as a fare-paying passenger in any public air, land or water conveyance provided by a common carrier primarily for passenger service; and
b) the Insured Person's death resulted from such Injury.

We will not pay this benefit if the Insured Person was an operator or member of the crew on the common carrier conveyance at the time of the Injury. This benefit amount is payable in addition to any other applicable benefits under the Policy.

Seat Belt Benefit

We will pay a benefit amount of 10% of the Principal Sum, up to a maximum of $25,000 if:

a) an Insured Person was Injured in an Accident while driving or riding in an Automobile and wearing a Seat Belt;
b) the Insured Person's death resulted from such Injury; and
c) a copy of the police accident report is submitted with the claim.

We will not pay this benefit if the Accident occurs when the:

a) Automobile was being used for racing, stunting, or exhibition work;
b) Seat Belt was used to restrain more than one person;
c) Automobile is equipped with an automatic Seat Belt and the lap belt is not fastened; or
d) Insured Person is breaking any laws of the jurisdiction in which the Accident occurred.

This benefit amount is payable in addition to any other applicable benefits under the Policy.

Childcare Benefit

We will pay a monthly benefit amount of 5% of the Principal Sum, up to a maximum of $5,000 a year. The benefit is payable for each Dependent child under the age of 12, and may be paid to You, Your Spouse or the Dependent child's legally appointed guardian, as applicable. The benefit amount will be paid at the end of the month for up to 2 year(s) if:

a) You or Your Spouse are Injured in an Accident and that Injury results in death;
b) You, Your Spouse or the Dependent child's legally appointed guardian incurs expenses for Childcare services within 365 days of Your or Your Spouse's death as a result of employment, education or training; and
c) We receive satisfactory proof of the Childcare expense incurred by You, Your Spouse or the Dependent child's legally appointed guardian.

If both parents of a Dependent child are insured under the Policy, benefits under this provision will be limited to payment under only one parent. This benefit amount is payable in addition to any other applicable benefits under the Policy.

Child Education Benefit

We will pay a benefit amount of 5% of the Principal Sum, up to a maximum of $5,000 a year. This benefit will be paid at the end of each school term for each Student for up to 4 consecutive year(s). This benefit may be paid to the Student or, if a minor child, to the Student's legally appointed guardian, if:

a) You or Your Spouse are Injured in an Accident and that Injury results in death;
b) a Dependent child is or becomes a Student within 1 year(s) after Your or Your Spouse's death;
c) the Student continues to be enrolled for each consecutive term; and
d) a copy of the Student's most recent grade report and tuition statement is submitted with the claim.

If both parents of a Student are insured under the Policy, benefits under this provision will be limited to payment under only one parent. This benefit amount is payable in addition to any other applicable benefits under the Policy.

For purposes of this benefit, the term Student does not include a Dependent child attending high school.

Continuation of Coverage for Your Dependent(s)

We will continue accidental death and dismemberment insurance under the Policy without payment of premium if:

a) You are Injured in an Accident and that Injury results in death; and

b) at the time of Your death, Your Spouse and/or Dependent child(ren) were insured under the Policy.

Insurance continued under this provision ends on the earliest of the day:
a) the Policy terminates;
b) that is 12 months after the day that insurance would otherwise end for Your Spouse and/or Dependent child(ren) under the Policy; or
c) Your Spouse and/or Dependent child(ren) becomes insured for accidental death and dismemberment insurance under the Continuation of Insurance Under Portability provision.

Spouse Education Benefit

We will pay a benefit amount of up to $3,000 a year to Your Spouse for education at an accredited trade school, college, university or other institution of higher learning. This benefit will be payable at the end of each school term for up to 4 consecutive year(s) if:
a) You are Injured in an Accident and that Injury results in Your death;
b) Your Spouse is enrolled or becomes enrolled at an accredited institution for the purpose of attaining or refreshing the skills needed for employment within 1 year(s) after Your death;
c) Your Spouse is enrolled full-time as indicated by evidence acceptable to Us.
d) Your Spouse continues to be enrolled for each consecutive term; and
e) a copy of Your Spouse's most recent grade report and tuition statement is submitted with the claim.

This benefit amount is payable in addition to any other applicable benefits under the Policy.

Coma Benefit

We will pay a monthly benefit amount of 5% of the Principal Sum. Benefits will be payable to the Insured Person's legal representative or legally appointed guardian at the end of the month for up to 20 months if:
a) the Insured Person was Injured in an Accident and, as a result, becomes Comatose within 31 consecutive days of the Injury; and
b) the Insured Person remains Comatose for 31 consecutive days.

If the Insured Person's Glasgow Coma Score temporarily becomes nine (9) points or higher and then reverts to eight (8) points or less, this will not cause a discontinuance in the benefit payment if the lapses and subsequent Coma recurrences are due to the same Injury.

Benefits will be payable until the earlier of:
a) the end of the month in which the Insured Person is no longer Comatose; or
b) the end of the month in which the Insured Person dies.

EXCLUSIONS

We will not pay for any loss which:
a) results, whether the Insured Person is sane or insane, from:
    1. an intentionally self-inflicted Injury or Sickness; or
    2. suicide or attempted suicide;
b) results from the Insured Person's Participation in a Riot or in the commission of a felony;
c) results from an act of declared or undeclared war or armed aggression;
d) is incurred while the Insured Person is on active duty or training in the Armed Forces, National Guard or Reserves of any state or country and for which any governmental body or its agencies are liable;
e) is not permanent, unless specifically provided;
f) occurs more than 365 days after the Injury, except that this 365 day limit will not apply if the Insured Person is Comatose or being kept alive by an artificial support system at the end of the 365 days;
g) does not result from an Accident;
h) is caused by intentional, self-infliction of carbon monoxide poisoning emanating from a motor vehicle;
i) results from Injuries the Insured Person receives in any aircraft while operating, riding as a passenger, boarding or leaving, unless riding as a passenger in a commercial aircraft on a regularly-scheduled flight or while You are Traveling on Business of the Policyholder;
j) results from an Injury received while riding in any aircraft engaged in:
    1. racing;
    2. endurance tests;

3. acrobatic or stunt flying;

k) is caused by the Insured Person, and is a result of Injuries received while under the influence of any controlled drug, unless administered on the advice of a Physician;

l) is caused by the Insured Person and is a result of Injuries the Insured Person receives while voluntarily Intoxicated.

UNITED OF OMAHA LIFE INSURANCE COMPANY

Corporate Secretary

PAYMENT OF CLAIMS

Capitalized terms used in this section have the meanings assigned to them in this section or in other sections of the Policy.

CLAIM FORMS

Before benefits are paid, We must be given written proof of loss as described in this section.

HOW TO OBTAIN PLAN BENEFITS

Forward the completed claim form to:
Benefits Administrator
Hoover City Schools
2810 Metropolitan Way
Hoover, Alabama 35243

CLAIM ASSISTANCE

For assistance with filing a claim or an explanation of how a claim was paid, contact:
United of Omaha Life Insurance Company
Mutual of Omaha Plaza
Omaha, Nebraska 68175
Call Toll-Free: 1-800-775-8805

PROOF OF LOSS

The Insured Person or the beneficiary has 90 days from the date of loss to furnish Us with a completed claim form and other information needed to prove loss. Failure to furnish such proof within this time period shall not invalidate nor reduce any claim if:

a) it was not reasonably possible to give proof within that 90-day period; and
b) proof is furnished as soon as reasonably possible, but not later than one year after the date of loss, unless the Insured Person or the beneficiary is not legally capable.

We may occasionally require an Insured Person to be examined by a Physician of Our choice to assist in determining whether benefits are payable. We will pay for these examinations. We will not require more than a reasonable number of examinations. Where not prohibited by law, We may also require an autopsy. We will pay for this autopsy.

PAYMENT OF CLAIMS

Benefits will be paid after We receive acceptable written proof of loss. Benefits will be paid only if We determine that the claimant is entitled to benefits under the terms of the Policy. We may require supporting information which may include, but which is not limited to, the following:

a) clinical records;
b) charts;
c) x-rays; and
d) other diagnostic aids.

Benefits will be paid to the Insured Person or the beneficiary in accord with the Life Insurance Benefits section and/or Accidental Death and Dismemberment Benefits Rider.

MODE OF PAYMENT

Life insurance benefits will be available in one lump sum. Accidental death and dismemberment benefits will be available in one lump sum unless otherwise indicated in the Accidental Death and Dismemberment Benefits Rider.

REFUND TO US

If it is found that We paid more benefits than We should have paid under the Policy, We will have the right to a refund from You or the recipient of benefits.

We also have a right to recover any payments due to:

a) fraud or misrepresentation; or
b) any error We make in processing a claim.

You or the recipient of benefits must reimburse Us in full. We will determine the method by which the repayment is to be made.

AUTHORITY TO INTERPRET POLICY

By purchasing the Policy, the Policyholder grants Us the discretion and the final authority to construe and interpret the Policy. This means that We have the authority to decide all questions of eligibility and all questions regarding the amount and payment of any Policy benefits within the terms of the Policy as interpreted by Us. Benefits under the Policy will be paid only if We decide, in Our discretion, that a person is entitled to them. In making any decision, We may rely on the accuracy and completeness of any information furnished by the Policyholder, an Insured Person or any other third party.

The Policyholder further grants Us the authority to delegate to third parties, including, without limitation, Mutual of Omaha Insurance Company and any third party administrator with whom We have contracted to provide claims administration and other administrative services, the discretionary authority granted in the Policy. The Policyholder expressly grants such third party the full discretionary authority granted to Us under this Policy.

The Insured Person or beneficiary has the right to request a review of Our decision. If, after exercising the Policy's review procedures, the Insured Person or beneficiary's claim for benefits is denied or ignored, in whole or in part, the Insured Person or beneficiary may file suit and a court will review the Insured Person or beneficiary's eligibility or entitlement to benefits under the Policy.

The Policyholder, as Plan sponsor, agrees that the Policyholder retains full responsibility for the legal and tax status of its benefits program and releases Us from all responsibility for the reporting and the employment-based design of the program and from all other responsibilities not accepted in writing by Our authorized representative in Our home office.

CLAIM REVIEW AND APPEAL PROCEDURES FOR LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Capitalized terms used in this section have the meanings assigned to them in this section or in other sections of the Policy.

IMPORTANT NOTICE: In addition to the requirements described in this document, applicable state laws may contain requirements for claims review and appeal procedures. To the extent that any requirement in this document is inconsistent with any state law requirement, the requirement that is most favorable to the person insured under the Policy shall prevail. If you have any questions, please contact Us.

DEFINITIONS

The definitions set forth below shall apply to both the singular and plural versions of the defined term.

Adverse Benefit Determination means a denial, reduction, or termination of a benefit or a failure to provide or make payment (in whole or in part) for a benefit. This includes, without limitation, any such denial, reduction or termination of a benefit, or failure to provide or make payment, that is based upon ineligibility for insurance under the Policy.

Claimant means the person who submits a claim for benefits under the Policy, including the authorized representative of such person.

CLAIM REVIEW PROCEDURES

Once We receive information necessary to evaluate the claim, We will make a decision within the time periods set forth below. In the event an extension is necessary due to matters beyond Our control, We will notify the Claimant of the extension and the circumstances requiring the extension.

Except where the Claimant voluntarily agrees to provide Us with additional time, extensions are limited as set forth below. If an extension is necessary due to the Claimant's failure to submit complete information, We will notify the Claimant of the additional information required. Such notice of incomplete information will be sent within the time periods set forth below

In order for Us to continue processing the claim, the missing information must be provided to Us within the time periods set forth below. The Claimant may contact Us at any time for additional details about the processing of the claim.

INITIAL CLAIM DECISION

The period of time within which a claim decision will be made begins at the time the claim is filed, without regard to whether all the information necessary to make a claim decision accompanies the filing. The applicable time periods are shown below:

a) Initial claim decision period: 90 days
b) Extension period: 90 days

If additional information is needed, We will notify the Claimant within 15 days of Our receipt of the claim. Once the Claimant receives Our request for additional information, the Claimant will be given no less than 30 days to submit the additional information to Us. We will make Our determination within 60 days of Our receipt of the additional information. If We do not receive the additional information within the specified time period, We will make Our determination based upon the available information.

CLAIM DENIALS

If a request for a claim is denied, in whole or in part, the Claimant will receive notice of the denial, which will include:

a) the specific reason(s) for the denial;
b) reference to the specific Policy provisions on which the denial is based;
c) a description of the appeal procedures and time limits applicable to such procedures, including the right to request an appeal within 60 days and the right to bring a civil action following the appeal process; and

d) any other information which may be required under state or federal laws and regulations.

Additionally, if an internal rule, guideline, protocol or other similar criterion was relied upon in making the Adverse Benefit Determination, the Claimant has the right to request information about such internal rule, guideline, protocol or other similar criterion that was used in making the Adverse Benefit Determination, free of charge.

OPPORTUNITY TO REQUEST AN APPEAL

The Claimant shall have a reasonable opportunity to appeal a claim review decision. As part of the appeal, there will be a full and fair review of the claim review decision.

The Claimant will have no later than 60 days from the Claimant's receipt of notification of Our claim review decision to submit a request for an appeal. The request for an appeal should include:

a) the Insured Person's name;
b) the name of the person filing the appeal if different from the Claimant;
c) the Policy number; and
d) the nature of the appeal.

The request for an appeal can be submitted in any manner and should include any additional information that may have been omitted from Our review or that should be considered by Us. The notification regarding Our claim review decision will include instructions on how and where to submit an appeal.

By requesting an appeal, the Claimant has authorized Us, or anyone designated by Us, to review any and all records (including, but not limited to, medical records) which We determine may be relevant to the appeal.

RESPONSE TO APPEALS

We will respond no later than 60 days from Our receipt of the request for an appeal. However, if We determine that an extension is required, We will notify the Claimant in writing of the extension prior to the termination of the initial appeal period. In no event will the extension exceed 60 days from the end of the initial appeal period. The extension notice will indicate the special circumstances requiring the extension and the date by which We expect to render the appeal decision.

When We make Our determination, the Claimant will be provided with:

a) information regarding the decision; and
b) information regarding other internal or external appeal or dispute resolution alternatives, including any required state mandated appeal rights.

The period of time within which an appeal decision is required to be made will begin at the time an appeal is filed, without regard to whether all the information necessary to make an appeal decision accompanies the filing. If a period of time is extended as described above due to the Claimant's failure to submit information necessary to decide a claim, the period for making the appeal decision shall be "tolled" or suspended from the date on which the extension notice is sent until the earlier of (1) the date on which We receive the response; or (2) the date established by Us in the notice of extension for the furnishing of the requested information.

CLAIM REVIEW AND APPEAL PROCEDURES FOR CONTINUATION OF INSURANCE FOR TOTAL DISABILITY BENEFITS

Capitalized terms used in this section have the meanings assigned to them in this section or in other sections of this Certificate.

DEFINITIONS

The definitions set forth below shall apply to both the singular and plural versions of the defined term.

Adverse Benefit Determination means a denial, reduction, or termination of a benefit or a failure to provide or make payment (in whole or in part) for a benefit. This includes, without limitation, and such denial, reduction or termination of a benefit, or failure to provide or make payment, that is based upon ineligibility for insurance under the Policy.

Claimant means the person who submits a claim for benefits under the Policy, including the authorized representative of such person.

CLAIM REVIEW PROCEDURES

Once We receive information necessary to evaluate the claim, We will make a decision within the time periods set forth below. In the event an extension is necessary due to matters beyond Our control, We will notify the Claimant of the extension and the circumstances requiring the extension.

Except when the Claimant voluntarily agrees to provide Us with additional time, extensions are limited as set forth below. If an extension is necessary due to the Claimant's failure to submit complete information, We will notify the Claimant of the additional information required. Such notice of incomplete information will be sent within the time periods set forth below.

In order for Us to continue processing the claim, the missing information must be provided to Us within the time periods set forth below. The Claimant may contact Us at any time for additional details about the processing of the claim.

INITIAL CLAIM DECISION

The period of time within which a claim decision will be made begins at the time the claim is filed, without regard to whether all the information necessary to make a claim decision accompanies the filing. The applicable time periods are shown below:

a) initial claim decision period: 45 days unless additional information is requested as set forth below;
b) extension period: 30 days; and
c) maximum number of extensions: two.

If additional information is needed, We will notify the Claimant within 10 days of Our receipt of the claim. Once the Claimant receives Our request for additional information, the Claimant will be given no less than 45 days to submit the additional information to Us. We will make Our determination within 15 days of Our receipt of the additional information. If We do not receive the additional information within the specified time period, We will make Our determination based upon the available information.

CLAIM DENIALS

If a request for a claim is denied, in whole or in part, the Claimant will receive notice of the denial, which will include:

a) the specific reason(s) for the denial;
b) reference to the specific Policy provisions on which the denial is based;
c) a description of the appeal procedures and time limits applicable to such procedures, including the right to request an appeal within 180 days and the right to bring a civil action following the appeal process; and
d) any other information which may be required under state or federal laws and regulations.

Additionally, if an internal rule, guideline, protocol or other similar criterion was relied upon in making the Adverse Benefit Determination, the Claimant has the right to request information about such internal rule, guideline, protocol or other similar criterion that was used in making the Adverse Benefit Determination, free of charge.

OPPORTUNITY TO REQUEST AN APPEAL

The Claimant shall have a reasonable opportunity to appeal a claim review decision. As part of the appeal, there will be a full and fair review of the claim review decision.

The Claimant will have no later than 180 days from the Claimant's receipt of notification of Our claim review decision to submit a request for an appeal. The request for an appeal should include:

a) the Claimant's name;
b) the name of the person filing the appeal if different from the Claimant;
c) the Policy number; and
d) the nature of the appeal.

The request for an appeal can be submitted in any manner and should include any additional information that may have been omitted from Our review or that should be considered by Us. The notification regarding Our claim review decision will include instructions on how and where to submit an appeal.

By requesting an appeal, the Claimant has authorized Us, or anyone designated by Us, to review any and all records (including, but not limited to, medical records) which We determine may be relevant to the appeal.

A document, record, or other information will be considered relevant to a claim if it:

a) was relied upon in making the claim decision;
b) was submitted, considered, or generated in the course of making the claim decision, without regard to whether it was relied upon in making the claim decision; or
c) demonstrates compliance with administrative processes and safeguards designed to ensure and verify that claim decisions are made in accordance with the Policy and that, where appropriate, Policy provisions have been applied consistently with respect to similarly situated claimants.

RESPONSE TO APPEALS

We will respond no later than 45 days from Our receipt of the request for an appeal. However, if We determine that an extension is required, We will notify the Claimant in writing of the extension prior to the termination of the initial appeal period. In no event will the extension exceed 45 days from the end of the initial appeal period. The extension notice will indicate the special circumstances requiring the extension and the date by which We expect to render the appeal decision.

When We make Our determination, the Claimant will be provided with:

a) information regarding the decision; and
b) information regarding other internal or external appeal or dispute resolution alternatives, including any required state mandated appeal rights.

The period of time within which an appeal decision is required to be made will begin at the time an appeal is filed, without regard to whether all the information necessary to make an appeal decision accompanies the filing. If a period of time is extended as described above due to the Claimant's failure to submit information necessary to decide a claim, the period for making the appeal decision shall be "tolled" or suspended from the date on which the extension notice is sent until the earlier of (1) the date on which We receive the response; or (2) the date established by Us in the notice of extension for the furnishing of the requested information.

STANDARD PROVISIONS

Capitalized terms used in this section have the meanings assigned to them in this section or in other sections of the Policy.

INSURANCE CONTRACT

The insurance contract consists of:

a) the Policy;
b) the Policyholder's signed application attached to the Policy; and
c) any signed application for You or Your Dependent(s).

Statements in an application are considered representations and not warranties. We will not use any statements in an Insured Person's application to deny a claim or to contest the validity of this insurance unless We provide You or Your beneficiary with a copy of that application.

CHANGES IN THE INSURANCE CONTRACT

The insurance contract may be changed (including reducing or terminating benefits or increasing premium costs) any time We and the Policyholder both agree to a change. No one else has the authority to change the insurance contract. A change in the insurance contract:

a) does not require the consent of any Insured Person or beneficiary; and
b) must be:
    1. in writing;
    2. made a part of the Policy; and
    3. signed by Our authorized representative in Our home office.

A change may affect any class of Insured Persons included in the Policy.

INCONTESTABILITY

We will not use any statements in an Insured Person's application to contest the validity of this insurance after it has been in-force during the lifetime of the Insured Person for two years.

LEGAL ACTIONS

No legal action can be brought until at least 60 days after We have been given written proof of loss. No legal action can be brought more than six years after the date written proof of loss is required, unless otherwise required by state law in Your state of residence.

GENERAL DEFINITIONS

The following capitalized terms have the meanings assigned in this section. These terms are used throughout the Policy.

Annual Earnings means Your gross annual earnings received from the Policyholder and in effect immediately prior to the date of loss, as determined by the Policyholder and verified by the premium received by Us.

Your annual earnings include Your contributions to deferred compensation plans.

Your annual earnings do not include commissions, bonuses, overtime pay, other extra compensation, shift differential, or the Policyholder's contributions to deferred compensation plans.

Attained Age means the age of the Insured Person as of the Policy Anniversary that coincides with or follows the Insured Person's birthday. For example, if an Insured Person's 50th birthday is on January 1, 2021 and the Policy Anniversary is October 1, the Insured Person will reach the attained age of 50 on October 1, 2021.

Certificate means this document that describes the benefits, terms, conditions, exclusions and limitations of the insurance provided under the Policy.

Dependent means a citizen, permanent resident or lawful resident of the United States who, as indicated by evidence acceptable to Us, is:

a) Your Spouse;
b) Your natural born or legally adopted child;
c) Your stepchild; or
d) any other child who lives with You in a regular parent/child relationship and who qualifies as Your "dependent" as defined in the United States Internal Revenue Code.

A dependent does not include:

a) anyone who is a member of the Armed Forces, National Guard or Reserves of any state or country on active duty (except for temporary duty of 31 days or less);
b) Your divorced, legally separated or former Spouse;
c) a child less than 14 days old;
d) a child who has reached the age of 26 unless the child is Incapacitated;
e) Your child if the child has been legally adopted by another person; or
f) a child placed in Your home by a social service agency which retains control over the child.

Employee means a person who is:

a) a citizen or permanent resident of the United States; or
b) lawfully and legally able to work in the United States pursuant to applicable federal and state laws; and
c) receiving compensation from the Policyholder for work performed for the Policyholder at:
    1. the Policyholder's usual place of business;
    2. an alternative work site at the direction of the Policyholder; or
    3. a location to which the employee must travel to perform the job.

An employee does not include a person:

a) who resides outside the United States for a period in excess of 12 consecutive months unless written approval has been received from Our authorized representative in Our home office;
b) working on a seasonal or temporary basis; or
c) performing services for the Policyholder as an independent contractor, including persons reporting income on a 1099 form or subject to the terms of a leasing agreement between the Policyholder and a leasing organization.

Evidence of Insurability means proof of good health acceptable to Us. This proof may be obtained through questionnaires, physical exams or written documentation, as required by Us.

First Enrollment Period means the 31-day period following the day the Employee or Dependent becomes eligible for insurance under the Policy or any Prior Plan.

Guarantee Issue Amount means the amount of life insurance We may issue without requiring Evidence of Insurability.

Hospital means an accredited facility licensed by the proper authority of the area in which it is located to provide care and treatment for the condition causing confinement. A hospital does not include a facility or institution or part of a facility or institution which is licensed or used principally as a clinic, convalescent home, rest home, nursing home or home for the aged, halfway house or board and care facilities.

Incapacitated means that a Dependent child is continuously incapable of self-sustaining employment by reason of intellectual disability, developmental disability, mental illness or physical handicap.

Injured means the occurrence of an Injury.

Injury, Injuries means an accidental bodily injury that requires treatment by a Physician. It must result in loss independently of Sickness and other causes.

Insured Person(s) means You and/or Your Dependent(s) who are insured under the Policy.

Our, We, Us means United of Omaha Life Insurance Company.

Physician means any of the following licensed practitioners:

a) a doctor of medicine (MD), osteopathy (DO), podiatry (DPM) or chiropractic (DC);
b) a licensed doctoral clinical psychologist;
c) a Master's level counselor and licensed or certified social worker who is acting under the supervision of a doctor of medicine or a licensed doctoral clinical psychologist;
d) a licensed physician's assistant (PA) or nurse practitioner (NP); or
e) where required by law, any other licensed practitioner of a healing art who is acting within the scope of his/her license.

A physician does not include:

a) a naturopathic doctor;
b) an acupuncturist;
c) a physician in training; or
d) You, Your Spouse or a child, brother, sister or parent of You or Your Spouse or any person who lives with You.

Plan Administrator means the person or entity designated as the plan administrator for the Policyholder's group life insurance plan.

Policy means the group policy issued to the Policyholder by Us, including this Certificate.

Policy Anniversary means October 1 of each Policy Year.

Policy Effective Date means October 1, 2019.

Policy Year means the period commencing on the Policy Effective Date and ending on the next succeeding Policy Anniversary and, thereafter, each 12-month period commencing on the Policy Anniversary.

Prior Plan means any policy or plan of benefits:

a) replaced by insurance under part or all of the Policy; and
b) in effect and maintained or sponsored by the Policyholder on the day before the Policy Effective Date.

Schedule means the section of the Certificate identified as the "Schedule".

Sickness means a disease, disorder or condition that requires treatment by a Physician.

Spouse means the person to whom You are legally married.

Student means Your Dependent child who attends an accredited high school, trade school, college, university or other institution of higher learning and is enrolled full-time as indicated by evidence acceptable to Us. Student includes a Dependent child who would otherwise qualify as a student but cannot maintain full-time enrollment due to Sickness or Injury.

Subsequent Enrollment Period means any period of up to 31 consecutive calendar days designated for enrollment under the Policy by the Policyholder and agreed to in writing by Our authorized representative in Our home office.

Written Request means a request that is signed, dated and submitted to the Policyholder or Us. The request must be on a form We supply or be in a form and content acceptable to Us.

You, Your means the Employee who is insured under the Policy.

Group Voluntary Term Life Benefits

Hoover City Schools

Group Number: G000BJXW

United of Omaha Life Insurance Company

Home Office:
Mutual of Omaha Plaza
Omaha, Nebraska 68175

YOUR GROUP VOLUNTARY SHORT-TERM DISABILITY BENEFITS

FOR EMPLOYEES OF:

Hoover City Schools

CLASS(ES):

All Eligible Employees

REVISION EFFECTIVE DATE:

October 1, 2019

PUBLICATION DATE:

October 31, 2019

NOTICE(S)

THIS CERTIFICATE DESCRIBES THE BENEFITS THAT ARE AVAILABLE TO YOU. PLEASE READ YOUR CERTIFICATE CAREFULLY. BENEFITS ARE PROVIDED THROUGH A GROUP POLICY ISSUED IN THE STATE OF ALABAMA.

FRAUD WARNING
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Group Number: G000BJXW

If You have any questions about or concerns with this insurance, please first contact the Policyholder or Your benefits administrator. If, after doing so, You still have a question or concern, You may contact Us at:

United of Omaha Life Insurance Company
Mutual of Omaha Plaza
Omaha, Nebraska 68175
Call Toll-Free: 1-800-877-5176
www.mutualofomaha.com

When contacting Us, please have Your Policy number available.

TABLE OF CONTENTS

PAGE

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CERTIFICATE OF INSURANCE

UNITED OF OMAHA LIFE INSURANCE COMPANY

Home Office:
Mutual of Omaha Plaza
Omaha, Nebraska 68175

United of Omaha Life Insurance Company certifies that Group Policy Number GUC-BJXW (the Policy) has been issued to Hoover City Schools (the Policyholder).

Insurance is provided for Employees of the Policyholder subject to the terms and conditions of the Policy.

Please read this Certificate carefully. The benefits described in this Certificate are effective only if You are eligible for the insurance, become insured and remain insured as described in this Certificate and according to the terms and conditions of the Policy.

If the provisions of this Certificate and those of the Policy do not agree, the provisions of the Policy will apply. The Policy is part of a contract between United of Omaha Life Insurance Company and the Policyholder, and may be amended, changed or terminated without Your consent or notice to You.

This Certificate replaces any certificate previously issued under the Policy.

James T. Blackledge
Chief Executive Officer

Daryl Vanbeat
Corporate Secretary

SCHEDULE

This Schedule describes some of the terms and conditions of the Policy including, but not limited to, the maximum amounts of benefits payable under the Policy, exclusions, and limitations. For a complete description of the terms and conditions of the Policy, refer to the appropriate section of this Certificate.

A person is not necessarily entitled to insurance under the Policy because he or she received this Schedule. A person is only entitled to insurance if he or she is eligible in accordance with the terms of this Certificate. Capitalized terms used in this section have the meanings assigned to them in this section or in other sections of the Policy.

POLICY INFORMATION

Policyholder:	Hoover City Schools
Policy Effective Date:	October 1, 2019
Policy Anniversary:	October 1
Policy Number:	GUC-BJXW
Group Number:	G000BJXW
Classification:	All Eligible Employees
Minimum Work Hours Required:	20 hours per week
Eligibility Present Waiting Period:	None
Eligibility Future Waiting Period:	None
When Insurance Begins:	the first day of the month that coincides with or follows the day the Employee becomes eligible. Additional eligibility conditions apply as described in the Certificate.
Elimination Period:	
Injury:	The Elimination Period is the later of: a) 30 calendar days; or b) After the exhaustion of Your accumulated sick leave, paid time off (PTO) and vacation.
Sickness:	The Elimination Period is the later of: a) 30 calendar days; or b) After the exhaustion of Your accumulated sick leave, paid time off (PTO) and vacation.

BENEFITS

Weekly Benefit Percentage:	60%
Maximum Weekly Benefit:	$1,500
Minimum Weekly Benefit:	$25
Maximum Benefit Period:	22 weeks
Portability:	Included
Vocational Rehabilitation Benefit:	10%

EXCLUSION

Pre-existing Condition Exclusion:	3/6

DEFINITIONS

The definitions set forth below shall apply to both the singular and plural versions of the defined term.

Basic Weekly Earnings for salaried Employees means Your gross annual salary from the Policyholder in effect on the day immediately prior to the date on which Your Disability began, divided by 52.

Basic weekly earnings for hourly Employees means Your hourly rate of pay from the Policyholder in effect on the day immediately prior to Your Disability multiplied by the average number of hours You worked per week, not including overtime, during the 12 month period immediately prior to the date on which Your Disability began. If You were employed with the Policyholder for a period of less than 12 months, basic weekly earnings means Your hourly rate of pay multiplied by the average number of hours You worked per week during that period, not including overtime.

Basic weekly earnings is verified by premium We have received.

Basic weekly earnings includes Employee contributions to Deferred Compensation plans received from the Policyholder.

Basic weekly earnings does not include commissions, bonuses, overtime pay, Policyholder contributions to Deferred Compensation plans, Differentials, and other extra compensation received from the Policyholder.

Proof of Earnings is required.

Differentials mean additional compensation You receive from the Policyholder for time or duties beyond those normally required or to accommodate specific working conditions, including, but not limited to:

a) shift differentials;
b) hazardous duties differentials;
c) pay for longevity;
d) on-call pay;
e) lead nurse differentials;
f) English as a Second Language (ESL) differentials;
g) charge pay;
h) weekend differentials;
i) coaching and other extra curricular activities compensation; and
j) on-call differentials.

Other Income Source(s) has the meaning set forth in the Other Income Sources provision of this Schedule.

Recurrent Disability means a Disability which is caused by, attributable to, or resulting from the same Injury or Sickness that caused the prior Disability for which You received a Weekly Benefit under the Policy.

Reimbursement Agreement means the written agreement that We provide to You under which You agree to repay Us any overpayment resulting from Your or Your Spouse's or child(ren)'s receipt of Other Income Sources.

Social Security Normal Retirement Age (SSNRA) means Your normal retirement age under the U. S. Social Security Act in effect as of the date of Your Disability.

ELIMINATION PERIOD

If Your Disability is a result of an Injury, the Elimination Period is the later of:

a) 30 calendar days. If Your Disability begins more than 7 calendar days after Your Injury date, the Elimination Period for Sickness will apply; or
b) the date on which You have exhausted Your accumulated sick leave, paid time off (PTO) and vacation.

If Your Disability is a result of a Sickness, the Elimination Period is the later of:

a) 30 calendar days; or
b) the date on which You have exhausted Your accumulated sick leave, paid time off (PTO) and vacation.

The Elimination Period begins on the first day of Disability. The Elimination Period can be satisfied if You are working.

RECURRENT DISABILITY

A Recurrent Disability will be treated as part of Your prior claim and You will not be required to satisfy a new Elimination Period if:

a) You were continuously insured under the Policy from the date benefits ended for Your prior claim to the date Your Recurrent Disability begins; and
b) Your Recurrent Disability occurs within 180 days after the date benefits ended for Your prior claim.

In order to prevent over-insurance because of duplication of benefits, benefits payable under this Recurrent Disability provision will cease if benefits are payable to You under any other Policyholder sponsored group long-term disability income policy or plan.

WEEKLY BENEFIT

Total Disability

If You are Disabled and earning less than 20% of Your Basic Weekly Earnings, the Weekly Benefit while Disabled is the lesser of:

a) 60% of Your Basic Weekly Earnings, less Other Income Sources; or
b) the Maximum Weekly Benefit, less any Other Income Sources.

Partial Disability

If You are Disabled and You are able to generate Current Earnings of at least 20% and not more than 99% of Your Basic Weekly Earnings, the Weekly Benefit payable will be the Weekly Benefit for Total Disability, unless the sum of:

a) the Gross Weekly Benefit while You are Disabled; plus
b) Other Income Sources You receive or are eligible to receive; plus
c) Current Earnings while You are Disabled

exceeds 100% of Your Basic Weekly Earnings. If this sum exceeds 100% of Your Basic Weekly Earnings, the Weekly Benefit will be reduced by the amount in excess of 100% of Your Basic Weekly Earnings.

INTEGRATION ABOVE 100% OF COMBINED EARNINGS

Your Weekly Benefit, as calculated above, will be reduced by the amount of salary continuance, sick leave benefits and severance pay for which You are eligible or that You receive from the Policyholder that, when combined with Your Weekly Benefit, exceeds 100% of Your Basic Weekly Earnings. The Weekly Benefit will be reduced by such amount to the extent the Weekly Benefit exceeds 100% of Your Basic Weekly Earnings.

MINIMUM BENEFIT

If subtracting Other Income Sources from Your Gross Weekly Benefit results in a zero benefit, a Weekly Benefit of $25 will be paid, unless We reduce the Weekly Benefit to recover an overpayment. If We reduce the Weekly Benefit to recover an overpayment, Your Weekly Benefit may be reduced to zero until We fully recover the overpayment.

When less than one week of Disability benefits is due, a pro rata benefit will be paid for each day of Disability. This pro rata benefit will be equal to 1/7th of Your Weekly Benefit.

VOCATIONAL REHABILITATION BENEFIT

While You are participating in a plan of vocational rehabilitation approved by Us, Your Weekly Benefit will be increased by 10%.

MAXIMUM BENEFIT PERIOD

The maximum number of weeks that benefits are payable for a continuous period of Disability is 22 weeks.

OTHER INCOME SOURCES

We take into account the total of all Your income from other sources of income in determining the amount of Your Weekly Benefit. Your Other Income Sources are any of the following amounts that You receive or are eligible to receive as a result of Your Disability or the Sickness and/or Injury that caused, in whole or in part, Your Disability:

a) Any amount under:
    1. a workers' compensation law up to 100%;
    2. an occupational disease law;
    3. the Jones Act, (46 U.S.C. Statute 688(a) (1920)); or
    4. any other act or law of like intent to the laws described in 1, 2 or 3 above.
b) Any amount under another group or individual short-term or long-term disability insurance policy or plan for which the Policyholder has paid any part of the cost, except any group short-term or long-term disability insurance policy or plan underwritten by United of Omaha Life Insurance Company.
c) Any amount as disability income payments under any:
    1. state compulsory benefit act or law;
    2. government retirement system as a result of Your job with the Policyholder; or
    3. work loss provision in a no-fault motor vehicle insurance plan, unless state law or regulation does not allow group disability income benefits to be reduced by benefits from no-fault motor vehicle coverage.
d) Any amount of benefits under the Policyholder's Retirement Plan. Benefits payable before the plan's normal retirement age are considered Other Income Sources only if You voluntarily elect to receive these benefits.
e) Any benefits for You or Your Spouse and Dependent Child under:
    1. the Canada Pension Plan;
    2. the Quebec Pension Plan;
    3. the Railroad Retirement Act;
    4. any public employee retirement plan;
    5. any teachers employment retirement plan; or
    6. any similar plan or act that provides:
        a. Disability benefits; or
        b. retirement benefits (except this will not apply if Your Disability begins after Your Social Security Normal Retirement Age and You were already receiving Social Security retirement benefits. This exception only applies to U.S. Social Security Benefits).
f) Any amount payable as:
    1. salary continuance, except
        a. paid time off (PTO) that is not specified as sick leave;
        b. vacation;
        c. any earned time off program;
    2. sick leave; or
    3. severance allowance.
g) Any amount from a third party (after subtracting attorneys' fees) by judgment, settlement or otherwise.
h) Any amount from any unemployment insurance law or program.

EXPLANATION OF OTHER INCOME SOURCES

You must apply for and pursue Other Income Sources for which You are or may become eligible, including but not limited to Social Security disability and/or dependent benefits, and do what is needed to obtain them. If Your application or claim for

Other Income Sources is denied, We may require that You appeal the decision to a level that is satisfactory to Us and provide written proof of all levels of appeal.

As part of Your proof of Disability, We require that You furnish evidence to Us that You have applied for and pursued Other Income Sources for which You are or may become eligible.

After the initial reduction for each type of Other Income Source, We will not further reduce Your Weekly Benefit due to any cost of living increases payable under such type of Other Income Source.

Other Income Sources that are paid in a lump sum will be prorated on a weekly basis over a period for which the sum is given. If no time period is stated, the sum will be prorated on a weekly basis over the lesser of the following:

a) the Policy's Maximum Benefit Period; or
b) 12 equal payments.

If Other Income Sources are paid on a retroactive basis, We may reduce or suspend the Weekly Benefit to recover any overpayment.

Regardless of how funds from a Retirement Plan are distributed, We will consider Your contributions and the Policyholder's contributions to be distributed simultaneously during Your lifetime.

We will pay the full amount of the Weekly Benefit if You:

a) apply for Other Income Sources; and
b) sign Our Reimbursement Agreement.

Until You have signed Our Reimbursement Agreement and have given written proof to Us that application has been made or all available appeals have been exhausted for Other Income Sources, We may:

a) estimate Your Other Income Sources; and
b) reduce Your Weekly Benefit by that amount.

If We reduce Your benefit on this basis, and if all of Your appeals are denied, We will restore Your Weekly Benefit amount and refund any underpayment to You in a lump sum.

ELIGIBILITY

Capitalized terms used in this section have the meanings assigned to them in this section or in other sections of this Certificate.

DEFINITIONS

The definitions set forth below shall apply to both the singular and plural versions of the defined term.

Actively Working, Active Work means an Employee is performing the normal duties of his or her Regular Job for the Policyholder on a regular and continuous basis 20 or more hours each week. An Employee will be considered to be actively working on any day that is a regular paid holiday or day of vacation, or regular or scheduled non-working day, provided the Employee was actively working on the last preceding regular work day.

First Enrollment Period means the 31-day period following the day the Employee becomes eligible for insurance under the Policy or any Prior Plan.

Portability Period means the period of time that is 31 days from the date Your insurance under the Policy ends.

Portability Policy means any type of group or individual disability insurance policy customarily issued by Us for purposes of providing coverage after Your insurance under the Policy ends.

Prior Plan means any group disability plan or individual worksite disability plan of benefits:

a) replaced by insurance under part or all of the Policy; and
b) in effect and maintained or sponsored by the Policyholder on the day before the Policy Effective Date.

Subsequent Enrollment Period means any period of up to 31 consecutive calendar days designated for enrollment under the Policy by the Policyholder and agreed to in writing by Our authorized representative in Our home office.

Written Request means a request that is signed, dated and submitted to the Policyholder. The request must be on a form We supply or be in a form and content acceptable to Us.

WHEN AN EMPLOYEE BECOMES ELIGIBLE FOR INSURANCE

An Employee who is Actively Working on the Policy Effective Date becomes eligible for insurance under the Policy on the Policy Effective Date.

An Employee who is hired after the Policy Effective Date becomes eligible for insurance under the Policy on the day the Employee begins Active Work.

The day on which an Employee becomes eligible for insurance under the Policy may not be the same as the day on which insurance begins. The When Insurance Begins provision describes the day on which insurance begins.

CONTINUITY OF INSURANCE UPON TRANSFER OF INSURANCE CARRIER

If You are not Actively Working on the Policy Effective Date due to Injury or Sickness, upon payment of the premium, You will be insured under the Policy if You:

a) were covered under a Prior Plan on the day before the Policy Effective Date; and
b) resume Active Work.

EFFECT OF A PRE-EXISTING CONDITION WITH PRIOR COVERAGE

Prior Individual Worksite or Group Disability Plan Coverage

If You become insured under the Policy on the Policy Effective Date and were covered under an individual worksite or group disability plan obtained through the Policyholder on the day before the Policy Effective Date, We will pay the benefit payable under the Policy. The Pre-existing Condition Exclusion provision of the Policy will not apply.

WHEN INSURANCE BEGINS

An eligible Employee must enroll for insurance by submitting a Written Request for insurance. The Written Request must be submitted to the Policyholder within 31 days following the day the Employee become(s) eligible. If the Written Request for insurance is not submitted within 31 days following the day the Employee become(s) eligible for insurance, We will require Evidence of Insurability.

An eligible Employee will become insured on the first day of the month that coincides with or follows the latest of the day:

a) the Employee begins Active Work;
b) the Employee submits a Written Request to enroll for insurance, if applicable; or
c) We approve Evidence of Insurability, if required.

If the Employee is not Actively Working on the day insurance would otherwise begin, insurance will begin on the day the Employee returns to Active Work.

EXCEPTIONS TO WHEN INSURANCE BEGINS

This provision does not apply if the Employee is eligible for coverage under the Continuity of Insurance Upon Transfer of Insurance Carrier provision.

Insurance for an Employee who has an Injury or Sickness and is confined:

a) in a Hospital as an inpatient;
b) in any institution or facility other than a Hospital; or
c) at home and under the care or supervision of a Physician;

on the day insurance is to begin will not take effect until the first day of the month that coincides with or follows the day the Employee returns to Active Work.

THE FIRST ENROLLMENT PERIOD

An Employee may elect insurance for him/herself during the Employee's First Enrollment Period.

If an Employee does not elect insurance during the Employee's First Enrollment Period, future elections may only be made in accordance with the Subsequent Enrollment Periods provision, or as otherwise provided under the When Election Changes Are Permitted provision.

SUBSEQUENT ENROLLMENT PERIODS

An Employee may elect, drop, increase, decrease or change insurance during a Subsequent Enrollment Period.

WHEN ELECTION CHANGES ARE PERMITTED

An Employee may elect, drop, increase, decrease or change insurance as allowed by the Policyholder. Any election of or increase in insurance is subject to the Pre-Existing Conditions provision of the Policy as of the effective date of the increase.

CHANGES TO INSURANCE BENEFITS

Any allowable change in Your classification or amount of insurance, whether requested by You or the Policyholder, or as a result of the terms of the Policy, will take effect on the later of the first day of the month that follows the date of the request or the change, or the first day of the month that follows the day We approve any required Evidence of Insurability.

If You are not Actively Working on the day any increase in insurance would otherwise take effect, the increase will become effective the first day of the month that follows the day You return to Active Work.

In no event will any change take effect during a period of Disability.

REINSTATEMENT OF INSURANCE

You may be eligible to reinstate insurance that has ended in accordance with this provision. You must submit a Written Request to reinstate insurance within 31 days of Your return to Active Work.

Reinstated insurance will take effect on the first day of the month that coincides with or follows the date of the Written Request, or the first day of the month that follows the day We approve any required Evidence of Insurability. If You are not Actively Working on the day the reinstated insurance would otherwise take effect, insurance will become effective on the day You return to Active Work.

Non-Payment of Premium or Voluntary Termination of Insurance

If insurance ended due to Your non-payment of premium or voluntary termination of insurance, We will require Evidence of Insurability to reinstate insurance.

WHEN INSURANCE ENDS

Insurance will end on the earliest of the day:

a) You are no longer eligible for insurance under the Policy;
b) You begin active duty in the Armed Forces, National Guard or Reserves of any state or country (except for temporary active duty of 31 days or less);
c) the Policy terminates; or
d) insurance ends in accordance with the Grace Period provision.

If You are Disabled on the day the Policy terminates, benefits will continue subject to the When Benefits End provision located in the Benefits section.

EXCEPTIONS TO WHEN INSURANCE ENDS

If insurance for You ends but the Policy is in effect, You may be able to continue or obtain insurance under one of the following provisions:

a) Continuation of Insurance During Disability
b) Continuation of Insurance Under the Family and Medical Leave Act (FMLA) and Uniformed Services Employment and Reemployment Rights Act (USERRA)
c) Portability

CONTINUATION OF INSURANCE DURING DISABILITY

If You become Disabled, Your insurance will continue for as long as You are entitled to receive Weekly Benefits. Any premium for Your insurance that is payable by You will be waived from the first day of the month following the date of Your approved Disability through the last day of the month in which Your last Disability benefit payment under the Policy is issued.

CONTINUATION OF INSURANCE UNDER THE FAMILY MEDICAL LEAVE ACT (FMLA) AND UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

The federal Family Medical Leave Act (FMLA) and Uniformed Services Employment and Reemployment Rights Act (USERRA) and any amendments thereto, as well as other applicable federal or state laws, may allow continuation of insurance in certain instances for leaves of absence, layoff or termination. Contact the Policyholder for additional information regarding any other continuation options that may be available.

PORTABILITY

When Employment or Class Membership Ends

If group disability insurance ends because Your employment or membership in a class (as shown under Classification(s) on the Schedule) ends, You have the right to continue group disability insurance under this provision.

The Portability Policy does not provide the same insurance benefits You had while insured under the Policy and premiums will change. You may contact the Policyholder or Us at any time for a description of the benefits available under the Portability Policy. The Portability Policy is subject to change.

When Portability Coverage is Available

Portability coverage is available when:

a) You are under age 70;
b) You are not Disabled;
c) You are not retired;
d) You are not on a leave of absence;
e) You are not absent due to a labor strike;
f) You are not covered under any other similar individual or group disability coverage; and
g) You were insured under the Policy (and the plan it replaced, if applicable) for at least six consecutive months immediately prior to the date Your employment or membership in a class ended.

How to Request Continued Coverage Under this Provision

Coverage under the Portability Policy begins immediately after insurance under the Policy ends, provided You are eligible for portability and submit a Written Request within the Portability Period. Evidence of Insurability is not required unless an increased level of insurance is requested.

The Portability Policy

Group insurance continued under this provision is available under another group disability insurance policy (the "Portability Policy") issued by Us. The continued group insurance under the Portability Policy is available as a result of the portability rights that arise solely from the Policy, as arranged for You as an employee welfare benefit subject to the Employee Retirement Income Security Act of 1974, as amended.

When Portability Coverage Ends

Insurance coverage continued under this provision will end in accordance with the terms of the Portability Policy.

SHORT-TERM DISABILITY BENEFITS

Capitalized terms used in this section have the meanings assigned to them in this section or in other sections of this Certificate.

DEFINITIONS

The definitions set forth below shall apply to both the singular and plural versions of the defined term.

Good Cause means documented physical or mental impairments that:
a) render You incapable of rehabilitation;
b) interfere with a medical program You are currently participating in; or
c) conflict with any other program You are participating in that will enable You to return to active employment.

Participation in a Riot means actively participating in a tumultuous disturbance of the peace by three or more persons assembling together of their own authority with intent to mutually assist one another in an illegal or legal act.

SHORT-TERM DISABILITY BENEFITS

If You become Disabled due to an Injury or Sickness, while insured under the Policy, We will pay the Weekly Benefit shown in the Schedule in accordance with the terms of the Policy. Benefits will begin after You satisfy the Elimination Period shown in the Schedule.

VOCATIONAL REHABILITATION PROVISION

If You are Disabled and are receiving Disability benefits as provided by the Policy, You may be eligible to receive vocational rehabilitation services. These services include, but are not limited to:
a) worksite modification and/or special equipment;
b) job placement;
c) retraining; and
d) other services reasonably necessary to help You return to work.

While You are participating in a plan of vocational rehabilitation approved by Us, Your Weekly Benefit will be increased by a percentage as shown in the Schedule.

Eligibility for vocational rehabilitation services is based on Your education, training, experience and physical/mental capabilities. Before vocational rehabilitation services will be considered:
a) Your Disability must not allow You to perform Your Regular Job;
b) You must have the physical and mental capability to complete a rehabilitation program; and
c) there must be reasonable expectation that rehabilitation services will help You return to active employment.

We will develop an Individual Written Rehabilitation Plan (IWRP), which may include input from You, Your Physician and the Policyholder. The IWRP will describe:
a) the vocational rehabilitation goals and services;
b) the responsibilities of Us, You and any third parties associated with the IWRP;
c) the times and dates of the vocational rehabilitation services; and
d) all costs associated with the services.

Either We, Your Physician, or You may initiate consideration for Your participation in vocational rehabilitation. Failure to participate without Good Cause will result in reduction or termination of Disability benefits. Reduction of benefits will be based on Your income potential if You were employed after a vocational rehabilitation program.

We will make the final determination of any vocational rehabilitation services provided, eligibility for participation and any continued benefit payments.

While You are a participant in an IWRP, Weekly Benefits will continue to be payable. Eligibility for continued Weekly Benefits will be assessed at the completion of the IWRP.

WHEN BENEFITS END

Benefits will be paid during a period of Disability until the earliest of the day:

a) You are no longer Disabled;
b) You die;
c) on which the Maximum Benefit Period ends as shown in the Schedule;
d) You fail to provide Us satisfactory proof of continuous Disability;
e) You fail to provide Us satisfactory Proof of Earnings;
f) You have been incarcerated or imprisoned for 31 days or longer;
g) You fail to comply with Our request to be examined by a Physician and/or vocational rehabilitation expert of Our choice;
h) You are not under Regular and Appropriate Care and Treatment for the Injury or Sickness that caused the Disability; or
i) You are able to return to work with the Policyholder on a part-time or Full-Time basis and do not do so.

If You are eligible to receive Disability payments on the day the Policy ends, benefits will continue subject to all other Policy provisions.

PRE-EXISTING CONDITION EXCLUSION

A *Pre-existing Condition* means any Injury or Sickness for which You received medical treatment, advice or consultation, care or services, including diagnostic measures, or had drugs or medicines prescribed or taken in the 3 months prior to the day You become insured under the Policy.

We will not provide benefits for any Disability caused by, attributable to, or resulting from a Pre-existing Condition which begins in the first 6 months after You are continuously insured under the Policy.

EXCLUSIONS

We will not pay benefits for any Disability which:

a) results from an act of declared or undeclared war or armed aggression;
b) results from Your Participation in a Riot or Your commission of or attempt to commit a felony or any type of assault or battery;
c) results, whether You are sane or insane, from:
    1. an intentionally self-inflicted Injury or Sickness; or
    2. attempted suicide;
d) occurs while You are incarcerated or imprisoned for any period exceeding 31 days; or
e) is solely a result of a loss of a professional license, occupational license, or certification.

PREMIUM PAYMENTS

Capitalized terms used in this section have the meanings assigned to them in this section or in other sections of this Certificate.

PAYMENT OF PREMIUMS THROUGH PAYROLL DEDUCTION

You are responsible for the payment of premiums for Your insurance under the Policy.

Premiums will be automatically deducted from Your paychecks by the Policyholder, then remitted to Us, as authorized by You during the enrollment process. Please contact the Policyholder for information regarding Your paycheck deductions.

Payment of premium does not guarantee eligibility for coverage or benefits.

GRACE PERIOD

All premiums for insurance under the Policy must be paid within the grace period. There is a grace period of 60 days for payment of premiums. This means that, except for the initial premium, if premium is not paid on or before the date it is due, the premium must be paid in the 60-day period that follows. We will consider premium to be paid on the date We receive it.

Insurance will stay in force during the grace period, unless You or the Policyholder provides Us with written notice that insurance will terminate during the grace period. If We receive such notice, insurance will terminate on the date requested.

If any premium due is not paid during the grace period, insurance will end on the last day of the grace period. If insurance ends, it may be reinstated as described in the Reinstatement of Insurance provision.

PREMIUM CHANGES

If You request a change in the amount of insurance, the Policyholder will provide You with notice of Your new premium amount upon request.

If there is a change in the amount of the premium for insurance in accordance with the terms of the Policy, the Policyholder will provide You with notice of the change at least 31 days prior to the date of the change.

Premium amounts will change if premium rates under the Policy are changed.

PAYMENT OF CLAIMS

Capitalized terms used in this section have the meanings assigned to them in this section or in other sections of this Certificate.

HOW TO OBTAIN PLAN BENEFITS FOR DISABILITY OR OTHER LOSS

Forward the completed claim form for Disability or other benefits to:
Benefits Administrator
Hoover City Schools
2810 Metropolitan Way
Hoover, Alabama 35243

You will be responsible for any fees charged by Your Physician for completing a claim form.

CLAIM ASSISTANCE

For assistance with filing a claim or an explanation of how a claim was paid, contact:
United of Omaha Life Insurance Company
Group Disability Management Services
Mutual of Omaha Plaza
Omaha, Nebraska 68175
Call Toll-Free: 1-800-877-5176

PROOF OF DISABILITY

A claim form can be requested from the Plan Administrator, from Us or obtained on Our website. A request for a claim form should be made within 20 days after a Disability occurs or as soon as reasonably possible. If You do not receive a claim form within 15 days of Your request, You can provide a written or verbal statement to Us, stating:

a) that You are under the Regular and Appropriate Care and Treatment of a Physician;
b) the appropriate documentation of Your job duties at Your Regular Job and Your Basic Weekly Earnings;
c) the date Your Disability began;
d) the cause of your Disability;
e) any restrictions and limitations preventing You from performing Your Regular Job; and
f) the name and address of any attending Physician, Hospital or institution where You received treatment.

A completed claim form and other information needed to prove loss must be submitted to Us within 90 days after the end of the Elimination Period.

Failure to furnish such proof within this time period shall not invalidate nor reduce any claim if:

a) it was not reasonably possible to give proof within that 90-day period; and
b) proof is furnished as soon as reasonably possible, but not later than one year after the end of the Elimination Period, unless You or Your beneficiary are not legally capable.

Proof of continued Disability, Regular and Appropriate Care and Treatment of a Physician and any Other Income Sources must be given to Us, upon request. This proof must be received within 45 days of Our request. If it is not, benefits may be denied or suspended.

ADDITIONAL SUPPORTING INFORMATION FOR DISABILITY AND OTHER CLAIMS

We may occasionally require You to be examined by a Physician or vocational rehabilitation expert of Our choice to assist in determining whether benefits are payable. We will pay for these examinations; however, You may be responsible for fees associated with failure to notify the examination office of Your appointment cancellation within the required amount of time specified by the examiner. We may recover this fee by reduction of benefits that are payable. We will not require more than a reasonable number of examinations.

Disability and other benefits will be paid after We receive acceptable proof of loss. Benefits will be paid only if We determine that the claimant is entitled to benefits under the terms of the Policy. We may require supporting information which may include, but is not limited to, the following:

a) clinical records;
b) charts;
c) x-rays;
d) Proof of Earnings; and
e) other diagnostic aids.

MODE OF PAYMENT FOR DISABILITY

Disability benefits will be paid by Us weekly after We receive acceptable proof of Disability. Benefits will be paid to You, except benefits unpaid at Your death may be paid, at Our option, to:

a) Your Eligible Survivor; or
b) Your estate.

REFUND TO US

If it is found that We paid more benefits than We should have paid under the Policy, We have the right to a refund from You or the recipient of benefits.

We also have a right to a refund for any payments due to:

a) fraud or misrepresentation;
b) any error We make in processing a claim; or
c) Your receipt of Other Income Sources.

You or the recipient of benefits must reimburse Us in full. We will determine the method by which the repayment is to be made, including without limitation, reducing or withholding Your Weekly Benefit or any benefits payable to You under any other disability insurance policy issued by Us. We will credit these payments to the refund until the refund is fully recovered.

AUTHORITY TO INTERPRET POLICY

By purchasing the Policy, the Policyholder grants Us the discretion and the final authority to construe and interpret the Policy. This means that We have the authority to decide all questions of eligibility and all questions regarding the amount and payment of any Policy benefits within the terms of the Policy as interpreted by Us. Benefits under the Policy will be paid only if We decide, in Our discretion, that a person is entitled to them. In making any decision, We may rely on the accuracy and completeness of any information furnished by the Policyholder, You or any other third party.

The Policyholder further grants Us the authority to delegate to third parties, including, without limitation, United of Omaha Life Insurance Company and any third party administrator with whom We have contracted to provide claims administration and other administrative services, the discretionary authority granted in the Policy. The Policyholder expressly grants such third party the full discretionary authority granted to Us under this Policy.

You or Your beneficiary has the right to request a review of Our decision. If, after exercising the Policy's review procedures, You or Your beneficiary's claim for benefits is denied or ignored, in whole or in part, You or Your beneficiary may file suit and a court will review Your or Your beneficiary's eligibility or entitlement to benefits under the Policy.

CLAIM REVIEW AND APPEAL PROCEDURES

Capitalized terms used in this section have the meanings assigned to them in this section or in other sections of this Certificate.

DEFINITIONS

The definitions set forth below shall apply to both the singular and plural versions of the defined term.

Adverse Benefit Determination means a denial, reduction, or termination of a benefit or a failure to provide or make payment (in whole or in part) for a benefit. This includes, without limitation, any such denial, reduction or termination of a benefit, or failure to provide or make payment, that is based upon ineligibility for insurance under the Policy.

Claimant means the person who submits a claim for benefits under the Policy, including the authorized representative of such person.

CLAIM REVIEW PROCEDURES

Once We receive information necessary to evaluate the claim, We will make a decision within the time periods set forth below. In the event an extension is necessary due to matters beyond Our control, We will notify the Claimant of the extension and the circumstances requiring the extension.

Except when the Claimant voluntarily agrees to provide Us with additional time, extensions are limited as set forth below. If an extension is necessary due to the Claimant's failure to submit complete information, We will notify the Claimant of the additional information required. Such notice of incomplete information will be sent within the time periods set forth below.

In order for Us to continue processing the claim, the missing information must be provided to Us within the time periods set forth below. The Claimant may contact Us at any time for additional details about the processing of the claim.

INITIAL CLAIM DECISION

The period of time within which a claim decision will be made begins at the time the claim is filed, without regard to whether all the information necessary to make a claim decision accompanies the filing. The applicable time periods are shown below:

a) initial claim decision period: 45 days unless additional information is requested as set forth below;
b) extension period: 30 days; and
c) maximum number of extensions: two.

If additional information is needed, We will notify the Claimant within 10 days of Our receipt of the claim. Once the Claimant receives Our request for additional information, the Claimant will be given no less than 45 days to submit the additional information to Us. We will make Our determination within 15 days of Our receipt of the additional information. If We do not receive the additional information within the specified time period, We will make Our determination based upon the available information.

CLAIM DENIALS

If a request for a claim is denied, in whole or in part, the Claimant will receive notice of the denial, which will include:

a) the specific reason(s) for the denial;
b) reference to the specific Policy provisions on which the denial is based;
c) a description of the appeal procedures and time limits applicable to such procedures, including the right to request an appeal within 180 days and the right to bring a civil action following the appeal process; and
d) any other information which may be required under state or federal laws and regulations.

Additionally, if an internal rule, guideline, protocol or other similar criterion was relied upon in making the Adverse Benefit Determination, the Claimant has the right to request information about such internal rule, guideline, protocol or other similar criterion that was used in making the Adverse Benefit Determination, free of charge.

OPPORTUNITY TO REQUEST AN APPEAL

The Claimant shall have a reasonable opportunity to appeal a claim review decision. As part of the appeal, there will be a full and fair review of the claim review decision.

The Claimant will have no later than 180 days from the Claimant's receipt of notification of Our claim review decision to submit a request for an appeal. The request for an appeal should include:

a) the Claimant's name;
b) the name of the person filing the appeal if different from the Claimant;
c) the Policy number; and
d) the nature of the appeal.

The request for an appeal can be submitted in any manner and should include any additional information that may have been omitted from Our review or that should be considered by Us. The notification regarding Our claim review decision will include instructions on how and where to submit an appeal.

By requesting an appeal, the Claimant has authorized Us, or anyone designated by Us, to review any and all records (including, but not limited to, medical records) which We determine may be relevant to the appeal.

A document, record, or other information will be considered relevant to a claim if it:

a) was relied upon in making the claim decision;
b) was submitted, considered, or generated in the course of making the claim decision, without regard to whether it was relied upon in making the claim decision; or
c) demonstrates compliance with administrative processes and safeguards designed to ensure and verify that claim decisions are made in accordance with the Policy and that, where appropriate, Policy provisions have been applied consistently with respect to similarly situated claimants.

RESPONSE TO APPEALS

We will respond no later than 45 days from Our receipt of the request for an appeal. However, if We determine that an extension is required, We will notify the Claimant in writing of the extension prior to the termination of the initial appeal period. In no event will the extension exceed 45 days from the end of the initial appeal period. The extension notice will indicate the special circumstances requiring the extension and the date by which We expect to render the appeal decision.

When We make Our determination, the Claimant will be provided with:

a) information regarding the decision; and
b) information regarding other internal or external appeal or dispute resolution alternatives, including any required state mandated appeal rights.

The period of time within which an appeal decision is required to be made will begin at the time an appeal is filed, without regard to whether all the information necessary to make an appeal decision accompanies the filing. If a period of time is extended as described above due to the Claimant's failure to submit information necessary to decide a claim, the period for making the appeal decision shall be "tolled" or suspended from the date on which the extension notice is sent until the earlier of (1) the date on which We receive the response; or (2) the date established by Us in the notice of extension for the furnishing of the requested information.

STANDARD PROVISIONS

INSURANCE CONTRACT

The insurance contract consists of:

a) the Policy;
b) the Policyholder's signed application attached to the Policy; and
c) any application signed by You.

Statements in an application are considered representations and not warranties. We will not use any statements in Your application to deny a claim or to contest the validity of this insurance unless We provide You with a copy of that application.

CHANGES IN THE INSURANCE CONTRACT

The insurance contract may be changed (including reducing or terminating benefits or increasing premium costs) any time We and the Policyholder both agree to a change. No one else has the authority to change the insurance contract. A change in the insurance contract:

a) does not require Your consent; and
b) must be:
    1. in writing;
    2. made a part of the Policy; and
    3. signed by Our authorized representative in Our home office.

A change may affect any class of Employees included in the Policy.

INCONTESTABILITY

We will not use any statements in Your application to contest the validity of this insurance after it has been in-force during Your lifetime for two years.

LEGAL ACTIONS

No legal action can be brought until at least 60 days after We have been given proof of loss. No legal action can be brought more than 6 years after the date proof of loss is required, unless otherwise required by state law in Your state of residence.

GENERAL DEFINITIONS

The following capitalized terms have the meanings assigned in this section. These terms are used throughout this Certificate.

The definitions set forth below shall apply to both the singular and plural versions of the defined term.

Certificate means this document that describes the benefits, terms, conditions, exclusions and limitations of the insurance provided under the Policy.

Current Earnings means any actual pre-tax weekly income You receive while You are working and eligible to receive a Weekly Benefit, or the pre-tax earnings You could receive if You were working at Your Maximum Capacity. If Your current earnings fluctuate, We may average Your current earnings over the most recent three-month period and continue Your claim provided the average does not exceed the percentage of Basic Weekly Earnings allowed by the Policy. A Weekly Benefit will not be payable for any week during which Your current earnings exceed that percentage.

Deferred Compensation means contributions You make through a salary reduction agreement with Policyholder to a plan or arrangement under the following Internal Revenue Code (IRC) sections or any other plan or arrangement defined as deferred compensation under the IRC:

a) 401(k);
b) 403(b);
c) 408(k); or
d) 457.

Dependent Child means:

a) Your natural born or legally adopted child;
b) Your stepchild or child of Your domestic or civil union partner or equivalent living in Your home; or
c) any other child who lives with You in a regular parent/child relationship and who qualifies as Your "dependent" as defined in the U.S. Internal Revenue Code.

Dependent child does not include:

a) a child who is married, in a domestic partnership, in a civil union partnership or equivalent, as recognized and allowed by federal law, or by state law in a child's state of residence;
b) a child who has been legally adopted by another person; or
c) a child:
    1. temporarily living in Your home;
    2. placed in Your home by a social service agency which retains control over the child; or
    3. who has a natural parent in a position to exercise parental responsibility and control.

Disability and *Disabled* mean that because of an Injury or Sickness, a significant change in Your mental or physical functional capacity has occurred, as a result of which:

a) during the Elimination Period, You are prevented from performing at least one of the Material Duties of Your Regular Job (on a part-time or full-time basis); and
b) after the Elimination Period, You are:
    1. prevented from performing at least one of the Material Duties of Your Regular Job (on a part-time or full-time basis); and
    2. unable to generate Current Earnings which exceed 99% of Your Basic Weekly Earnings due to that same Injury or Sickness.

Disability is determined relative to Your ability or inability to work. It is not determined by the availability of a suitable position with the Policyholder.

Eligible Survivor means Your Spouse, if living; otherwise, it means Your Dependent Child under age 26. An eligible survivor must be living at the time of Your death.

Elimination Period means the number of days of continuous Disability which must be satisfied before You are eligible to receive benefits. The elimination period is shown in the Schedule.

Employee means a person who is:

a) a citizen or permanent resident of the United States; or

b) lawfully and legally able to work in the United States pursuant to applicable federal and state laws; and
c) receiving compensation from the Policyholder for work performed for the Policyholder at:
    1. the Policyholder's usual place of business;
    2. an alternative work site at the direction of the Policyholder; or
    3. a location to which the employee must travel to perform the job.

An employee does not include a person:
a) who resides outside the United States for a period in excess of 12 consecutive months unless written approval has been received from Our authorized representative in Our home office;
b) working on a seasonal or temporary basis; or
c) performing services for the Policyholder as an independent contractor, including persons reporting income on a 1099 form or subject to the terms of a leasing agreement between the Policyholder and a leasing organization.

Evidence of Insurability means proof of good health acceptable to Us. This proof may be obtained through questionnaires, physical exams or written documentation, as required by Us.

Full-Time means working the required number of hours to be considered a full-time employee of the Policyholder.

Gross Weekly Benefit means Your Weekly Benefit amount before any reduction for Other Income Sources and Current Earnings.

Hospital means an accredited facility licensed by the proper authority of the area in which it is located to provide care and treatment for the condition causing confinement. A hospital does not include a facility or institution or part of a facility or institution which is licensed or used principally as a clinic, convalescent home, rest home, nursing home or home for the aged, halfway house or board and care facilities.

Injury means an accidental bodily injury that requires treatment by a Physician. It must result in loss independently of Sickness and other causes. Disability resulting from an injury must occur while You are insured under the Policy.

Material Duties means the essential tasks, functions, and operations relating to Your Regular Job that cannot be reasonably omitted or modified.

Maximum Capacity means, based on Your medical restrictions and limitations, the greatest extent of work You are able to do in Your Regular Job.

Maximum Weekly Benefit means the maximum dollar amount of disability benefit You may receive per week as shown in the Schedule.

Medically Necessary means care that is ordered, prescribed, or rendered by a Physician or Hospital, and is determined by Us, or a qualified party or entity selected by Us, to be:
a) provided for the diagnosis or direct treatment of Your Injury or Sickness;
b) appropriate and consistent with the symptoms and findings or diagnosis and treatment of Your Injury or Sickness; and
c) provided in accordance with generally accepted national professional standards and/or medical practice.

Our, We, Us means United of Omaha Life Insurance Company.

Physician means any of the following licensed practitioners:
a) a doctor of medicine (MD), osteopathy (DO), podiatry (DPM) or chiropractic (DC);
b) a licensed doctoral clinical psychologist;
c) a Master's level counselor and licensed or certified social worker who is acting under the supervision of a doctor of medicine or a licensed doctoral clinical psychologist;
d) a licensed physician's assistant (PA) or nurse practitioner (NP); or
e) where required by law, any other licensed practitioner of a healing art who is acting within the scope of his/her license.

A physician does not include:
a) a naturopathic doctor;
b) an acupuncturist;

c) a physician in training; or
d) You, Your Spouse, any person who lives with You, a child, brother, sister or parent of You or Your Spouse.

Plan Administrator means the person or entity designated as the plan administrator for the Policyholder's group disability welfare benefit plan.

Policy means the group policy issued to the Policyholder by Us, including this Certificate.

Policy Anniversary means October 1 of each Policy Year.

Policy Effective Date means October 1, 2019.

Policy Year means the period commencing on the Policy Effective Date and ending on the next succeeding Policy Anniversary and, thereafter, each 12-month period commencing on the Policy Anniversary.

Policyholder's Retirement Plan means any Retirement Plan:
a) which is part of any federal, state, county, municipal, or association retirement system; and
b) for which You are eligible as a result of employment with the Policyholder.

Proof of Earnings means:
a) copies of Your U.S. individual income tax returns and business income tax returns, including all forms, schedules and attachments, if applicable;
b) payroll records; and
c) any other records We request.

Regular and Appropriate Care and Treatment means You visit and receive care and treatment from a Physician as frequently as is medically required, to effectively manage and treat Your Injury or Sickness. Such care and treatment must be:
a) Medically Necessary;
b) received from a Physician whose expertise, medical training, and clinical experience are suitable for treating Your Injury or Sickness; and
c) received primarily is to improve Your medical condition and thereby aid in Your ability to return to work.

Regular Job means the occupation You are routinely performing when Your Disability begins.

Retirement Plan means a plan which:
a) provides benefits to You, either in a lump sum or in the form of periodic payments, upon the later of:
    1. early or normal retirement as defined in the plan or under the U.S. Social Security Act; or
    2. disability, if the payment does not reduce the amount of money which would have been paid at the normal retirement age under the plan if the disability had not occurred; and
b) is not funded wholly by Your contributions.

A retirement plan shall not include a profit-sharing plan or a plan such as a 401(k), a thrift plan, an individual retirement account (IRA), a tax sheltered annuity (TSA), a stock ownership plan, or a Deferred Compensation plan.

Sickness means a disease, disorder or condition, including pregnancy, that requires treatment by a Physician. Disability resulting from a sickness must occur while You are insured under the Policy. Sickness does not include elective or cosmetic surgery or procedures, or resulting complications. Sickness includes the donation of an organ in a non-experimental organ transplant procedure.

Spouse means the person to whom You are legally married, or Your domestic partner, civil union partner or equivalent, as recognized and allowed by federal law, or by state law in Your state of residence.

You, Your means the Employee who is insured under the Policy.

Group Voluntary Short-Term Disability Benefits

Hoover City Schools

Group Number: G000BJXW

United of Omaha Life Insurance Company

Home Office:
Mutual of Omaha Plaza
Omaha, Nebraska 68175

YOUR GROUP
LONG-TERM DISABILITY BENEFITS

FOR EMPLOYEES OF:

Hoover City Schools

CLASS(ES):

All Eligible Employees

EFFECTIVE DATE:

October 1, 2019

PUBLICATION DATE:

July 12, 2019

NOTICE(S)

THIS CERTIFICATE DESCRIBES THE BENEFITS THAT ARE AVAILABLE TO YOU. PLEASE READ YOUR CERTIFICATE CAREFULLY. BENEFITS ARE PROVIDED THROUGH A GROUP POLICY ISSUED IN THE STATE OF ALABAMA.

FRAUD WARNING
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Group Number: G000BJXW

If You have any questions about or concerns with this insurance, please first contact the Policyholder or Your benefits administrator. If, after doing so, You still have a question or concern, You may contact Us at:

United of Omaha Life Insurance Company
Mutual of Omaha Plaza
Omaha, Nebraska 68175
Call Toll-Free: 1-800-877-5176
www.mutualofomaha.com

When contacting Us, please have Your Policy number available.

TABLE OF CONTENTS

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CERTIFICATE OF INSURANCE

UNITED OF OMAHA LIFE INSURANCE COMPANY

Home Office:
Mutual of Omaha Plaza
Omaha, Nebraska 68175

United of Omaha Life Insurance Company certifies that Group Policy Number GLTD-BJXW (the Policy) has been issued to Hoover City Schools (the Policyholder).

Insurance is provided for Employees of the Policyholder subject to the terms and conditions of the Policy.

Please read this Certificate carefully. The benefits described in this Certificate are effective only if You are eligible for the insurance, become insured and remain insured as described in this Certificate and according to the terms and conditions of the Policy.

If the provisions of this Certificate and those of the Policy do not agree, the provisions of the Policy will apply. The Policy is part of a contract between United of Omaha Life Insurance Company and the Policyholder, and may be amended, changed or terminated without Your consent or notice to You.

This Certificate replaces any certificate previously issued under the Policy.

James T. Blackledge
Chief Executive Officer

David Vanheat
Corporate Secretary

SCHEDULE

This Schedule describes some of the terms and conditions of the Policy including, but not limited to, the maximum amounts of benefits payable under the Policy, exclusions and limitations. For a complete description of the terms and conditions of the Policy, refer to the appropriate section of the Certificate.

A person is not necessarily entitled to insurance under the Policy because he or she received this Schedule. A person is only entitled to insurance if he or she is eligible in accordance with the terms of the Certificate. Capitalized terms used in this section have the meanings assigned to them in this section or in other sections of this Certificate.

POLICY INFORMATION

Policyholder:	Hoover City Schools
Policy Effective Date:	October 1, 2019
Policy Anniversary:	October 1
Policy Number:	GLTD-BJXW
Group Number:	G000BJXW
Classification:	All Eligible Employees
Minimum Work Hours Required:	20 hours per week
Eligibility Present Waiting Period:	none
Eligibility Future Waiting Period:	none
When Insurance Begins:	the first day of the month that coincides with or follows the day the Employee becomes eligible. Additional eligibility conditions apply as described in the Certificate.
Elimination Period:	The later of: a) 180 calendar days; or b) the date Your short-term Disability ends.

BENEFITS

Monthly Benefit Percentage:	60%
Maximum Monthly Benefit:	$9,000
Minimum Monthly Benefit:	$100

Maximum Benefit Period:

Age at Disability	Maximum Benefit Period
61 or less	to age 65, Your SSNRA, or 3 years and 6 months, whichever is longest;
62	Your SSNRA, or 3 years and 6 months, whichever is longer;
63	Your SSNRA, or 3 years, whichever is longer;
64	Your SSNRA, or 2 years and 6 months, whichever is longer;
65	2 years;
66	1 year and 9 months;
67	1 year and 6 months;
68	1 year and 3 months;
69 or older	1 year.

Own Occupation Definition:	2 years
Family Care Benefit:	Included
Recovery Income Protection:	12 months
Survivor Benefit:	3 months
Vocational Rehabilitation Benefit:	10%

LIMITATIONS/EXCLUSIONS

Alcohol/Drug Abuse/Substance Abuse Limitation:	24 months
Mental Disorder Limitation:	24 months
Pre-existing Condition Exclusion:	3/12

DEFINITIONS

The definitions set forth below shall apply to both the singular and plural versions of the defined term.

Basic Monthly Earnings for salaried Employees means Your gross annual salary from the Policyholder in effect on the day immediately prior to the date on which Your Disability began, divided by 12.

Basic monthly earnings for hourly Employees means Your hourly rate of pay from the Policyholder in effect on the day immediately prior to Your Disability multiplied by the average number of hours You worked per month, not including overtime, during the 12 month period immediately prior to the date on which Your Disability began. If You were employed with the Policyholder for a period of less than 12 months, basic monthly earnings means Your hourly rate of pay multiplied by the average number of hours You worked per month during that period, not including overtime.

Basic monthly earnings is verified by premium We have received.

Basic monthly earnings includes Employee contributions to Deferred Compensation plans received from the Policyholder.

Basic monthly earnings does not include commissions, bonuses, overtime pay, Policyholder contributions to Deferred Compensation plans, Differentials, and other extra compensation received from the Policyholder.

Proof of Earnings is required.

Differentials mean additional compensation You receive from the Policyholder for time or duties beyond those normally required or to accommodate specific working conditions, including, but not limited to:

a) shift differentials;
b) hazardous duties differentials;
c) pay for longevity;
d) on-call pay;
e) lead nurse differentials;
f) English as a Second Language (ESL) differentials;
g) charge pay;
h) weekend differentials;
i) coaching and other extra curricular activities compensation; and
j) on-call differentials.

Other Income Source(s) has the meaning set forth in the Other Income Sources provision of this Schedule.

Recurrent Disability means a Disability which is caused by, attributable to, or resulting from the same Injury or Sickness that caused the prior Disability for which You received a Monthly Benefit under the Policy.

Reimbursement Agreement means the written agreement that We provide to You under which You agree to repay Us any overpayment resulting from Your or Your Spouse's or child(ren)'s receipt of Other Income Sources.

Social Security Normal Retirement Age (SSNRA) means Your normal retirement age under the U. S. Social Security Act determined as follows:

Year of Birth	Social Security Normal Retirement Age
1937 or earlier	65 years;
1938	65 years and 2 months;
1939	65 years and 4 months;
1940	65 years and 6 months;
1941	65 years and 8 months;
1942	65 years and 10 months;
1943 through 1954	66 years;
1955	66 years and 2 months;
1956	66 years and 4 months;
1957	66 years and 6 months;

1958..... 66 years and 8 months;
1959..... 66 years and 10 months;
1960 or later.....67 years.

NOTE: Your Social Security Normal Retirement Age may change subject to any changes to the U. S. Social Security Act.

ELIMINATION PERIOD

The Elimination Period is the later of:
a) 180 calendar days; or
b) the date Your short-term Disability ends.

For purposes of accumulating days of Disability to satisfy the Elimination Period, the following will apply:
a) a period of Disability will be treated as continuous during the Elimination Period unless Disability stops for more than 180 accumulated days during the Elimination Period; and
b) days in which You return to work for a full work day as verified by Policyholder records will not count towards the Elimination Period.

The Elimination Period begins on the first day of Disability. If You are not continuously Disabled, the Elimination Period must be satisfied within a period of time which does not exceed two times the length of the Elimination Period; otherwise, a new Elimination Period will apply.

RECURRENT DISABILITY

A Recurrent Disability will be treated as part of Your prior claim and You will not be required to satisfy a new Elimination Period if:
a) You were continuously insured under the Policy from the date benefits ended for Your prior claim to the date Your Recurrent Disability begins; and
b) Your Recurrent Disability occurs within 180 days after the date benefits ended for Your prior claim.

In order to prevent over-insurance because of duplication of benefits, benefits payable under this Recurrent Disability provision will cease if benefits are payable to You under any other Policyholder sponsored group long-term disability income policy or plan.

MONTHLY BENEFIT

Total Disability

If You are Disabled and earning less than 20% of Your Basic Monthly Earnings, the Monthly Benefit while Disabled is the lesser of:
a) 60% of Your Basic Monthly Earnings, less Other Income Sources; or
b) the Maximum Monthly Benefit, less any Other Income Sources.

Partial Disability

You may work for wage or profit and, after a Monthly Benefit has been paid for 2 years, receive up to 85% of Your Basic Monthly Earnings while Disabled. As an incentive to work while Disabled, You will receive the Monthly Benefit for Total Disability, unless the sum of:
a) the Gross Monthly Benefit while You are Disabled; plus
b) Current Earnings; plus
c) the amount of Family Care Expense You incur in accordance with the Family Care Expense Provision;
exceeds 100% of Your Basic Monthly Earnings. If this sum exceeds 100% of Your Basic Monthly Earnings, the Monthly Benefit for Partial Disability will be reduced by that excess amount.

MINIMUM BENEFIT

As long as You are Disabled Your Monthly Benefit will never be less than $100, unless We reduce the Monthly Benefit to recover an overpayment. If We reduce the Monthly Benefit to recover an overpayment, Your Monthly Benefit may be reduced to zero until We fully recover the overpayment.

When less than one month of Disability benefits is due, a pro rata benefit will be paid for each day of Disability. This pro rata benefit will be equal to 1/30th of Your Monthly Benefit.

VOCATIONAL REHABILITATION BENEFIT

While You are participating in a plan of vocational rehabilitation approved by Us, Your Monthly Benefit will be increased by 10%.

MAXIMUM BENEFIT PERIOD

If You are Disabled because of an Injury or Sickness, We will pay benefits as follows, subject to any limitations described in this Certificate.

Age at Disability	Maximum Benefit Period
61 or less	to age 65, Your SSNRA, or 3 years and 6 months, whichever is longest;
62	Your SSNRA, or 3 years and 6 months, whichever is longer;
63	Your SSNRA, or 3 years, whichever is longer;
64	Your SSNRA, or 2 years and 6 months, whichever is longer;
65	2 years;
66	1 year and 9 months;
67	1 year and 6 months;
68	1 year and 3 months;
69 or over	1 year.

OTHER INCOME SOURCES

We take into account the total of all Your income from other sources of income in determining the amount of Your Monthly Benefit. Your Other Income Sources are any of the following amounts that You receive or are eligible to receive as a result of Your Disability or the Sickness and/or Injury that caused, in whole or in part, Your Disability:

a) Any amount under:
    1. a workers' compensation law;
    2. an occupational disease law;
    3. the Jones Act, (46 U.S.C. Statute 688(a) (1920)); or
    4. any other act or law of like intent to the laws described in 1, 2 or 3 above.
b) Any amount under another group short-term or long-term disability insurance policy or plan for which the Policyholder has paid any part of the cost or for which the Policyholder has made payroll deductions, except any group short-term or long-term disability insurance policy or plan underwritten by United of Omaha Life Insurance Company.
c) Any amount as disability income payments under any:
    1. state compulsory benefit act or law;
    2. government retirement system as a result of Your job with the Policyholder; or

3. work loss provision in a no-fault motor vehicle insurance plan, unless state law or regulation does not allow group disability income benefits to be reduced by benefits from no-fault motor vehicle coverage.

d) Any amount of benefits under the Policyholder's Retirement Plan. Benefits payable before the plan's normal retirement age are considered Other Income Sources only if You voluntarily elect to receive these benefits.

e) Any benefits for You or Your Spouse and Dependent Child under:
   1. the U.S. Social Security Act;
   2. the Canada Pension Plan;
   3. the Quebec Pension Plan;
   4. the Railroad Retirement Act;
   5. any public employee retirement plan;
   6. any teachers employment retirement plan; or
   7. any similar plan or act that provides:
      a. Disability benefits; or
      b. retirement benefits (except this will not apply if Your Disability begins after Your Social Security Normal Retirement Age and You were already receiving Social Security retirement benefits. This exception only applies to U.S. Social Security Benefits).

f) Any amount payable as:
   1. salary continuance, except
      a. paid time off (PTO) that is not specified as sick leave;
      b. vacation;
      c. any earned time off program;
   2. sick leave; or
   3. severance allowance.

g) Any amount from a third party (after subtracting attorneys' fees) by judgment, settlement or otherwise.

h) Any amount from any unemployment insurance law or program.

EXPLANATION OF OTHER INCOME SOURCES

You must apply for Other Income Sources for which You are or may become eligible, including but not limited to Social Security disability and/or dependent benefits, and do what is needed to obtain them. If Your application is denied, We may require that You appeal the decision to a level that is satisfactory to Us and provide written proof of all levels of appeal.

As part of Your proof of Disability, We require that You furnish evidence to Us that You have applied for Other Income Sources for which You are or may become eligible.

After the initial reduction for each type of Other Income Sources, We will not further reduce Your Monthly Benefit due to any cost of living increases payable under such type of Other Income Sources.

Other Income Sources that are paid in a lump sum will be prorated on a monthly basis over a period for which the sum is given. If no time period is stated, the sum will be prorated on a monthly basis over the lesser of the following:

a) the Policy's Maximum Benefit Period; or
b) 60 equal payments.

If Other Income Sources are paid on a retroactive basis, We may reduce or suspend the Monthly Benefit to recover any overpayment.

Regardless of how funds from a Retirement Plan are distributed, We will consider Your contributions and the Policyholder's contributions to be distributed simultaneously during Your lifetime.

We will pay the full amount of the Monthly Benefit if You:

a) apply for Other Income Sources; and
b) sign Our Reimbursement Agreement.

Until You have signed Our Reimbursement Agreement and have given written proof to Us that application has been made or all available appeals have been exhausted for Other Income Sources, We may:

a) estimate Your Other Income Sources; and
b) reduce Your Monthly Benefit by that amount.

If We reduce Your benefit on this basis, and if all of Your appeals are denied, We will restore Your Monthly Benefit amount and refund any underpayment to You in a lump sum.

ASSISTANCE WITH FILING FOR SOCIAL SECURITY DISABILITY BENEFITS

We can arrange for advice regarding Your claim for Social Security disability benefits and assist You with Your application or appeal. In order to be eligible for assistance, You must be receiving Monthly Benefits from Us.

Receiving Social Security disability benefits may enable:

a) You to receive Medicare after 24 months of disability payments;
b) You to protect Your Social Security retirement benefits; and
c) Your family to be eligible for Social Security disability benefits.

We can arrange assistance in obtaining Social Security disability benefits by:

a) helping You find appropriate representation;
b) obtaining medical and vocational evidence; and
c) reimbursing pre-approved case management expense.

ELIGIBILITY

Capitalized terms used in this section have the meanings assigned to them in this section or in other sections of this Certificate.

DEFINITIONS

The definitions set forth below shall apply to both the singular and plural versions of the defined term.

Actively Working, Active Work means an Employee is performing the normal duties of his or her Regular Job for the Policyholder on a regular and continuous basis 20 or more hours each week. An Employee will be considered to be actively working on any day that is a regular paid holiday or day of vacation, or regular or scheduled non-working day, provided the Employee was actively working on the last preceding regular work day.

Prior Plan means any group disability plan or individual worksite disability plan of benefits:

a) replaced by insurance under part or all of the Policy; and
b) in effect and maintained or sponsored by the Policyholder on the day before the Policy Effective Date.

Written Request means a request that is signed, dated and submitted to the Policyholder. The request must be on a form We supply or be in a form and content acceptable to Us.

WHEN AN EMPLOYEE BECOMES ELIGIBLE FOR INSURANCE

An Employee who is Actively Working on the Policy Effective Date becomes eligible for insurance under the Policy on the Policy Effective Date.

An Employee who is hired after the Policy Effective Date becomes eligible for insurance under the Policy on the day the Employee begins Active Work.

The day on which an Employee becomes eligible for insurance under the Policy may not be the same as the day on which insurance begins. The When Insurance Begins provision describes the day on which insurance begins.

CONTINUITY OF INSURANCE UPON TRANSFER OF INSURANCE CARRIER

If You are not Actively Working on the Policy Effective Date due to Injury or Sickness, upon payment of the premium, You will be insured under the Policy if You:

a) were covered under a Prior Plan on the day before the Policy Effective Date; and
b) resume Active Work.

EFFECT OF A PRE-EXISTING CONDITION WITH PRIOR COVERAGE

Prior Group Disability Plan Coverage Maintained by the Policyholder

If You become insured under the Policy on the Policy Effective Date and were covered under a prior group disability plan on the day before the Policy Effective Date, any benefits payable under the Policy for a Disability due to a Pre-existing Condition will be determined as follows:

a) If You cannot satisfy the Pre-existing Conditions provision of the Policy, but have satisfied the pre-existing condition provision under the prior group disability plan, giving consideration towards continuous time covered under both plans, We will pay the lesser of the benefit:
    1. that would have been paid under the prior group disability plan; or
    2. payable under the Policy.
b) If You cannot satisfy the Pre-existing Conditions provision under the Policy or of the prior group disability plan, no benefit under the Policy will be payable.

Prior Group Disability Plan Coverage Not Maintained by the Policyholder

If You become insured under the Policy after the Policy Effective Date and were covered under an employer's group long-term disability plan provided by Your previous employer, and not maintained by the Policyholder, within 31 days prior to the day You become employed with the Policyholder, any benefits payable under the Policy for a Disability due to a Pre-existing Condition will be determined as follows:

a) If You cannot satisfy the Pre-existing Conditions provision of the Policy, but have satisfied the pre-existing condition provision under Your prior group disability plan, giving consideration towards continuous time covered under both plans, We will pay the lesser of the benefit:
    1. that would have been paid under Your prior group long-term disability plan; or
    2. payable under the Policy.
b) If You cannot satisfy the Pre-existing Conditions provision under the Policy or Your prior group long-term disability plan, no benefit under the Policy will be payable.

In order to qualify under this provision, You must provide the following supporting documentation within 31 days from the date We request this information:

a) a copy of Your prior employer's long-term disability plan; and
b) payroll records or other documentation verifying prior group long-term disability coverage under Your prior employer's plan.

WHEN INSURANCE BEGINS

An eligible Employee will become insured on the first day of the month that coincides with or follows the day the Employee begins Active Work.

If the Employee is not Actively Working on the day insurance would otherwise begin, insurance will begin on the day the Employee returns to Active Work.

EXCEPTIONS TO WHEN INSURANCE BEGINS

This provision does not apply if the Employee is eligible for coverage under the Continuity of Insurance Upon Transfer of Insurance Carrier provision.

Insurance for an Employee who has an Injury or Sickness and is confined:

a) in a Hospital as an inpatient;
b) in any institution or facility other than a Hospital; or
c) at home and under the care or supervision of a Physician;

on the day insurance is to begin will not take effect until the first day of the month that coincides with or follows the day the Employee returns to Active Work.

CHANGES TO INSURANCE BENEFITS

Any allowable change in Your classification or amount of insurance, whether requested by You or the Policyholder, or as a result of the terms of the Policy, will take effect on the first day of the month that follows the date of the request or the change.

WHEN INSURANCE ENDS

Insurance will end on the earliest of the day:

a) You are no longer eligible for insurance under the Policy;
b) You begin active duty in the Armed Forces, National Guard or Reserves of any state or country (except for temporary active duty of 31 days or less);
c) the Policy terminates; or
d) insurance ends in accordance with the Grace Period provision.

If You are Disabled on the day the Policy terminates, benefits will continue subject to the When Benefits End provision located in the Benefits section.

EXCEPTIONS TO WHEN INSURANCE ENDS

If insurance for You ends but the Policy is in effect, You may be able to continue or obtain insurance under one of the following provisions:

a) Continuation of Insurance During Disability
b) Continuation of Insurance Under the Family and Medical Leave Act (FMLA) and Uniformed Services Employment and Reemployment Rights Act (USERRA)

CONTINUATION OF INSURANCE DURING DISABILITY

If You become Disabled, Your insurance will continue without payment of premium for as long as You are entitled to receive Monthly Benefits, except that premium must be paid during the Elimination Period. Premium will be waived from the first day of the month following the end of the Elimination Period through the last day of the month in which Your last Disability benefit payment under the Policy is issued.

CONTINUATION OF INSURANCE UNDER THE FAMILY MEDICAL LEAVE ACT (FMLA) AND UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

The federal Family Medical Leave Act (FMLA) and Uniformed Services Employment and Reemployment Rights Act (USERRA) and any amendments thereto, as well as other applicable federal or state laws, may allow continuation of insurance in certain instances for leaves of absence, layoff or termination. Contact the Policyholder for additional information regarding any other continuation options that may be available.

LONG-TERM DISABILITY BENEFITS

Capitalized terms used in this section have the meanings assigned to them in this section or in other sections of this Certificate.

DEFINITIONS

The definitions set forth below shall apply to both the singular and plural versions of the defined term.

Good Cause means documented physical or mental impairments that:

a) render You incapable of rehabilitation;
b) interfere with a medical program You are currently participating in; or
c) conflict with any other program You are participating in that will enable You to return to Active Employment.

Participation in a Riot means actively participating in a tumultuous disturbance of the peace by three or more persons assembling together of their own authority with intent to mutually assist one another in an illegal or legal act.

LONG-TERM DISABILITY BENEFITS

If You become Disabled due to an Injury or Sickness, while insured under the Policy, We will pay the Monthly Benefit shown in the Schedule in accordance with the terms of the Policy. Benefits will begin after You satisfy the Elimination Period shown in the Schedule.

FAMILY CARE BENEFIT

We will offer an additional benefit amount of up to $350 per month for each Qualifying Family Member. The additional benefit amount will be included in the Monthly Benefit for Partial Disability formula described in the Schedule if:

a) You have received a total of 12 months of Disability benefits;
b) You continue to be Disabled;
c) You incur expenses for Family Care services; and
d) We receive satisfactory proof of the Family Care expense incurred by You.

The Family Care benefit will not exceed 100% of Your Current Earnings.

RECOVERY INCOME PROTECTION BENEFIT

Long Term Disability benefits normally end when You are no longer Disabled, however, benefits will continue to be paid under this provision when You are no longer Disabled if the following conditions are satisfied:

a) immediately prior to the date You are no longer Disabled You have received at least 6 months of continuous Disability benefits and suffered an earnings loss of 20% or more of Your Basic Monthly Earnings during that period; and
b) You are performing each of the Material Duties of Your Regular Occupation on a Full-Time basis for the Policyholder.

Benefits under this provision will end on the earliest of the day:

a) You have received 12 monthly payments; or
b) Your Current Earnings exceed 80% of Your Indexed Pre-Disability Earnings.

This benefit will be calculated according to the Monthly Benefit and Other Income Sources sections of this Certificate.

SURVIVOR BENEFIT

We will pay a Survivor Benefit to Your Eligible Survivor when We receive proof that You died:

a) after being Disabled; and
b) while receiving or eligible to receive a Monthly Benefit under the Policy.

The Survivor Benefit will be payable as a lump sum amount equal to 3 times Your Monthly Benefit for the month immediately prior to Your death.

If a Survivor Benefit is payable to Your Dependent Child and, if there is more than one such Dependent Child, then the Survivor Benefit will be divided equally among such Dependent Children.

If payment becomes due to Your Dependent Child or Dependent Children, the payment will be made to:

a) Your Dependent Child; or
b) a person legally authorized to receive payments or the Dependent Child's or Dependent Children's behalf. This payment will be valid and effective against all claims by the Dependent Child or Dependent Children or by others representing or claiming to represent such Dependent Child or Dependent Children.

If there are no Eligible Survivors, the Survivor Benefit will be paid to Your estate.

Any payment made in good faith will fully discharge Us to the extent of the payment.

VOCATIONAL REHABILITATION PROVISION

If You are Disabled and are receiving Disability benefits as provided by the Policy, You may be eligible to receive vocational rehabilitation services. These services include, but are not limited to:

a) worksite modification and/or special equipment;
b) job placement;
c) retraining; and
d) other services reasonably necessary to help You return to work.

While You are participating in a plan of vocational rehabilitation approved by Us, Your Monthly Benefit will be increased by a percentage as shown in the Schedule.

Eligibility for vocational rehabilitation services is based on Your education, training, experience and physical/mental capabilities. Before vocational rehabilitation services will be considered:

a) Your Disability must not allow You to perform Your Regular Occupation;
b) You must have the physical and mental capability to complete a rehabilitation program; and
c) there must be reasonable expectation that rehabilitation services will help You return to active employment.

We will develop an Individual Written Rehabilitation Plan (IWRP), which may include input from You, Your Physician and the Policyholder. The IWRP will describe:

a) the vocational rehabilitation goals and services;
b) the responsibilities of Us, You and any third parties associated with the IWRP;
c) the times and dates of the vocational rehabilitation services; and
d) all costs associated with the services.

Either We, Your Physician, or You may initiate consideration for Your participation in vocational rehabilitation. Failure to participate without Good Cause will result in reduction or termination of Disability benefits. Reduction of benefits will be based on Your income potential if You were employed after a vocational rehabilitation program.

We will make the final determination of any vocational rehabilitation services provided, eligibility for participation and any continued benefit payments.

While You are a participant in an IWRP, Monthly Benefits will continue to be payable. Eligibility for continued Monthly Benefits will be assessed at the completion of the IWRP.

LIMITATIONS

Alcohol and Drug Abuse and/or Substance Abuse

If You are Disabled and Your Disability is a result of Alcohol or Drug Abuse and/or Substance Abuse, Your benefits will be limited to a total of 24 months while insured under the Policy, unless You are confined as resident inpatient in a Hospital due to Your dependency at the end of that 24-month period. The Monthly Benefit will continue to be paid during such confinement.

If You are still Disabled when You are discharged from a Hospital, the Monthly Benefit will be paid for a recovery period of up to 90 additional days. If You become re-confined as a resident inpatient in a Hospital during the recovery period for at least 14 consecutive days, benefits will be paid for the duration of the subsequent confinements.

Mental Disorder

If You are Disabled and Your Disability is a result of a Mental Disorder, Your benefits will be limited to a total of 24 months while insured under the Policy, unless You are confined as a resident inpatient in a Hospital due to Your Mental Disorder at the end of that 24-month period. The Monthly Benefit will continue to be paid during such confinement.

If You are still Disabled when You are discharged from a Hospital, the Monthly Benefit will be paid for a recovery period of up to 90 additional days. If You become re-confined as a resident inpatient in a Hospital during the recovery period for at least 14 consecutive days, benefits will be paid for the duration of the subsequent confinements.

WHEN DISABILITY BENEFITS END

Benefits will be paid during a period of Disability until the earliest of the day:

a) You are no longer Disabled;
b) You die;
c) on which the Maximum Benefit Period ends as shown in the Schedule;
d) You fail to provide Us satisfactory proof of continuous Disability;
e) You fail to provide Us satisfactory Proof of Earnings;
f) You have been incarcerated or imprisoned for 31 days or longer;
g) You fail to comply with Our request to be examined by a Physician and/or vocational rehabilitation expert of Our choice;
h) You are not under Regular and Appropriate Care and Treatment for the Injury or Sickness that caused the Disability;
i) You are able to return to work with the Policyholder on a part-time or Full-Time basis and do not do so; or
j) We have paid You 12 Monthly Benefit payments, if You reside outside the U.S., its territories or possessions, or Canada. You will be considered to reside outside the U.S., its territories or possessions, or Canada if You have been outside the U.S., its territories or possessions, or Canada for a total of six months or more during any twelve consecutive month period during which You were continuously Disabled.

If You are eligible to receive Disability payments on the day the Policy ends, benefits will continue subject to all other Policy provisions.

PRE-EXISTING CONDITION EXCLUSION

A *Pre-existing Condition* means any Injury or Sickness for which You received medical treatment, advice or consultation, care or services, including diagnostic measures, or had drugs or medicines prescribed or taken in the 3 months prior to the day You become insured under the Policy.

We will not provide benefits for any Disability caused by, attributable to, or resulting from a Pre-existing Condition which begins in the first 12 months after You are continuously insured under the Policy.

EXCLUSIONS

We will not pay benefits for any Disability or loss which:

a) results from an act of declared or undeclared war or armed aggression;

b) results from Your Participation in a Riot or Your commission of or attempt to commit a felony or any type of assault or battery;
c) results, whether You are sane or insane, from:
    1. an intentionally self-inflicted Injury or Sickness; or
    2. attempted suicide;
d) results from Alcohol and Drug Abuse and/or Substance Abuse, except as specifically provided in the Limitations Section;
e) results from a Mental Disorder, except as specifically provided in the Limitations Section;
f) is caused by Alcohol and Drug Abuse and/or Substance Abuse, while You are not being actively supervised by and receiving continuing treatment from a rehabilitation center or designated institution approved for such treatment by an appropriate body in the governing jurisdiction, or if none, by Us;
g) occurs while You are incarcerated or imprisoned for any period exceeding 31 days; or
h) is solely a result of a loss of a professional license, occupational license, or certification.

PREMIUM PAYMENTS

Capitalized terms used in this section have the meanings assigned to them in this section or in other sections of this Certificate.

GRACE PERIOD

All premiums for insurance under the Policy must be paid within the grace period. There is a grace period of 60 days for payment of premiums. This means that, except for the initial premium, if premium is not paid on or before the date it is due, the premium must be paid in the 60-day period that follows. We will consider premium to be paid on the date We receive it.

Insurance will stay in force during the grace period, unless You or the Policyholder provides Us with written notice that insurance will terminate during the grace period. If We receive such notice, insurance will terminate on the date requested.

If any premium due is not paid during the grace period, insurance will end on the last day of the grace period. If insurance ends, it may be reinstated as described in the Reinstatement of Insurance provision.

PREMIUM CHANGES

If You request a change in the amount of insurance, the Policyholder will provide You with notice of Your new premium amount upon request.

If there is a change in the amount of the premium for insurance in accordance with the terms of the Policy, the Policyholder will provide You with notice of the change at least 31 days prior to the date of the change.

Premium amounts will change if premium rates under the Policy are changed.

PAYMENT OF CLAIMS

Capitalized terms used in this section have the meanings assigned to them in this section or in other sections of this Certificate.

HOW TO OBTAIN PLAN BENEFITS FOR DISABILITY OR OTHER LOSS

Forward the completed claim form for Disability or other benefits to:
Benefits Administrator
Hoover City Schools
2810 Metropolitan Way
Hoover, Alabama 35243

You will be responsible for any fees charged by Your Physician for completing a claim form.

CLAIM ASSISTANCE

For assistance with filing a claim or an explanation of how a claim was paid, contact:
United of Omaha Life Insurance Company
Group Disability Management Services
Mutual of Omaha Plaza
Omaha, Nebraska 68175
Call Toll-Free: 1-800-877-5176

PROOF OF DISABILITY

A claim form can be requested from the Plan Administrator, from Us or obtained on Our website. A request for a claim form should be made within 20 days after a Disability occurs or as soon as reasonably possible. If You do not receive a claim form within 15 days of Your request, You can provide a written statement to Us, stating:

a) that You are under the Regular and Appropriate Care and Treatment of a Physician;
b) the appropriate documentation of Your job duties at Your Regular Occupation and Your Basic Monthly Earnings;
c) the date Your Disability began;
d) the cause of your Disability;
e) any restrictions and limitations preventing You from performing Your Regular Occupation; and
f) the name and address of any attending Physician, Hospital or institution where You received treatment.

A completed claim form and other information needed to prove loss must be submitted to Us within 90 days after the end of the Elimination Period.

Failure to furnish such proof within this time period shall not invalidate nor reduce any claim if:

a) it was not reasonably possible to give proof within that 90-day period; and
b) proof is furnished as soon as reasonably possible, but not later than one year after the end of the Elimination Period, unless You or Your beneficiary are not legally capable.

Proof of continued Disability, Regular and Appropriate Care and Treatment of a Physician and any Other Income Sources must be given to Us, upon request. This proof must be received within 45 days of Our request. If it is not, benefits may be denied or suspended.

ADDITIONAL SUPPORTING INFORMATION FOR DISABILITY AND OTHER CLAIMS

We may occasionally require You to be examined by a Physician or vocational rehabilitation expert of Our choice to assist in determining whether benefits are payable. We will pay for these examinations; however, You may be responsible for fees associated with failure to notify the examination office of Your appointment cancellation within the required amount of time specified by the examiner. We may recover this fee by reduction of benefits that are payable. We will not require more than a reasonable number of examinations.

Disability and other benefits will be paid after We receive acceptable proof of loss. Benefits will be paid only if We determine that the claimant is entitled to benefits under the terms of the Policy. We may require supporting information which may include, but is not limited to, the following:

a) clinical records;
b) charts;
c) x-rays;
d) Proof of Earnings; and
e) other diagnostic aids.

MODE OF PAYMENT FOR DISABILITY

Disability benefits will be paid by Us monthly after We receive acceptable proof of Disability. Benefits will be paid to You, except benefits unpaid at Your death may be paid, at Our option, to:

a) Your Eligible Survivor; or
b) Your estate.

REFUND TO US

If it is found that We paid more benefits than We should have paid under the Policy, We have the right to a refund from You or the recipient of benefits.

We also have a right to a refund for any payments due to:

a) fraud or misrepresentation;
b) any error We make in processing a claim; or
c) Your receipt of Other Income Sources.

You or the recipient of benefits must reimburse Us in full. We will determine the method by which the repayment is to be made, including without limitation, reducing or withholding Your Monthly Benefit or any benefits payable to You under any other disability insurance policy issued by Us. We will credit these payments to the refund until the refund is fully recovered.

AUTHORITY TO INTERPRET POLICY

By purchasing the Policy, the Policyholder grants Us the discretion and the final authority to construe and interpret the Policy. This means that We have the authority to decide all questions of eligibility and all questions regarding the amount and payment of any Policy benefits within the terms of the Policy as interpreted by Us. Benefits under the Policy will be paid only if We decide, in Our discretion, that a person is entitled to them. In making any decision, We may rely on the accuracy and completeness of any information furnished by the Policyholder, You or any other third party.

The Policyholder further grants Us the authority to delegate to third parties, including, without limitation, United of Omaha Life Insurance Company and any third party administrator with whom We have contracted to provide claims administration and other administrative services, the discretionary authority granted in the Policy. The Policyholder expressly grants such third party the full discretionary authority granted to Us under this Policy.

You or Your beneficiary has the right to request a review of Our decision. If, after exercising the Policy's review procedures, You or Your beneficiary's claim for benefits is denied or ignored, in whole or in part, You or Your beneficiary may file suit and a court will review Your or Your beneficiary's eligibility or entitlement to benefits under the Policy.

CLAIM REVIEW AND APPEAL PROCEDURES

Capitalized terms used in this section have the meanings assigned to them in this section or in other sections of this Certificate.

DEFINITIONS

The definitions set forth below shall apply to both the singular and plural versions of the defined term.

Adverse Benefit Determination means a denial, reduction, or termination of a benefit or a failure to provide or make payment (in whole or in part) for a benefit. This includes, without limitation, any such denial, reduction or termination of a benefit, or failure to provide or make payment, that is based upon ineligibility for insurance under the Policy.

Claimant means the person who submits a claim for benefits under the Policy, including the authorized representative of such person.

CLAIM REVIEW PROCEDURES

Once We receive information necessary to evaluate the claim, We will make a decision within the time periods set forth below. In the event an extension is necessary due to matters beyond Our control, We will notify the Claimant of the extension and the circumstances requiring the extension.

Except when the Claimant voluntarily agrees to provide Us with additional time, extensions are limited as set forth below. If an extension is necessary due to the Claimant's failure to submit complete information, We will notify the Claimant of the additional information required. Such notice of incomplete information will be sent within the time periods set forth below.

In order for Us to continue processing the claim, the missing information must be provided to Us within the time periods set forth below. The Claimant may contact Us at any time for additional details about the processing of the claim.

INITIAL CLAIM DECISION

The period of time within which a claim decision will be made begins at the time the claim is filed, without regard to whether all the information necessary to make a claim decision accompanies the filing. The applicable time periods are shown below:

a) initial claim decision period: 45 days unless additional information is requested as set forth below;
b) extension period: 30 days; and
c) maximum number of extensions: two.

If additional information is needed, We will notify the Claimant within 10 days of Our receipt of the claim. Once the Claimant receives Our request for additional information, the Claimant will be given no less than 45 days to submit the additional information to Us. We will make Our determination within 15 days of Our receipt of the additional information. If We do not receive the additional information within the specified time period, We will make Our determination based upon the available information.

CLAIM DENIALS

If a request for a claim is denied, in whole or in part, the Claimant will receive notice of the denial, which will include:

a) the specific reason(s) for the denial;
b) reference to the specific Policy provisions on which the denial is based;
c) a description of the appeal procedures and time limits applicable to such procedures, including the right to request an appeal within 180 days and the right to bring a civil action following the appeal process; and
d) any other information which may be required under state or federal laws and regulations.

Additionally, if an internal rule, guideline, protocol or other similar criterion was relied upon in making the Adverse Benefit Determination, the Claimant has the right to request information about such internal rule, guideline, protocol or other similar criterion that was used in making the Adverse Benefit Determination, free of charge.

OPPORTUNITY TO REQUEST AN APPEAL

The Claimant shall have a reasonable opportunity to appeal a claim review decision. As part of the appeal, there will be a full and fair review of the claim review decision.

The Claimant will have no later than 180 days from the Claimant's receipt of notification of Our claim review decision to submit a request for an appeal. The request for an appeal should include:

a) the Claimant's name;
b) the name of the person filing the appeal if different from the Claimant;
c) the Policy number; and
d) the nature of the appeal.

The request for an appeal can be submitted in any manner and should include any additional information that may have been omitted from Our review or that should be considered by Us. The notification regarding Our claim review decision will include instructions on how and where to submit an appeal.

By requesting an appeal, the Claimant has authorized Us, or anyone designated by Us, to review any and all records (including, but not limited to, medical records) which We determine may be relevant to the appeal.

A document, record, or other information will be considered relevant to a claim if it:

a) was relied upon in making the claim decision;
b) was submitted, considered, or generated in the course of making the claim decision, without regard to whether it was relied upon in making the claim decision; or
c) demonstrates compliance with administrative processes and safeguards designed to ensure and verify that claim decisions are made in accordance with the Policy and that, where appropriate, Policy provisions have been applied consistently with respect to similarly situated claimants.

RESPONSE TO APPEALS

We will respond no later than 45 days from Our receipt of the request for an appeal. However, if We determine that an extension is required, We will notify the Claimant in writing of the extension prior to the termination of the initial appeal period. In no event will the extension exceed 45 days from the end of the initial appeal period. The extension notice will indicate the special circumstances requiring the extension and the date by which We expect to render the appeal decision.

When We make Our determination, the Claimant will be provided with:

a) information regarding the decision; and
b) information regarding other internal or external appeal or dispute resolution alternatives, including any required state mandated appeal rights.

The period of time within which an appeal decision is required to be made will begin at the time an appeal is filed, without regard to whether all the information necessary to make an appeal decision accompanies the filing. If a period of time is extended as described above due to the Claimant's failure to submit information necessary to decide a claim, the period for making the appeal decision shall be "tolled" or suspended from the date on which the extension notice is sent until the earlier of (1) the date on which We receive the response; or (2) the date established by Us in the notice of extension for the furnishing of the requested information.

STANDARD PROVISIONS

INSURANCE CONTRACT

The insurance contract consists of:

a) the Policy;
b) the Policyholder's signed application attached to the Policy; and
c) any application signed by You.

Statements in an application are considered representations and not warranties. We will not use any statements in Your application to deny a claim or to contest the validity of this insurance unless We provide You with a copy of that application.

CHANGES IN THE INSURANCE CONTRACT

The insurance contract may be changed (including reducing or terminating benefits or increasing premium costs) any time We and the Policyholder both agree to a change. No one else has the authority to change the insurance contract. A change in the insurance contract:

a) does not require Your consent; and
b) must be:
    1. in writing;
    2. made a part of the Policy; and
    3. signed by Our authorized representative in Our home office.

A change may affect any class of Employees included in the Policy.

INCONTESTABILITY

We will not use any statements in Your application to contest the validity of this insurance after it has been in-force during Your lifetime for two years.

LEGAL ACTIONS

No legal action can be brought until at least 60 days after We have been given proof of loss. No legal action can be brought more than 6 years after the date proof of loss is required, unless otherwise required by state law in Your state of residence.

GENERAL DEFINITIONS

The following capitalized terms have the meanings assigned in this section. These terms are used throughout this Certificate.

The definitions set forth below shall apply to both the singular and plural versions of the defined term.

Alcohol and Drug Abuse and/or Substance Abuse means any condition or disease, regardless of its cause, listed in the most recent edition of the International Classification of Diseases as an alcohol or drug related condition or disease.

Certificate means this document that describes the benefits, terms, conditions, exclusions and limitations of the insurance provided under the Policy.

Current Earnings means any actual pre-tax monthly income You receive while You are working and eligible to receive a Monthly Benefit, or the pre-tax earnings You could receive if You were working at Your Maximum Capacity. If Your current earnings fluctuate, We may average Your current earnings over the most recent three-month period and continue Your claim provided the average does not exceed the percentage of Basic Monthly Earnings allowed by the Policy. A Monthly Benefit will not be payable for any month during which Your current earnings exceed that percentage.

Deferred Compensation means contributions You make through a salary reduction agreement with Policyholder to a plan or arrangement under the following Internal Revenue Code (IRC) sections or any other plan or arrangement defined as deferred compensation under the IRC:

a) 401(k);
b) 403(b);
c) 408(k); or
d) 457.

Dependent Child means:

a) Your natural born or legally adopted child;
b) Your stepchild or child of Your domestic or civil union partner or equivalent living in Your home; or
c) any other child who lives with You in a regular parent/child relationship and who qualifies as Your "dependent" as defined in the U.S. Internal Revenue Code.

Dependent child does not include:

a) a child who is married, in a domestic partnership, in a civil union partnership or equivalent, as recognized and allowed by federal law, or by state law in a child's state of residence;
b) a child who has been legally adopted by another person; or
c) a child:
    1. temporarily living in Your home;
    2. placed in Your home by a social service agency which retains control over the child; or
    3. who has a natural parent in a position to exercise parental responsibility and control.

Disability and *Disabled* mean that because of an Injury or Sickness, a significant change in Your mental or physical functional capacity has occurred in which:

a) during the Elimination Period, You are prevented from performing at least one of the Material Duties of Your Regular Occupation on a part-time or full-time basis; and
b) after the Elimination Period, You are:
    1. prevented from performing at least one of the Material Duties of Your Regular Occupation on a part-time or full-time basis; and
    2. unable to generate Current Earnings which exceed 99% of Your Basic Monthly Earnings due to that same Injury or Sickness.

After a Monthly Benefit has been paid for 2 years, *Disability* and *Disabled* mean You are unable to perform all of the Material Duties of any Gainful Occupation.

Disability is determined relative to Your ability or inability to work. It is not determined by the availability of a suitable position with the Policyholder.

Eligible Survivor means Your Spouse, if living; otherwise, it means Your Dependent Child under age 26. An eligible survivor must be living at the time of Your death.

Elimination Period means the number of days of Disability which must be satisfied before You are eligible to receive benefits. The elimination period is shown in the Schedule.

Employee means a person who is:

a) a citizen or permanent resident of the United States; or
b) lawfully and legally able to work in the United States pursuant to applicable federal and state laws; and
c) receiving compensation from the Policyholder for work performed for the Policyholder at:
    1. the Policyholder's usual place of business;
    2. an alternative work site at the direction of the Policyholder; or
    3. a location to which the employee must travel to perform the job.

An employee does not include a person:

a) who resides outside the United States for a period in excess of 12 consecutive months unless written approval has been received from Our authorized representative in Our home office;
b) working on a seasonal or temporary basis; or
c) performing services for the Policyholder as an independent contractor, including persons reporting income on a 1099 form or subject to the terms of a leasing agreement between the Policyholder and a leasing organization.

Family means Your Spouse, a Dependent Child, parents of You or Your Spouse, grandparents of You or Your Spouse, and brothers and sisters of You or Your Spouse.

Family Care means care, supervision, and/or support provided for a Qualifying Family Member on a regular basis for daily periods of less than 24 hours, whether the care is for daytime or nighttime hours. This care must be provided by an adult other than You or a person who is part of Your Family.

Full-Time means working the required number of hours to be considered a full-time employee of the Policyholder.

Gainful Occupation means an occupation for which You are reasonably fitted by training, education or experience.

Gross Monthly Benefit means Your Monthly Benefit amount before any reduction for Other Income Sources and Current Earnings.

Hospital means an accredited facility licensed by the proper authority of the area in which it is located to provide care and treatment for the condition causing confinement. A hospital does not include a facility or institution or part of a facility or institution which is licensed or used principally as a clinic, convalescent home, rest home, nursing home or home for the aged, halfway house or board and care facilities.

Indexed Pre-Disability Earnings means Your Basic Monthly Earnings increased on the first anniversary of Monthly Benefits and each subsequent anniversary by the lesser of 10% or the percentage increase in the Consumer Price Index (CPI-W). The percentage increase in the CPI-W is the difference between the current year's CPI-W and the prior year's CPI-W divided by the prior year's CPI-W.

Injury means an accidental bodily injury that requires treatment by a Physician. It must result in loss independently of Sickness and other causes. Disability resulting from an injury must occur while You are insured under the Policy.

Material Duties means the essential tasks, functions, and operations relating to an occupation that cannot be reasonably omitted or modified. In no event will We consider working an average of more than the required Full-Time hours per week in itself to be a part of material duties. One of the material duties of Your Regular Occupation is the ability to work for an employer on a full-time basis.

Maximum Capacity means, based on Your medical restrictions and limitations:

a) during the first 24 months of Disability payments, the greatest extent of work You are able to do in Your Regular Occupation; and
b) after 24 months of Disability payments, the greatest extent of work You are able to do in any occupation that is reasonably available and for which You are reasonably fitted by education, training, or experience.

Maximum Monthly Benefit means the maximum dollar amount of disability benefit You may receive per month as shown in the Schedule.

Medically Necessary means care that is ordered, prescribed, or rendered by a Physician or Hospital, and is determined by Us, or a qualified party or entity selected by Us, to be:

a) provided for the diagnosis or direct treatment of Your Injury or Sickness;
b) appropriate and consistent with the symptoms and findings or diagnosis and treatment of Your Injury or Sickness; and
c) provided in accordance with generally accepted national professional standards and/or medical practice.

Mental Disorder means any condition or disease, regardless of its cause, listed in the most recent edition of the International Classification of Diseases (ICD) and the Diagnostic and Statistical Manual of Mental Disorders (DSM) as a mental disorder. Not included in this definition are conditions or diseases related to Alcohol and Drug Abuse and/or Substance Abuse.

Monthly Benefit means the amount of disability benefit You may receive per month as described in the Schedule.

Our, We, Us means United of Omaha Life Insurance Company.

Physician means any of the following licensed practitioners:

a) a doctor of medicine (MD), osteopathy (DO), podiatry (DPM) or chiropractic (DC);
b) a licensed doctoral clinical psychologist;
c) a Master's level counselor and licensed or certified social worker who is acting under the supervision of a doctor of medicine or a licensed doctoral clinical psychologist;
d) a licensed physician's assistant (PA) or nurse practitioner (NP); or
e) where required by law, any other licensed practitioner of a healing art who is acting within the scope of his/her license.

A physician does not include:

a) a naturopathic doctor;
b) an acupuncturist;
c) a physician in training; or
d) You, Your Spouse, any person who lives with You, a child, brother, sister or parent of You or Your Spouse.

Plan Administrator means the person or entity designated as the plan administrator for the Policyholder's group disability welfare benefit plan.

Policy means the group policy issued to the Policyholder by Us, including this Certificate.

Policy Anniversary means October 1 of each Policy Year.

Policy Effective Date means October 1, 2019.

Policy Year means the period commencing on the Policy Effective Date and ending on the next succeeding Policy Anniversary and, thereafter, each 12-month period commencing on the Policy Anniversary.

Policyholder's Retirement Plan means any Retirement Plan:

a) which is part of any federal, state, county, municipal, or association retirement system; and
b) for which You are eligible as a result of employment with the Policyholder.

Proof of Earnings means:

a) copies of Your U.S. individual income tax returns and business income tax returns, including all forms, schedules and attachments, if applicable;
b) payroll records; and
c) any other records We request.

Qualifying Family Member means:

a) a Dependent Child under the age of 12; or
b) a member of Your Family living with You who is mentally or physically handicapped and dependent upon You for support and maintenance.

Regular and Appropriate Care and Treatment means You visit and receive care and treatment from a Physician as frequently as is medically required, to effectively manage and treat Your Injury or Sickness. Such care and treatment must be:

a) Medically Necessary;

b) received from a Physician whose expertise, medical training, and clinical experience are suitable for treating Your Injury or Sickness; and
c) received primarily is to improve Your medical condition and thereby aid in Your ability to return to work.

Regular Occupation means the occupation You are routinely performing when Your Disability begins. Your regular occupation is not limited to Your specific position held with the Policyholder, but will instead be considered to be a similar position or activity based on job descriptions included in the most current edition of the U.S. Department of Labor Dictionary of Occupational Titles (DOT). We have the right to substitute or replace the DOT with another service or other information that We determine to be of comparable purpose, with or without notice. To determine Your regular occupation, We will look at Your occupation as it is normally performed in the national economy, instead of how work tasks are performed for a specific employer, at a specific location, or in a specific area or region.

Retirement Plan means a plan which:
a) provides benefits to You, either in a lump sum or in the form of periodic payments, upon the later of:
    1. early or normal retirement as defined in the plan or under the U.S. Social Security Act; or
    2. disability, if the payment does not reduce the amount of money which would have been paid at the normal retirement age under the plan if the disability had not occurred; and
b) is not funded wholly by Your contributions.

A retirement plan shall not include a profit-sharing plan or a plan such as a 401(k), a thrift plan, an individual retirement account (IRA), a tax sheltered annuity (TSA), a stock ownership plan, or a Deferred Compensation plan.

Sickness means a disease, disorder or condition, including pregnancy, that requires treatment by a Physician. Disability resulting from a sickness must occur while You are insured under the Policy. Sickness does not include elective or cosmetic surgery or procedures, or resulting complications. Sickness includes the donation of an organ in a non-experimental organ transplant procedure.

Spouse means the person to whom You are legally married, or Your domestic partner, civil union partner or equivalent, as recognized and allowed by federal law, or by state law in Your state of residence.

You, Your means the Employee who is insured under the Policy.

Group Long-Term Disability Benefits

Hoover City Schools

Group Number: G000BJXW

United of Omaha Life Insurance Company

Home Office:
Mutual of Omaha Plaza
Omaha, Nebraska 68175

UNITED OF OMAHA LIFE INSURANCE COMPANY
A MUTUAL *of* OMAHA COMPANY

YOUR GROUP VOLUNTARY CRITICAL ILLNESS BENEFITS

FOR EMPLOYEES OF:

Hoover City Schools

CLASS(ES): All Eligible Employees

REVISION EFFECTIVE DATE: July 1, 2020

PUBLICATION DATE: July 7, 2020

NOTICE(S)

THE POLICY PROVIDES LIMITED BENEFITS. THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR HOSPITAL OR MEDICAL EXPENSE INSURANCE, A HEALTH MAINTENANCE ORGANIZATION (HMO) CONTRACT, OR MAJOR MEDICAL EXPENSE INSURANCE. THE INSURANCE PROVIDED UNDER THE POLICY DOES NOT SATISFY THE INDIVIDUAL MANDATE OF THE ACA BECAUSE THE COVERAGE DOES NOT MEET THE REQUIREMENTS OF MINIMUM ESSENTIAL COVERAGE.

THE POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. IT DOES NOT FULLY SUPPLEMENT FEDERAL MEDICARE HEALTH INSURANCE. IF YOU ARE ELIGIBLE FOR MEDICARE, REVIEW THE *GUIDE TO HEALTH INSURANCE FOR PEOPLE WITH MEDICARE*, AVAILABLE FROM US OR ONLINE AT WWW.MEDICARE.GOV.

PLEASE READ YOUR CERTIFICATE CAREFULLY. THIS CERTIFICATE DESCRIBES THE BENEFITS THAT ARE AVAILABLE TO YOU UNDER THE POLICY. THE POLICY ONLY PAYS BENEFITS FOR THE DIAGNOSIS OF THE CRITICAL ILLNESSES LISTED IN THE CERTIFICATE. THE POLICY IS ISSUED IN THE STATE OF ALABAMA AND PROVIDES ALL OF THE BENEFITS REQUIRED BY APPLICABLE ALABAMA LAW.

FRAUD WARNING

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Group Number: G000BJXW

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IMPORTANT NOTICE TO PERSONS ON MEDICARE

THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits because Medicare generally pays for most of the expenses for the diagnosis and treatment of the specific conditions or diagnoses named in the policy.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice care
- other approval items and services

BEFORE YOU BUY THIS INSURANCE

- ✓ Check the coverage in **all** health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company or at *www.medicare.gov*.
- ✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

NOTICE(S)

If You have any questions about or concerns with this insurance, please first contact the Policyholder or Your benefits administrator. If after doing so You still have a question or concern, You may contact Us at:

United of Omaha Life Insurance Company
Mutual of Omaha Plaza
Omaha, Nebraska 68175
Call Toll-Free: 1-800-775-8805
www.mutualofomaha.com

When contacting Us, please have Your Policy number available.

IF YOU ARE NOT SATISFIED WITH YOUR CERTIFICATE, YOU MAY RETURN IT TO US WITHIN 30 DAYS AFTER YOU RECEIVE IT, UNLESS A CLAIM HAS PREVIOUSLY BEEN RECEIVED BY US UNDER YOUR CERTIFICATE. WE WILL REFUND WITHIN 30 DAYS OF OUR RECEIPT OF THE RETURNED CERTIFICATE ANY PREMIUM THAT HAS BEEN PAID AND THE CERTIFICATE WILL THEN BE CONSIDERED TO HAVE NEVER BEEN ISSUED. YOU SHOULD BE AWARE THAT IF YOU ELECT TO RETURN THE CERTIFICATE FOR A REFUND OF PREMIUMS, ILLNESS OR LOSSES WHICH OTHERWISE WOULD HAVE BEEN COVERED UNDER YOUR CERTIFICATE WILL NOT BE COVERED.

TABLE OF CONTENTS

PAGE

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CERTIFICATE OF INSURANCE

UNITED OF OMAHA LIFE INSURANCE COMPANY

Home Office:
Mutual of Omaha Plaza
Omaha, Nebraska 68175

Capitalized terms used in this section have the meanings assigned to them in the Definitions section of this Certificate.

United of Omaha Life Insurance Company certifies that Group Policy Number GUDE-BJXW (the Policy) has been issued to Hoover City Schools (the Policyholder). The Policy provides Group Critical Illness Insurance.

Insurance is provided for Employees of the Policyholder subject to the terms and conditions of the Policy. This Certificate is made a part of the Policy.

Please read this Certificate carefully. The benefits described in this Certificate are effective only if You and Your Dependent(s), if applicable, are eligible for the insurance, become insured and remain insured as described in this Certificate and according to the terms and conditions of the Policy.

If the provisions of this Certificate and those of the Policy do not agree, the provisions of the Policy will apply. The Policy is part of a contract between United of Omaha Life Insurance Company and the Policyholder, and may be amended, changed or terminated without Your consent or notice to You.

This Certificate replaces any certificate previously issued under the Policy.

The Policy is nonparticipating, therefore it will pay no dividends. The Policy is noncontributory.

James T. Blackledge
Chief Executive Officer

Daryl Vankat
Corporate Secretary

SCHEDULE

Capitalized terms used in this section have the meanings assigned to them in the Definitions section of this Certificate.

CLASS(ES)

All Eligible Employees

CRITICAL ILLNESS INSURANCE FOR YOU (THE EMPLOYEE)

You may elect to be insured for an amount of critical illness (CI) insurance from $10,000 to $20,000 in increments of $10,000.

Your amount of CI insurance is also referred to as Your CI Principal Sum. Your CI Principal Sum is subject to any reductions indicated in the Benefit Reductions provision in this Schedule. If You have questions regarding the amount of Your CI insurance, You may contact the Policyholder.

CRITICAL ILLNESS INSURANCE FOR YOUR DEPENDENT(S)

Provided You have elected some amount of insurance, You may elect to have Your Spouse insured for an amount of critical illness (CI) insurance from $5,000 to $10,000, in increments of $5,000, provided the amount elected does not exceed 50% of Your CI Principal Sum.

Your Spouse's amount of CI insurance is subject to any reductions indicated in the Benefit Reductions provision in this Schedule.

Provided You have elected some amount of CI insurance, the amount of CI insurance for Your eligible Dependent child(ren) is 25% of Your CI Principal Sum.

Any amount of CI insurance for Your Dependent(s) will be rounded to the next higher multiple of $1,000, if not already an even multiple of $1,000. Any amount of CI insurance for a Dependent is the Dependent's CI Principal Sum. If You have questions regarding the amount of CI insurance for Your Dependent(s), You may contact the Policyholder.

GUARANTEE ISSUE AMOUNT(S) AND EVIDENCE OF INSURABILITY

Guarantee Issue Amount(s) is/are subject to any reductions indicated in the Benefit Reductions provision of this Schedule. Guarantee issue is only available if the total number of Employees insured under the Policy attains or remains above 10 Employees or 15% of the eligible Employees, whichever is greater. If the total number falls below the required level, the Guarantee Issue Amount(s) may be reduced or rescinded.

Guarantee Issue Amount For You (The Employee)

Your Guarantee Issue Amount is $20,000, unless You were insured under a Prior Plan. If You were insured under a Prior Plan, Your Guarantee Issue Amount is equal to the amount of insurance that was in-force for You under the Prior Plan the day before the Policy Effective Date, but in no event more than the maximum amount of insurance stated in the Critical Illness Insurance for You (the Employee) section of this Schedule.

If You are eligible for and elect insurance under the Policy as both an Employee and Spouse, the Guarantee Issue Amount available to You under the Policy is $30,000.00.

Guarantee Issue Amount For Your Spouse

The Guarantee Issue Amount for Your Spouse is $10,000, unless Your Spouse was insured under a Prior Plan. If Your Spouse was insured under a Prior Plan, the Guarantee Issue Amount for Your Spouse is equal to the amount of insurance that was in-force for Your Spouse under the Prior Plan the day before the Policy Effective Date, but in no event more than the maximum amount of insurance stated in the Critical Illness Insurance for Your Dependent(s) section of this Schedule.

Guarantee Issue Amount For Your Dependent Child(ren)

The Guarantee Issue Amount for Your Dependent child(ren) is $5,000, unless Your Dependent child(ren) were insured under a Prior Plan. If Your Dependent child(ren) were insured under a Prior Plan, the Guarantee Issue Amount for Your Dependent children is equal to the amount of insurance that was in-force for Your Dependent children under the Prior Plan the day before the Policy Effective Date, but in no event more than the maximum amount of insurance stated in the Critical Illness Insurance for Your Dependent(s) section of this Schedule.

Insurance is only available on a guarantee issue basis:

a) during Your First Enrollment Period;
b) during a Subsequent Enrollment Period; or
c) as otherwise stated or allowed in the Policy.

Evidence of Insurability

Evidence of Insurability is required for:

a) insurance elected more than 31 days after the date the Employee or Dependent becomes eligible;
b) any amount of insurance elected in excess of a Guarantee Issue Amount for the Employee or Dependent;
c) any increase in the amount of insurance after the initial election of insurance for the Employee or Dependent, unless during a Subsequent Enrollment Period or as otherwise stated or allowed in the Policy;
d) an Employee or Dependent who was eligible for insurance under a Prior Plan but did not elect such insurance; or
e) an Employee or Dependent whose amount of insurance elected under the Policy is in excess of the amount of insurance that was in-force under a Prior Plan the day before the Policy Effective Date, unless elected during a Subsequent Enrollment Period or as otherwise stated or allowed in the Policy.

If Evidence of Insurability is required for items a), d) or e) above, We may require that such evidence be provided at Your expense.

Evidence of Insurability will be waived for any Dependent child(ren) for whom insurance is elected within 31 days after the date a Dependent child(ren) become(s) eligible, if Dependent child insurance requires an election and Dependent child insurance for any other child(ren) is not already in effect under the Policy.

Evidence of Insurability will be waived for any Dependent child(ren) for whom insurance is elected within 31 days after the date a Dependent child(ren) become(s) eligible, if Dependent child insurance requires an election and Dependent child insurance for any other child(ren) is not already in effect under the Policy.

BENEFIT REDUCTIONS

As You grow older, the Principal Sum for critical illness (CI) for You or Your Spouse will be reduced according to the following schedule:

At the Age of:	The Original Amount of Insurance Will Reduce to:
70	50%

Reductions become effective on the first day of the month that coincides with or follows the day You reach the specified age. Any reduced amount of insurance will round to the next higher dollar.

If You are age 70 or older on the date insurance becomes effective, the Principal Sum for CI for You and Your Spouse will be reduced as shown above.

If a reduction to Your CI Principal Sum causes the CI Principal Sum for one or more of Your Dependents to exceed the maximum amount of insurance described previously in this Schedule, the CI Principal Sum for the Dependent will be adjusted to comply with the maximum available.

ELIGIBILITY

Capitalized terms used in this section have the meanings assigned to them in the Definitions section of this Certificate.

WHEN AN EMPLOYEE BECOMES ELIGIBLE FOR INSURANCE

An Employee who is Actively Working on the Policy Effective Date becomes eligible for insurance under the Policy on the Policy Effective Date.

An Employee who is hired after the Policy Effective Date becomes eligible for insurance under the Policy on the day the Employee begins Active Work.

The day on which an Employee becomes eligible for insurance under the Policy may not be the same as the day on which insurance begins. The When Insurance Begins provision describes the day on which insurance begins.

For Residents of California
An Employee must be insured by an individual or group policy or contract that arranges or provides medical, hospital, and surgical coverage not designed to supplement other private or governmental plans.

WHEN A DEPENDENT BECOMES ELIGIBLE FOR INSURANCE

A Dependent becomes eligible for insurance under the Policy on the later of:

a) the day You become eligible for insurance under the Policy; or
b) the day You acquire the Dependent;

provided You elect insurance for yourself under the Policy.

If both You and Your Spouse are eligible for insurance under the Policy as Employees of the Policyholder, You or Your Spouse may also elect insurance as a Dependent of the other person.

If both You and Your Spouse are eligible for insurance under the Policy as Employees of the Policyholder, both You and Your Spouse may elect insurance for Your Dependent child(ren) under the Policy.

In order to insure an eligible Dependent child, You must insure all of Your eligible Dependent child(ren).

The day on which a Dependent becomes eligible for insurance under the Policy may not be the same as the day on which insurance begins. The When Insurance Begins provision describes the day on which insurance begins.

For Residents of California
A Dependent must be insured by an individual or group policy or contract that arranges or provides medical, hospital, and surgical coverage not designed to supplement other private or governmental plans.

CONTINUITY OF INSURANCE UPON TRANSFER OF INSURANCE CARRIER

If there is a conflict between this provision and any other provision of the Policy, this provision shall control.

If the Policy replaces a Prior Plan, the Policy will provide insurance for an Employee who:

a) was insured under the Prior Plan on the day before the Policy Effective Date;
b) is otherwise eligible under the Policy, but is not Actively Working on the Policy Effective Date due to:
    1. Injury or Sickness; or
    2. a leave of absence protected under:
        a. the federal Family and Medical Leave Act (FMLA) or Uniformed Services Employment and Reemployment Rights Act (USERRA) and any amendments thereto; or
        b. any other applicable federal or state law that allows for continuation of insurance in certain instances;
c) is not a retired Employee; and

d) is not insured under any provision of the Prior Plan.

The Policy will not provide insurance under this provision for any Employee who does not satisfy the criteria above unless approved in writing by Our authorized representative in Our home office.

Insurance under this provision is subject to the following conditions:

a) insurance under the Policy may not exceed Your amount of insurance under the Prior Plan on the day before the Policy Effective Date;
b) the benefit payable under the Policy will be the amount which would have been paid by the Prior Plan had insurance remained in-force under the Prior Plan, less the amount of any benefit payable under the Prior Plan;
c) the Policyholder must notify Us in writing prior to the Policy Effective Date of the amount of Your insurance under the Prior Plan on the day before the Policy Effective Date;
d) insurance is subject to uninterrupted payment of premium to Us when due; and
e) insurance is subject to any reductions shown in the Schedule (if applicable) and all other terms and conditions of the Policy.

If insurance is provided for the Employee, insurance may also be provided for any eligible Dependent(s).

We reserve the right to request any information We need from the Policyholder to determine whether the conditions necessary to be eligible for insurance under this provision have been satisfied.

Insurance under this provision will end on the earliest of:

a) the day the Employee returns to Active Work for the Policyholder or begins employment with any other employer;
b) the last day the Employee would have been insured under the Prior Plan, if the Prior Plan had not ended or terminated;
c) the day the Employee's insurance under the Policy ends for any reason shown in the When Insurance Ends provision;
d) the last day of the twelfth month following the Policy Effective Date; or
e) the last day of the time period allowed by FMLA, USERRA or applicable federal or state law that allows for continuation.

If an Employee is eligible for insurance under this provision, the Employee will not be eligible for insurance under any continuation provision in this Certificate.

WHEN INSURANCE BEGINS

An Employee must enroll for any insurance requiring an election by submitting a Written Request for insurance for the Employee and any Dependents. The Written Request must be submitted to the Policyholder no later than 31 days following the day the Employee and any Dependents become(s) eligible. If the Written Request for insurance is not submitted within the required time frame, the Employee and/or Dependents must provide Evidence of Insurability.

An Employee will become insured for any amount of insurance that does not require Evidence of Insurability on the first day of the month that coincides with or follows the latest of the day:

a) the Employee becomes eligible and is Actively Working; or
b) the Employee submits a Written Request to enroll for insurance, if required.

An eligible Dependent will become insured for any amount of insurance that does not require Evidence of Insurability on the latest of the day:

a) the Employee becomes insured;
b) the Employee acquires the eligible Dependent; or
c) the Employee submits a Written Request to enroll the Dependent for insurance, if required.

An eligible Employee or Dependent must provide Evidence of Insurability if it is required. An eligible Employee or Dependent will become insured for any amount of insurance that requires Evidence of Insurability, including any amount in excess of the Guarantee Issue Amount for the Employee and any Dependent(s), on the later of:

a) the first day of the month that follows the day We approve Evidence of Insurability; and
b) the October 1st that follows the day We approve Evidence of Insurability if Evidence of Insurability is properly completed, signed and received by Us due to the Policyholder's annual enrollment period.

Insurance for a Dependent child who became Incapacitated prior to reaching the age of 26 will begin in accordance with the above terms, provided the child otherwise meets the definition of Dependent.

Insurance for a newborn child begins at the moment of live birth. Insurance for a newly adopted newborn child begins with the date of placement into Your custody, or at the moment of live birth if a written agreement to adopt the child was previously entered into by You. If Dependent child insurance requires an election and Dependent child insurance for any other child(ren) is not already in effect under the Policy, a Written Request for insurance for any newborn or newly adopted Dependent child(ren) must be submitted to the Policyholder within 31 days following the day the Dependent child(ren) become(s) eligible in order to continue insurance beyond the 31-day period.

EXCEPTIONS TO WHEN INSURANCE BEGINS (DEFERRED EFFECTIVE DATE)

This provision does not apply if the Employee is eligible for insurance under the Continuity of Insurance Upon Transfer of Insurance Carrier provision. This provision also does not apply to any Dependent who was eligible and insured under any Prior Plan on the day before the Policy Effective Date.

Insurance for an Employee or Dependent who is:

a) confined in a Hospital as an inpatient;
b) confined in any institution or facility other than a Hospital; or
c) confined at home and under the care or supervision of a Physician;

on the day insurance is to begin will not take effect until the day after the Employee has completed one full day of Active Work or Dependent is no longer confined.

Insurance for an Employee who is not Actively Working when insurance would otherwise begin will not take effect until the day after the Employee has completed one full day of Active Work.

In addition, insurance for a Dependent who is unable to perform two or more Activities of Daily Living (ADLs), whether or not confined, will not take effect until the day the Dependent has performed all ADLs for at least 15 consecutive days. This exception does not apply to any Incapacitated Dependent child.

Insurance for a newborn Dependent child, regardless of confinement, will begin in accordance with the When Insurance Begins provision, provided the child otherwise meets the definition of Dependent.

THE FIRST ENROLLMENT PERIOD

An Employee may elect insurance for him/herself and any Dependent(s) during the First Enrollment Period.

If an Employee does not elect insurance during the Employee's or Dependent(s) First Enrollment Period, future elections may only be made in accordance with the Subsequent Enrollment Periods provision, or as otherwise provided under the When Election Changes Are Permitted provision.

SUBSEQUENT ENROLLMENT PERIODS

An Employee may elect, drop, increase, decrease or change insurance for the Employee and any Dependent(s) during a Subsequent Enrollment Period.

WHEN ELECTION CHANGES ARE PERMITTED

An Employee may elect, drop, increase, decrease or change insurance as allowed by the Policyholder. Any election of or increase in insurance for an Employee or Dependent will require Evidence of Insurability unless otherwise stated or allowed in this Certificate.

Life Events

Within 31 days of a Life Event, You may submit a Written Request to change insurance.

If You experience a Life Event and You are currently insured under the Policy, insurance for You and any Dependent(s) may be issued up to the Guarantee Issue Amount without Evidence of Insurability. For any amount of insurance over the Guarantee Issue Amount, or if the Written Request is submitted more than 31 days after the date of a Life Event, We will require Evidence of Insurability.

An Employee who experiences a Life Event who previously declined insurance under the Policy must submit Evidence of Insurability for any change of insurance to be considered by Us.

CHANGES TO INSURANCE BENEFITS

Any allowable change in the benefits, class or amount of insurance for any Insured Person, whether requested by You or the Policyholder, or as a result of the terms of the Policy, will take effect on the first day of the month that follows the date of the request or the change, or the first day of the month that follows the day We approve Evidence of Insurability (if required by Us), whichever is later.

For any increase in insurance, We will use the Policyholder's records and/or the premium We have received to verify that the amount of insurance being requested is the appropriate insurance amount for which the Insured Person is eligible under the terms of the Policy.

If You are not Actively Working on the day any increase in insurance would otherwise take effect, the increase will become effective the first day of the month that follows the day after You return to Active Work.

REINSTATEMENT OF INSURANCE

You may be eligible to reinstate insurance that has ended in accordance with this provision. For any insurance requiring an election, You must submit a Written Request to reinstate insurance within 31 days of Your return to Active Work. We will require Evidence of Insurability if the amount of insurance being requested exceeds the amount of insurance in effect on the Employee's last day of Active Work. If insurance is reinstated for You, insurance may also be reinstated for any eligible Dependent(s).

Reinstated insurance will take effect on the first day of the month that coincides with or follows the date of the Written Request, or the first day of the month that follows the day We approve Evidence of Insurability (if required by Us), whichever is later. If You are not Actively Working on the day the reinstated insurance would otherwise take effect, insurance will become effective on the day after You return to Active Work.

The following reinstatement option(s) is/are available:

Non-Payment of Premium or Voluntary Termination of Insurance

If insurance ended due to the non-payment of premium or voluntary termination of insurance by the Employee, We will require Evidence of Insurability to reinstate insurance.

Involuntary Reduction in Hours

If insurance ended because the Employee was no longer Actively Working due to an involuntary reduction of hours worked, insurance may be reinstated if the Employee returns to Active Work within 90 days from the date insurance ended.

Rehired Employee Due to Layoff or Termination

If insurance ended because the Employee was no longer Actively Working due to layoff or termination of employment with the Policyholder, insurance may be reinstated if the Employee is rehired and returns to Active Work within 90 days from the date insurance ended.

Rehired Employee Due to Leave of Absence

If insurance ended because the Employee was no longer Actively Working due to an approved leave of absence, insurance may be reinstated within 90 days from the date insurance ended upon return to Active Work. If insurance ended because the Employee was no longer Actively Working due to military leave, insurance may be reinstated upon return to Active Work within 31 days of discharge from active duty without satisfying another Eligibility Waiting Period.

Transfer From Portability

If insurance was obtained under the Portability provision while an Employee was not Actively Working, insurance may be reinstated up to the amount of insurance that was in effect under the Portability Policy. Any insurance provided through the Portability Policy will terminate upon reinstatement of insurance as an Actively Working Employee.

WHEN INSURANCE ENDS

Insurance for You and Your Dependent(s), if applicable, will end:

a) on the last day of the month in which You are no longer eligible for insurance under the Policy;
b) on the last day of the month in which You begin active duty in the Armed Forces, National Guard or Reserves of any state or country (except for temporary active duty of 31 days or less);
c) on the day the Policy terminates; or
d) in accordance with the Grace Period provision.

Insurance for You will also end on the date that benefits paid for You reach the Policy benefit maximum.

Insurance for a Dependent will also end:

a) on the last day of the month in which the Dependent is no longer eligible for insurance under the Policy; or
b) on the date that benefits paid for the Dependent reach the Policy benefit maximum.

Insurance ending has no effect on benefits payable for any Critical Illness incurred by an Insured Person while insured under the Policy.

EXCEPTIONS TO WHEN INSURANCE ENDS

If insurance for You and Your Dependent(s), if applicable, would otherwise end, You or Your Dependent(s) may be able to continue insurance under one of the following provisions:

a) Continuation of Insurance for Layoff or Leave
b) Continuation of Insurance for Your Dependents in the Event of Your Death
c) Portability

CONTINUATION OF INSURANCE FOR LAYOFF OR LEAVE

If there is a conflict between this provision and any other provision of the Policy, this provision shall control.

You may be able to continue insurance from the day You cease to be Actively Working in the event of:

a) a temporary involuntary layoff; or
b) a leave of absence approved by the Policyholder due to any personal reason.

In addition, the federal Family and Medical Leave Act (FMLA) and Uniformed Services Employment and Reemployment Rights Act (USERRA) and any amendments thereto, as well as other applicable federal or state laws, may allow continuation of insurance in certain instances for leaves of absence, layoff or termination. Contact the Policyholder for additional information regarding any other continuation options that may be available.

Insurance may be continued for You and Your Dependent(s).

Any insurance continued under this provision will be subject to the following conditions:

a) insurance may not be continued beyond the earliest of:
    1. 12 weeks for Your temporary involuntary layoff;
    2. 12 weeks for Your leave of absence due to any personal reason; or
    3. the time period allowed by FMLA, USERRA or applicable federal or state law that allows for continuation;
b) the amount of insurance for any Insured Person may not be increased while insurance is continued under this provision;
c) We continue to receive premium payment when due (premiums must be paid by You or on Your behalf).

Insurance under this provision will end on the last day of the month which coincides with or follows the earliest of the day:

a) the time period in a) in the preceding paragraph has been satisfied;
b) Your temporary involuntary layoff becomes permanent, if insurance is continued under this provision due to Your temporary involuntary layoff;
c) You return to Active Work;
d) You begin full-time employment with an employer other than the Policyholder; or
e) the Policy terminates.

Insurance under this provision will also end in accordance with the Grace Period provision.

If continued insurance under this provision ends and You have not returned to Active Work, You and Your Dependent(s) may be able to continue or obtain insurance under the Portability provision.

See the Options for Payment of Premium for Continued Insurance provision for premium payment options.

CONTINUATION OF INSURANCE FOR YOUR DEPENDENTS IN THE EVENT OF YOUR DEATH

If there is a conflict between this provision and any other provision of the Policy, this provision shall control.

When insurance under the Policy would otherwise end because of Your death, Your Dependent(s) may be able to continue insurance under this provision if we continue to receive timely premium payment when due (premiums must be paid by Your Dependent(s) or on Your Dependent(s) behalf).

The amount of insurance for any Insured Person may not be increased while insured under this provision.

Insurance under this provision will end on the earliest of the last day of the month which coincides with or follows the day:
a) that is 3 months from the date of Your death; or
b) the Policy terminates.

Insurance under this provision will also end in accordance with the Grace Period provision.

If continued insurance under this provision ends, Your Dependent(s) may be able to continue or obtain insurance under the Portability provision.

See the Options for Payment of Premium for Continued Insurance provision of this Certificate for premium payment options.

PORTABILITY

You have the right to continue receiving group critical illness insurance under this provision if You are under age 70 when insurance would otherwise end for any of the following reasons:
a) You cease to be Actively Working and are not eligible for insurance under any other continuation provision in this Certificate (if applicable);
b) Your employment, membership or association with the Policyholder ends; or
c) the Policy terminates and the Policyholder does not obtain a replacement policy with another insurance carrier within 31 days.

In addition to the above reasons, Your Spouse may be able to continue receiving insurance, including insurance for Dependent child(ren), under this provision if Your Spouse is under age 70 when insurance would otherwise end for any of the following reasons:
a) You enter active duty in the Armed Forces, National Guard or Reserves of any state or country for a period of more than 31 days;
b) divorce or legal separation of You and Your Spouse; or
c) Your death.

In the event Your Spouse continues to receive insurance under this provision, Dependent child(ren) may be insured under You or Your Spouse, but not both.

If You are eligible for insurance under this provision and are not eligible for insurance under any other continuation provision of the Policy (if applicable), You must elect insurance under this provision in order for Your Dependent(s) to be eligible**.**

If an Insured Person requests to continue to receive group insurance under this provision, the amount of insurance available shall not exceed the amount in effect for the Insured Person under the Policy on the day insurance ended.

If You continue to receive group insurance under this provision, You and Your Dependent(s) can not continue insurance under any other continuation provision of the Policy (if applicable).

The Group Critical Illness Insurance Portability Policy

Group insurance continued under this provision is available under another group critical illness insurance policy (the "Portability Policy") issued by Us, as available at the time insurance under this provision is requested. If You or Your Spouse (if applicable) become insured under the Portability Policy, You or Your Spouse will receive a certificate of insurance that describes the terms and conditions of coverage under the Portability Policy.

The Portability Policy may not provide all the same benefits or have all the same terms and conditions that are included in the Policy. In addition, the premium rates charged for insurance under the Portability Policy may not be the same as the premium rates charged for insurance under the Policy. The benefits and premium rates of Our Portability Policy are described on Our portability request form. You may contact the Policyholder or Us to obtain Our portability request form.

We may change the benefits and conditions of the Portability Policy and associated premium rates at any time. We will provide notice of any change at least 31 days before the change is effective.

The continued group insurance coverage under the Portability Policy is available as a result of portability rights that arise solely from the Policy, as arranged for You as an employee welfare benefit subject to the Employee Retirement Income Security Act of 1974, as amended.

Notice of the Right to Continue Insurance Under this Provision

The portability period is the period of time that is 31 days from the date insurance under the Policy would otherwise end ("Portability Period"). When insurance under the Policy would otherwise end, notice of the right to continue insurance under this provision may be given. If notice is not given at least 15 days after the start of the Portability Period, an extension of the period of time in which to request continued insurance under this provision will be allowed. Any extension of the Portability Period will expire on the earlier of:

a) 15 days after notice has been received (if notice is received within 90 days after the start of the Portability Period); or
b) 60 days after the end of the Portability Period, even if notice is not received.

How to Request Continued Insurance Under this Provision

You or Your Spouse must submit a Written Request for insurance under this provision. The Written Request and the initial premium due must be submitted within the Portability Period.

ANNUAL INCREASE OPTION RIDER

This rider is made a part of Group Policy GUDE-BJXW. It is subject to all of the Policy provisions. When the Policy and this rider are in conflict, the rider prevails. This rider is effective the later of the July 1, 2020 or the day You and/or Your Spouse become insured under the Policy.

Capitalized terms used in this rider have the meanings assigned to them in this rider or in the other sections of the Policy.

You may submit a Written Request to increase the amount of insurance for You, Your Spouse and Your Dependent child(ren).

An increase in the amount of insurance will result in a higher premium payment for You. Please contact the Policyholder for more information about Your premium.

REQUESTING AN INCREASE

We will accept Your Written Request within a time period designated by the Policyholder and approved by Our authorized representative in Our home office. You may only submit one Written Request under this rider once per Policy Year.

EVIDENCE OF INSURABILITY

We will require Evidence of Insurability if Your requested amount exceeds $10,000. We will require Evidence of Insurability if Your Spouse's requested amount exceeds $10,000.

We will require Evidence of Insurability for the first increase that results in a total amount of insurance that exceeds the Guarantee Issue Amount for You, Your Spouse, and/or Your Dependent child(ren).

WHEN INCREASE BEGINS

If Your Written Request does not require Evidence of Insurability, an approved increase in the amount of insurance will become effective the first day of the month that follows the day You submit Your Written Request to increase the total amount of insurance.

If Your Written Request requires Evidence of Insurability, an approved increase in the amount of insurance will become effective the first day of the month that follows the day We approve Evidence of Insurability.

AMOUNT OF YOUR REQUEST

You may increase Your amount of insurance by up to $10,000, in increments as shown in the Schedule. Your total amount of insurance, including any requested increase, may not exceed Your maximum benefit amount.

You may increase Your Spouse's amount of insurance up to $5,000, in increments as shown in the Schedule. Your Spouse's total amount of insurance, including any requested increase, may not exceed Your Spouse's maximum benefit amount and may not exceed 50% of Your Principal Sum.

You may increase Your Dependent child(ren)'s amount of insurance. Your Dependent child(ren)'s amount of insurance will be equal to 25% of Your total amount of insurance. If not already an even multiple of $1,000, We will round any amount of insurance for Your Dependent child(ren) to the next higher multiple of $1,000. Your Dependent child(ren)'s total amount of insurance, including any requested increase, may not exceed Your Dependent child(ren)'s maximum benefit amount.

IF ELIGIBLE BUT HAVE NOT ELECTED COVERAGE

An Employee who previously declined insurance under the Policy may submit a Written Request to enroll for insurance for the Employee, the Employee's Spouse, and/or the Employee's Dependent child(ren) during a Subsequent Enrollment Period.

An Employee may request an amount of insurance up to $10,000, in increments as shown in the Schedule.

An Employee may request an amount of insurance for the Employee's Spouse by up to $5,000, in increments as shown in the Schedule.

An Employee may request an amount of insurance for the Employee's Dependent child(ren). The Employee's Dependent child(ren)'s amount of insurance will be equal to 25% of the Employee's new amount of insurance. We will round any amount of insurance for the Employee's Dependent child(ren) to the next higher multiple of $1,000, if not already an even multiple of $1,000.

LIMITATIONS AND EXCLUSIONS

Any election of or increase in insurance is subject to the Pre-existing Condition limitation of the Policy, as well as all additional limitations and exclusions as outlined in the Certificate.

An Employee, an Employee's Spouse, and/or an Employee's Dependent child(ren) are not eligible under this rider if that Employee, Employee's Spouse, and/or Employee's Dependent Child(ren) were previously declined for insurance through Evidence of Insurability.

If You have submitted a claim with Us, other than for the Health Screening Benefit, You and Your Dependent child(ren) are not eligible to increase under this rider. You may request an increase for Your Spouse.

If Your Spouse has submitted a claim with Us, other than for the Health Screening Benefit, Your Spouse is not eligible to increase under this rider. You may request an increase in the amount of insurance for You and Your Dependent child(ren).

If Your Dependent child(ren) has/have submitted a claim with Us, other than for the Health Screening Benefit, You and Your Dependent child(ren) are not eligible to increase under this rider. You may request an increase in the amount of insurance for Your Spouse.

TERMINATION OF RIDER

Your rights under this rider will terminate on the earliest of the day:

a) We receive notification from the Policyholder cancelling this rider;
b) We notify the Policyholder of Our decision to cancel this rider;
c) the Policy terminates; or
d) Your insurance under the Certificate ends.

UNITED OF OMAHA LIFE INSURANCE COMPANY

Corporate Secretary

PREMIUM PAYMENTS

Capitalized terms used in this section have the meanings assigned to them in the Definitions section of this Certificate.

PAYMENT OF PREMIUMS THROUGH PAYROLL DEDUCTION

You are responsible for the payment of premiums for insurance under the Policy. The premium owed by You equals the total premium for all Insured Person(s).

Premiums will be automatically deducted from Your paychecks by the Policyholder, then remitted to Us, as authorized by You during the enrollment process. Please contact the Policyholder for information regarding Your paycheck deductions.

Payment of premium does not guarantee eligibility for coverage.

OPTIONS FOR PAYMENT OF PREMIUM FOR CONTINUED INSURANCE

When insurance is continued We must receive premium payment when due for insurance to remain effective, unless otherwise stated or allowed in the Policy. Premium payment may be made in the following ways:

a) the Policyholder may pay the premiums; or
b) You may pay premium to the Policyholder who will then submit premium to Us.

Contact the Policyholder to determine which option is available to You.

Payment of premium does not guarantee eligibility for coverage.

GRACE PERIOD

All premiums must be paid within the grace period. There is a grace period of 60 days for payment of premiums. This means that, except for the initial premium, if premium is not paid on or before the date it is due, the premium must be paid in the 60-day period that follows. We will consider premium to be paid on the date We receive it.

Insurance will stay in force during the grace period, unless You or the Policyholder provides Us with written notice that insurance for any Insured Person will terminate during the grace period. If We receive such notice, insurance will terminate on the date requested.

If any premium due is not paid during the grace period, insurance will end on the last day of the grace period. If insurance ends, it may be reinstated as described in the Reinstatement of Insurance provision.

PREMIUMS AND PREMIUM CHANGES

The premium rate structure for insurance under the Policy is comprised of attained age rates per thousand dollars of insurance for each Insured Person, with specified age bands.

If You request a change in the amount of insurance for any Insured Person, the Policyholder will provide You with notice of Your new premium amount upon request if You are responsible for the payment of premiums for insurance.

If there is a change in the amount of the premium for insurance for any Insured Person in accordance with the terms of the Policy, or a change in the amount of insurance for any Insured Person as the result of a request of the Policyholder, the Policyholder will provide You with notice of the change at least 15 days prior to the date of the change if You are responsible for the payment of premiums for insurance.

Premium amounts will change if:

a) You reach the Attained Age of the next higher age band in the premium rate structure for the Policy;

b) You reach an Attained Age at which benefits are reduced as described in the Benefit Reductions provision in the Schedule; or
c) premium rates under the Policy are changed.

CRITICAL ILLNESS INSURANCE BENEFITS

Capitalized terms used in this section have the meanings assigned to them in the Definitions section of this Certificate.

BENEFITS

Basic Benefits

In the event an Insured Person is Diagnosed with a Critical Illness while insured under the Policy, We will pay a critical illness (CI) benefit. The benefit amounts payable are shown in the following Critical Illness Benefits Table (the "CI Table"). The amount of CI insurance for each Insured Person, also referred to as the CI Principal Sum, is provided in the Schedule.

Once benefits have been paid for a Critical Illness for an Insured Person, no additional benefits are payable under this Basic Benefits section of the Policy for the Insured Person:

a) for that same Critical Illness; or
b) for any other Critical Illness in that same Benefit Category if 100% of the CI Principal Sum has been paid for the Insured Person in that category.

Once benefits have been paid for a Critical Illness for an Insured Person, benefits remain payable under the Policy for:

a) any other Critical Illness in that same Benefit Category for the Insured Person until 100% of the CI Principal Sum has been paid in the category, if a Partial Benefit was paid for a previous Critical Illness for the Insured Person; or
b) a Critical Illness in a different Benefit Category for the Insured Person if the date of Diagnosis for a subsequent Critical Illness occurs at least 6 months from the date of Diagnosis of a previous Critical Illness for the Insured Person.

If more than one Critical Illness is incurred by an Insured Person at the same time, only the highest applicable benefit is payable. Benefit payments are subject to any policy benefit maximum stated in this Critical Illness Insurance Benefits section of the Policy. Benefit payment is also subject to the definitions, limitations, exclusions and other provisions of the Policy.

Critical Illness Benefits Table (the "CI Table")

Benefit Category/Critical Illness	Benefit
Heart/Circulatory/Motor Function Category	
Heart Attack (Myocardial Infarction)	100% of the CI Principal Sum
Heart Transplant/Placement on UNOS List	100% of the CI Principal Sum
Heart Valve Surgery	25% of the CI Principal Sum
Coronary Artery Bypass	25% of the CI Principal Sum
Aortic Surgery	25% of the CI Principal Sum
Stroke	100% of the CI Principal Sum
ALS (Lou Gehrig's) Disease*	100% of the CI Principal Sum
Advanced Alzheimer's Disease*	100% of the CI Principal Sum
Advanced Parkinson's Disease*	100% of the CI Principal Sum
Organ Category	
Major Organ Transplant/Placement on UNOS List	100% of the CI Principal Sum
End Stage Renal Failure	100% of the CI Principal Sum
Acute Respiratory Distress Syndrome (ARDS)	25% of the CI Principal Sum
Childhood/Developmental Category (These benefits are available to children only.)	
Cerebral Palsy*	100% of the CI Principal Sum
Structural Congenital Defects*	100% of the CI Principal Sum
Genetic Disorders*	100% of the CI Principal Sum
Congenital Metabolic Disorders*	100% of the CI Principal Sum
Type 1 Diabetes*	100% of the CI Principal Sum
Cancer Category	
Cancer (Invasive)	100% of the CI Principal Sum
Bone Marrow Transplant	50% of the CI Principal Sum
Carcinoma in Situ (Non-Invasive Cancer)	25% of the CI Principal Sum
Benign Brain Tumor	25% of the CI Principal Sum

To demonstrate how payment for a Partial Benefit works, assume that a person is insured under the Policy for a CI Principal Sum of $5,000. This person is Diagnosed with ductal breast cancer that has not spread outside of the breast. Under the Policy, this would be considered Carcinoma in Situ (Non-Invasive Cancer), which offers a benefit of 25% of the CI Principal Sum. Since the CI Principal Sum is $5,000, the benefit payable under the Policy is $1,250.

Additional Category Occurrence Benefit

Once benefits have been paid for a Critical Illness for an Insured Person, no additional benefits are payable under the Policy for that same Critical Illness for the Insured Person, but with the additional category occurrence benefit, benefits are still payable for any other Critical Illness for the Insured Person in that same Benefit Category. This benefit allows an Insured Person to receive up to 200% of the CI Principal Sum in the Heart/Circulatory/Motor Function Category and the Organ Category.

An additional category occurrence benefit for an Insured Person is only payable if the date of Diagnosis for an additional Critical Illness occurs at least 12 months after the date of Diagnosis of a previous Critical Illness for the Insured Person in the same Benefit Category for which benefits were paid under the Policy. This benefit does not apply to the Cancer Category or the Childhood/Developmental Category. Additional benefit payments are subject to any policy benefit maximum stated in this Critical Illness Insurance Benefits section of the Policy. Benefit payment is also subject to the definitions, limitations, exclusions and other provisions of the Policy.

To demonstrate how this benefit works, assume that a person is insured under the Policy for a CI Principal Sum of $5,000. This person is Diagnosed with a Heart Attack and receives a benefit of 100% of the Principal Sum ($5,000). 12 months or more later, the same person is Diagnosed with a Stroke, and because the Additional Category Occurrence Benefit is included in the Policy, the person receives another benefit of 100% of the CI Principal Sum ($5,000) for a total of 200% of the CI Principal Sum in the Heart/Circulatory/Motor Function Category.

Reoccurrence Benefit

Once benefits have been paid for a Critical Illness for an Insured Person, a reoccurrence benefit is payable one time for a subsequent Diagnosis of that same Critical Illness. Benefits for some illnesses are only payable once per Insured Person under the Policy, as indicated in the CI Table. The amount of the reoccurrence benefit is the benefit shown in the CI Table for the reoccurring Critical Illness.

A reoccurrence benefit for an Insured Person is only payable if the initial and subsequent dates of Diagnosis for the same Critical Illness under the Policy occur at least 12 months apart without Treatment. Additional benefit payments are subject to any policy benefit maximum stated in this Critical Illness Insurance Benefits section of the Policy. Benefit payment is subject to the definitions, limitations, exclusions and other provisions of the Policy.

To demonstrate how this benefit works, assume that a person is insured under the Policy for a CI Principal Sum of $5,000. This person is Diagnosed with a Heart Attack and receives a benefit of 100% of the Principal Sum ($5,000). 12 months or more later, the same person is Diagnosed with another Heart Attack, and because the Reoccurrence Benefit is included in the Policy, the person receives another benefit of 100% of the CI Principal Sum ($5,000).

Health Screening Benefit

We will pay a health screening benefit of $75 for each Insured Person who has a Health Screening Test performed while insurance under the Policy is in force. This benefit is payable once per calendar year for each Insured Person. Payment of this benefit has no impact on any other benefits payable under this Policy. Benefit payment is subject to the definitions, limitations, exclusions and other provisions of the Policy.

Policy Benefit Maximum

For each Insured Person, the total amount of CI benefits payable under the Policy is subject to a benefit maximum of 200% of the CI Principal Sum in effect for the Insured Person. Any benefits paid for the health screening benefit are not applied toward the benefit maximum.

If the CI benefits paid for an Insured Person reach the benefit maximum, all insurance under the Policy for the Insured Person will terminate. Insurance for any other Insured Persons will remain in effect, subject to this maximum. If insurance terminates for You under this provision, Your Dependent(s), if applicable, may remain insured provided You continue to satisfy the eligibility requirements of the Policy.

LIMITATIONS AND EXCLUSIONS

Pre-Existing Condition Limitation

We will not provide benefits for any Critical Illness caused by, attributable to or resulting from a Pre-existing Condition until 12 months after an Insured Person is continuously insured under the Policy and any Prior Plan (if applicable).

In addition, We will not provide benefits for:

a) any increase in the CI Principal Sum for any Insured Person;
b) the addition by amendment of a benefit or category of benefits under the Policy for any Insured Person; or
c) the election after initial enrollment of any benefit provided by an amendment to the Policy for any Insured Person;

for any Critical Illness caused by, attributable to or resulting from a Pre-Existing Condition until 12 months after the date of the increase or change for any Insured Person.

This Pre-existing Condition limitation will not apply to newborn child(ren) as they are automatically eligible for insurance upon birth.

Exclusions

We will not pay benefits for any Critical Illness that:

a) results, whether the Insured Person is sane or insane, from:
    1. an intentionally self-inflicted Injury or Illness; or
    2. suicide or attempted suicide;
b) results from an act of declared or undeclared war or armed aggression;
c) is incurred while the Insured Person is on active duty or training in the Armed Forces, National Guard or Reserves of any state or country and for which any governmental body or its agencies are liable;
d) results from illegal activities, including participation in an illegal occupation;
e) is the result of:
    1. the voluntary use of illegal drugs by an Insured Person;
    2. the intentional misuse of over the counter medication or prescription drugs by an Insured Person that is not in accordance with recommended dosage and/or warning instruction(s); or
    3. the excessive or harmful use of alcohol and/or alcoholic drinks by an Insured Person; or
f) is Diagnosed outside of the United States.

PAYMENT OF CLAIMS

Capitalized terms used in this section have the meanings assigned to them in the Definitions section of this Certificate.

NOTICE OF CLAIM AND CLAIM FORMS

Before benefits are paid, We must be given written proof of claim as described in the Proof of Claim section below.

As an option, notice of claim may be made to Us within 20 days, or as soon as reasonably possible, after an Insured Person has been Diagnosed with a Critical Illness. The notice should include:

1. The Policyholder's name and the Policy number or group number.
2. The Insured Person's name and mailing address.
3. Your name, mailing address and relationship to the Insured Person, if You are not the Insured Person for whom the claim is being filed.
4. The Claimant's name and mailing address, if the Claimant is other than You or the Insured Person.

Failure to give notice within this time frame shall not invalidate nor reduce any claim.

If notice of claim is given to Us, within 15 days We will provide the requested or necessary claim form(s), instructions and assistance to You, the Insured Person, or the beneficiary, or to the Policyholder for delivery to You, the Insured Person, or the beneficiary. A claim form can also be obtained at any time through Our website.

If We do not provide the requested or necessary form(s) within 15 days, written proof of claim may be submitted that includes the nature, date, cause and extent of the loss for which claim is made, in addition to the information listed previously in this section.

HOW TO OBTAIN PLAN BENEFITS

Forward the completed claim form to:
United of Omaha Life Insurance Company
Mutual of Omaha Plaza
Omaha, Nebraska 68175

CLAIM ASSISTANCE

For assistance with filing a claim or an explanation of how a claim was paid, contact:
United of Omaha Life Insurance Company
Mutual of Omaha Plaza
Omaha, Nebraska 68175
Call Toll-Free: 1-800-775-8805

PROOF OF CLAIM

We must be given written proof of claim within 90 days from the date of Diagnosis of a Critical Illness for an Insured Person. Failure to furnish such proof within this time period shall not invalidate nor reduce any claim if:

a) it was not reasonably possible to give proof within that 90-day period; and
b) proof is furnished as soon as reasonably possible, but not later than one year after the date of Diagnosis or loss, except in the absence of legal capacity.

We may require supporting information which may include, but which is not limited to, the following:

a) clinical records;
b) charts;
c) x-rays; and
d) other diagnostic aids.

We may occasionally require an Insured Person to be examined by a Physician of Our choice to assist in determining whether benefits are payable. We will pay for these examinations. We will not require more than a reasonable number of examinations. Where not prohibited by law, We may also require an autopsy. We will pay for this autopsy.

PAYMENT OF CLAIMS

Benefits will be paid immediately after We receive acceptable proof of claim and confirm liability.

Unless You have assigned this insurance, critical illness (CI) benefits for any Insured Person will be paid to You, except benefits unpaid at Your death or payable due to Your death will be paid to:

a) Your designated beneficiary(ies); if none, then to
b) Your surviving Spouse; if none, then to
c) Your surviving natural and/or adopted child(ren), in equal shares; if none, then to
d) Your surviving parent(s), in equal shares; if none, then to
e) Your estate.

Any benefits paid to a minor may be paid to the legally appointed guardian of the minor. Any benefits paid by Us in good faith will discharge Our liability to the extent of the benefits payment.

BENEFICIARY DESIGNATION

In the event of Your death, a beneficiary should be designated to receive any benefits under the Policy that are unpaid at the time of Your death. Beneficiary records will be kept by the Policyholder, Plan Administrator or the office where beneficiary records for the Policy are kept. The most current beneficiary designation in effect under a Prior Plan will be accepted as a beneficiary designation under the Policy until changed (if applicable).

Certain states are community property states. If You live in a community property state and You designate someone other than Your Spouse as a beneficiary, state law may require that Your Spouse consent to such designation. If You do not obtain Your Spouse's consent to the designation, then such designation may not be effective. Community property states as of the Policy Effective Date include: Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington and Wisconsin.

Your beneficiary may be changed at any time by You or Your assignee (if You have assigned this insurance). To make a change, a Written Request should be provided to the Policyholder, Plan Administrator or to the office where beneficiary records for the Policy are kept. If You do not know where the records are kept, then the Written Request may be sent to Us. When received by the Policyholder or Us, the change will take effect as of the date the Written Request is signed. The change will not apply to any payments or other action taken by Us before the Written Request was received.

RIGHT OF ASSIGNMENT

The rights provided to You under the Policy for insurance are owned by You, unless You have previously assigned these rights to someone else, or You assign Your rights to an assignee. You should consult with a legal counsel prior to making an assignment.

We will recognize an assignee as the owner of the rights assigned only when:

a) the assignment is in writing and acceptable to Us; and
b) a signed or certified copy of the assignment has been received and approved by Us.

The assignment will not apply to any payments or other action taken by Us before the assignment was received and recorded in Our home office. We are not responsible for any legal, tax or other implications of any assignment.

FACILITY OF PAYMENT

In the event benefits under the Policy become payable to You or any person who is not legally competent to claim or receive benefits, a minor, or Your estate, We may pay an amount of up to $500 to any of the following:

a) a person related to You by blood or marriage;
b) a person or entity that has incurred expenses related to Your last illness or death;
c) the person who has assumed the care and support of You or any beneficiary;
d) a personal or legal representative of Your estate

Any benefits paid by Us in good faith will discharge Our liability to the extent of the benefits payment.

MODE OF PAYMENT

CI benefits will be paid by Us in one lump sum.

REFUND TO US

If it is found that We paid more benefits than We should have paid under the Policy, We will have the right to a refund from You or the recipient of benefits.

We also have a right to a refund for any payments due to:
a) fraud or misrepresentation;
b) any error We make in processing a claim;
c) You or Your agent's failure to provide complete information; or
d) an Insured Person not being eligible for coverage.

You or the recipient of benefits must reimburse Us in full. We will determine the method by which the repayment is to be made, including without limitation, reducing or withholding any benefits payable to You, Your survivor(s) or Your estate under this or any other group insurance policy issued by Us. We will credit any such payments to the refund until the refund is fully recovered.

If it is found that We paid less benefits than We should have paid under the Policy, We will make additional payment(s), as necessary.

AUTHORITY TO INTERPRET POLICY

By purchasing the Policy, the Policyholder grants Us the discretion and the final authority to construe and interpret the Policy. This means that We have the authority to decide all questions of eligibility and all questions regarding the amount and payment of any Policy benefits within the terms of the Policy as interpreted by Us. Benefits under the Policy will be paid only if We decide, in Our discretion, that a person is entitled to them. In making any decision, We may rely on the accuracy and completeness of any information furnished by the Policyholder, an Insured Person or any other third party. Our interpretation of the Policy as to the amount of benefits and eligibility shall be binding and conclusive on all persons.

The Policyholder further grants Us the authority to delegate to third parties, including, without limitation, Mutual of Omaha Insurance Company and any third party administrator with whom We have contracted to provide claims administration and other administrative services, the discretionary authority granted in the Policy. The Policyholder expressly grants such third party the full discretionary authority granted to Us under this Policy.

You or the claimant (in the event of Your death) have the right to request a review of Our decision. If, after exercising the Policy's review procedures, the claim for benefits is denied or ignored, in whole or in part, You or the claimant may file suit and a court will review Your or the claimant's eligibility or entitlement to benefits under the Policy.

CLAIM REVIEW AND APPEAL PROCEDURES

Capitalized terms used in this section have the meanings assigned to them in the Definitions section of this Certificate.

NOTICE: In addition to the requirements described in this document, applicable state laws may contain requirements for claims review and appeal procedures. To the extent that any requirement in this document is inconsistent with any state law requirement, the requirement that is most favorable to the Insured Person shall prevail. If You have any questions, please contact Us.

CLAIM REVIEW PROCEDURES

Once We receive information necessary to evaluate the claim, We will make a decision within the time periods set forth below. In the event an extension is necessary due to matters beyond Our control, We will notify the Claimant of the extension and the circumstances requiring the extension.

Except when the Claimant voluntarily agrees to provide Us with additional time, extensions are limited as set forth below. If an extension is necessary due to the Claimant's failure to submit complete information, We will notify the Claimant of the additional information required. Such notice of incomplete information will be sent within the time periods set forth below.

In order for Us to continue processing the claim, the missing information must be provided to Us within the time periods set forth below. The Claimant may contact Us at any time for additional details about the processing of the claim.

INITIAL CLAIM DECISION

The period of time within which a claim decision will be made begins at the time the claim is filed, without regard to whether all the information necessary to make a claim decision accompanies the filing. The applicable time periods are shown below:

a) initial claim decision period: 45 days unless additional information is requested as set forth below;
b) extension period: 30 days; and
c) maximum number of extensions: 2.

If additional information is needed, We will notify the Claimant within 10 days of Our receipt of the claim. Once the Claimant receives Our request for additional information, the Claimant will be given no less than 45 days to submit the additional information to Us. We will make Our determination within 15 days of Our receipt of the additional information. If We do not receive the additional information within the specified time period, We will make Our determination based upon the available information.

CLAIM DENIALS

If a request for a claim is denied, in whole or in part, the Claimant will receive notice of the denial, which will include:

a) the specific reason(s) for the denial;
b) reference to the specific Policy provisions on which the denial is based;
c) a description of the appeal procedures and time limits applicable to such procedures, including the right to request an appeal within 60 days and the right to bring a civil action following the appeal process; and
d) any other information which may be required under state or federal laws and regulations.

Additionally, if an internal rule, guideline, protocol or other similar criterion was relied upon in making the Adverse Benefit Determination, the Claimant has the right to request information about such internal rule, guideline, protocol or other similar criterion that was used in making the Adverse Benefit Determination, free of charge.

OPPORTUNITY TO REQUEST AN APPEAL

The Claimant shall have a reasonable opportunity to appeal a claim review decision. As part of the appeal, there will be a full and fair review of the claim review decision.

The Claimant will have no later than 60 days from the Claimant's receipt of notification of Our claim review decision to submit a request for an appeal. The request for an appeal should include:

1. The Policyholder's name and the Policy number or group number.
2. The Insured Person's name and mailing address.
3. The name and mailing address of the Claimant filing the appeal, if different from the Insured Person.
4. The nature of the appeal.

The request for an appeal can be submitted in any manner and should include any additional information that may have been omitted from Our review or that should be considered by Us. The notification regarding Our claim review decision will include instructions on how and where to submit an appeal.

By requesting an appeal, the Claimant has authorized Us, or anyone designated by Us, to review any and all records (including, but not limited to, medical records) which We determine may be relevant to the appeal.

RESPONSE TO APPEALS

We will respond no later than 45 days from Our receipt of the request for an appeal. However, if We determine that an extension is required, We will notify the Claimant in writing of the extension prior to the termination of the initial appeal period. In no event will the extension exceed 45 days from the end of the initial appeal period. The extension notice will indicate the special circumstances requiring the extension and the date by which We expect to render the appeal decision.

When We make Our determination, the Claimant will be provided with:

a) information regarding the decision; and
b) information regarding other internal or external appeal or dispute resolution alternatives, including any required state mandated appeal rights.

The period of time within which an appeal decision is required to be made will begin at the time an appeal is filed, without regard to whether all the information necessary to make an appeal decision accompanies the filing. If a period of time is extended as described above due to the Claimant's failure to submit information necessary to decide a claim, the period for making the appeal decision shall be "tolled" or suspended from the date on which the extension notice is sent until the earlier of (1) the date on which We receive the response; or (2) the date established by Us in the notice of extension for the furnishing of the requested information.

STANDARD PROVISIONS

Capitalized terms used in this section have the meanings assigned to them in the Definitions section of this Certificate.

INSURANCE CONTRACT

The insurance contract consists of:

a) the Policy (of which this Certificate is made a part of);
b) the Policyholder's signed application attached to the Policy; and
c) any signed application for You or Your Dependent(s).

Statements in an application are considered representations and not warranties. We will not use any statements in an Insured Person's application to deny a claim or to contest the validity of this insurance unless We provide You, Your beneficiary or Your authorized representative with a copy of that application.

CHANGES IN THE INSURANCE CONTRACT

The insurance contract may be changed (including reducing or terminating benefits or increasing premium costs) any time We and the Policyholder both agree to a change. No one else has the authority to change the insurance contract. A change in the insurance contract:

a) does not require the consent of any Insured Person or beneficiary; and
b) must be:
    1. in writing;
    2. made a part of the Policy; and
    3. signed by Our authorized representative in Our home office.

A change may affect any class of Insured Persons included in the Policy.

INCONTESTABILITY

We will not use any statements in an Insured Person's application to contest the validity of this insurance after it has been in-force during the lifetime of the Insured Person for two years.

LEGAL ACTIONS

No legal action can be brought until at least 60 days after We have been given written proof of claim. No legal action can be brought more than six years after the date written proof of claim is required, unless otherwise required by state law in Your state of residence.

MISSTATEMENT OF AGE OR GENDER

If an Insured Person's age or gender is misstated, We may adjust the premium or the benefits payable. An adjustment of the benefits payable will be based on what the premium would have purchased at the correct age or gender.

CONFORMITY WITH STATE STATUTES

Any provision of the Policy which, on its effective date, is in conflict with the statutes of the state in which an Insured Person resides on such date is hereby amended to conform to the minimum requirements of such statutes.

DEFINITIONS

The following capitalized terms have the meanings assigned in this section. These terms are used throughout the Policy.

Actively Working, *Active Work* means an Employee is:

a) performing the normal duties of his or her regular job for the Policyholder on a regular and continuous basis 20 or more hours each week; and
b) receiving compensation from the Policyholder for work performed for the Policyholder.

An Employee will be considered to be actively working on any day that is a regular paid holiday or day of vacation, or regular or scheduled non-working day, provided the Employee was actively working on the last preceding regular work day.

Activities of Daily Living means the basic activities of daily living consisting of the following self-care tasks:

a) personal hygiene (bathing, grooming, shaving and oral care);
b) dressing and undressing (putting on and taking off all items of clothing and any necessary braces or artificial limbs);
c) eating (the ability to feed oneself);
d) transferring (from bed to chair, and back; from sitting to standing, and back);
e) continence (controlling bladder and bowel function);
f) toileting (the ability to use a restroom); and
g) moving around (as opposed to being bedridden).

Acute Respiratory Distress Syndrome (ARDS) means Diagnosis of acute respiratory failure that results in inadequate oxygenation due to aspiration or infection. Diagnosis must be made by a board-certified or board-eligible Physician appropriately specialized for the involved organ(s). Evidence of infiltrates in both lungs in the absence of clinical heart failure and acute lung injury confirmed by testing of blood gases is required.

Adolescence means any biological age from age 12 through age 18.

Advanced Alzheimer's Disease means Diagnosis of Alzheimer's disease that has progressed to a classification of Stage 6 or greater of the Functional Assessment Staging Test (FAST). Diagnosis must be made by a board-certified or board-eligible neurologist, and based on neurological examination and cognitive testing for the involved condition/illness. There must be permanent clinical loss of the ability to do all of the following: remember, reason, and perceive; and understand, express and give effect to ideas. Other types of dementia are not included in this definition. Initial Diagnosis of Alzheimer's disease must occur while the Insured Person is insured under the Policy.

Advanced Parkinson's Disease means Diagnosis of Parkinson's disease that has progressed to a classification of Stage 4 or greater. There must be permanent clinical impairment of motor function with associated tremor, muscle rigidity and postural instability. Diagnosis must be made by a board-certified or board-eligible neurologist, and based on neurological examination and the results of imaging studies for the involved condition/illness. Parkinson's disease secondary to drug abuse and other Parkinsonian syndromes are not included in this definition. Initial Diagnosis of Parkinson's disease must occur while the Insured Person is insured under the Policy.

Adverse Benefit Determination means a denial, reduction, or termination of a benefit or a failure to provide or make payment (in whole or in part) for a benefit. This includes, without limitation, any such denial, reduction or termination of a benefit, or failure to provide or make payment, that is based upon ineligibility for insurance under the Policy.

ALS (Lou Gehrig's) Disease means Diagnosis of amyotrophic lateral sclerosis (ALS or Lou Gehrig's Disease) of the "Middle Stage" according to the Muscular Dystrophy Association. Diagnosis must be made by a board-certified or board-eligible neurologist according to the diagnostic criteria for the involved condition/illness. Other motor neuron diseases are not included in this definition. Initial Diagnosis of amyotrophic lateral sclerosis must occur while the Insured Person is insured under the Policy.

Aortic Surgery means Diagnosis of the need for surgery for disease to the aorta with excision and surgical replacement of a portion of the diseased aorta with a graft. The thoracic and abdominal aorta are included, but branches of the aorta are not included. Angiographic evidence to support the necessity of the surgery is required. Diagnosis must be made by a board-certified or board-eligible cardiologist. The need for any other surgical procedures, such as stent placement or endovascular repair, or surgery following traumatic injury to the aorta, are not included in this definition.

Attained Age means the age of the Insured Person as of the Policy Anniversary that coincides with or follows the Insured Person's birthday. For example, if an Insured Person's 50th birthday is on January 1, 2021 and the Policy Anniversary is October 1, the Insured Person will reach the attained age of 50 on October 1, 2021.

Benefit Category means a grouping of similar Critical Illnesses as shown in the CI Table in the Critical Illness Insurance Benefits section of the Policy.

Benign Brain Tumor means Diagnosis of a non-malignant tumor or cyst in the brain, cranial nerves or meninges within the skull, resulting in permanent neurological deficit with persisting clinical symptoms. Diagnosis must be made by a board-certified or board-eligible neurologist or Physician appropriately specialized for the involved condition, and confirmed by imaging and examination findings. Tumors in the pituitary gland or angiomas are not included in this definition.

Bone Marrow Transplant means Diagnosis of the need for an autologous or allogeneic transplant of bone marrow or stem cells, necessitated by compromise of the bone marrow's ability to appropriately produce blood cells. Diagnosis must be made by a board-certified or board-eligible hematologist or oncologist. The need for transplant of any other organs, parts of organs, tissues or cells is not included in this definition.

Cancer (Invasive) means Diagnosis of any malignant tumor or neoplasm with histological confirmation, characterized by the uncontrolled growth of malignant cells and invasion of tissue beyond the initial tissue. Diagnosis must be made by a board-certified or board-eligible oncologist or pathologist, and based upon Pathological Diagnosis or Clinical Diagnosis. The term malignant tumor includes leukemia, lymphoma and sarcoma. Malignant melanoma or other skin malignancies that have been histologically classified as having caused invasion beyond the epidermis (the outer layer of skin) with: a Clark's level III or greater; Breslow's depth of .75mm or greater; or AJCC TNM stage II or greater; are included in this definition.

Conditions which are not considered invasive cancer are not included in this definition. Such conditions include, but are not limited to:

a) all cancers which are histologically classified as pre-malignant, non-invasive, Carcinoma in Situ, having borderline malignancy or having low malignant potential;
b) benign tumors or polyps;
c) early prostate cancer that is histologically classified as T1N0M0 or equivalent staging;
d) chronic lymphocytic leukemia that is histologically classified as Rai Stage 0 or Binet Stage A; and
e) any skin cancer not previously incorporated in this definition, including:
    1. cutaneous lymphoma; and
    2. melanoma that is histologically classified as:
        a. Clark Level I or II;
        b. Breslow Thickness of less than .75mm; or
        c. AJCC TNM Stage 0 or I.

Carcinoma in Situ (Non-Invasive Cancer) means Diagnosis of cancer in which the tumor or cells still lie within the tissue of origin without having invaded neighboring tissue or regional lymph nodes. Diagnosis must be made by a board-certified or board-eligible oncologist or pathologist, and be based upon Pathological Diagnosis or Clinical Diagnosis. Carcinoma in situ includes, but is not limited to:

a) early prostate cancer that is histologically classified as AJCC TNM Stage T1N0M0 or equivalent staging;
b) chronic lymphocytic leukemia that is histologically classified as Rai Stage 0 or Binet Clinical Stage A;
c) cutaneous lymphoma; and
d) melanoma not invading the reticular (lower) dermis that is histologically classified as:
    1. Clark Level I or II;
    2. Breslow Thickness of less than .75mm; or
    3. AJCC TNM Stage 0 or I.

Lesser skin malignancies (basal cell and squamous cell carcinomas, for example), pre-malignant lesions (intraepithelial neoplasia, for example), and benign tumors or polyps are not included in this definition.

Cerebral Palsy means Diagnosis made during Childhood of cerebral palsy, which is the group of non-progressive disorders of movement and posture caused by abnormal development of or damage to the motor control centers of the brain. Evidence of significant disturbances of sensation, cognition, communication, perception and/or behavior, a seizure disorder, or inability to independently perform Activities of Daily Living, is required. Diagnosis must be made by a board-certified or board-eligible pediatrician or Physician appropriately specialized for the involved defect/disorder, and confirmed by diagnostic testing after the child reaches the biological age of 18 months. Other similar conditions such as degenerative nervous

disorders, genetic diseases, muscle diseases, metabolic disorders, nervous system tumors, coagulation disorders, or other injuries or disorders which delay early development (but can be outgrown) must be ruled out and are not included in this definition.

Certificate means this document that describes the benefits, terms, conditions, exclusions and limitations of the insurance provided under the Policy.

Childhood means any biological age from birth through age 11.

Claimant means the person who submits a claim for benefits for any Insured Person under the Policy, including the authorized representative of such person.

Clinical Diagnosis means a Diagnosis based on the study of symptoms and diagnostic test results. We will accept a clinical diagnosis if the following conditions are met:

a) a Pathological Diagnosis cannot be made because it is medically inappropriate or life-threatening;
b) medical evidence exists to support the Diagnosis; and
c) a Physician is treating the Insured Person for Cancer and/or Carcinoma in Situ (Non-Invasive Cancer).

Congenital Metabolic Disorders means Diagnosis made during Childhood of any of the following: Gaucher's disease (excluding type I); glutaric acidemia type 1; glycogen storage disease types I, II, IV and VII; infantile Tay-Sachs disease; Lesch-Nyhan syndrome; Niemann-Pick disease; or Zellweger syndrome. Diagnosis must be made by a board-certified or board-eligible pediatrician or Physician appropriately specialized for the involved defect/disorder, and based on screening or diagnostic tests, including gas chromatography/mass spectrometry (GC/MS) testing if available. A prenatal diagnosis of one or more of these defects/disorders for an eligible Dependent child is included in this definition upon the live birth of the Dependent child. In the event of a prenatal diagnosis, the date of Diagnosis under the Policy for the defect/disorder(s) will be the date of birth of the Dependent child.

Coronary Artery Bypass means Diagnosis of the need for surgery requiring median sternotomy (surgery to divide the breastbone) to correct narrowing or blockage of one or more coronary arteries with by-pass grafts. Angiographic evidence to support the necessity of the surgery is required. Diagnosis must be made by a board-certified or board-eligible cardiologist. Balloon angioplasty, laser embolectomy, atherectomy, stent placement or other non-surgical procedures are not included in this definition.

Critical Illness means any illness shown in the CI Table in the Critical Illness Insurance Benefits section of the Policy for which an Insured Person is Diagnosed after the effective date of insurance under the Policy for the Insured Person. This definition does not include the reoccurrence of a cancer that was previously diagnosed before the effective date of insurance for an Insured Person unless, after the previous diagnosis and before the date of the subsequent diagnosis, the Insured Person is free of any Treatment of the cancer during the 12 consecutive months prior to the effective date of insurance under the Policy for the Insured Person, or any 12 consecutive months thereafter.

Dependent means a citizen, permanent resident or lawful resident of the United States who, as indicated by evidence acceptable to Us, is:

a) Your Spouse;
b) Your natural born or legally adopted child;
c) Your stepchild;
d) a child that You or Your Spouse are required to provide insurance for under the terms of a:
    1. Qualified Medical Child Support Order (QMCSO), National Medical Support Notice or equivalent; or
    2. decree, judgment or order issued by a court of competent jurisdiction; or
e) any other child who lives with You in a regular parent/child relationship and who qualifies as Your "dependent" as defined in the United States Internal Revenue Code.

A dependent does not include:

a) anyone who is a member of the Armed Forces, National Guard or Reserves of any state or country on active duty (except for temporary duty of 31 days or less);
b) Your divorced, legally separated or former Spouse;
c) a child who has reached the age of 26 unless the child is Incapacitated;
d) a child who is not dependent upon You for support and maintenance;
e) Your child if the child has been legally adopted by another person; or
f) a child placed in Your home by a social service agency which retains control over the child.

Diagnosed or *Diagnosis* means the definitive establishment of a Critical Illness as defined in this section of the Policy.

Employee means a person who is:

a) a citizen or permanent resident of the United States; or
b) lawfully and legally able to work in the United States pursuant to applicable federal and state laws; and
c) performing work for the Policyholder at:
    1. the Policyholder's usual place of business;
    2. an alternative work site at the direction of the Policyholder; or
    3. a location to which the employee must travel to perform the job.

An employee does not include a person:

a) who resides outside the United States for a period in excess of 12 consecutive months unless written approval has been received from Our authorized representative in Our home office;
b) working for the Policyholder on a seasonal or temporary basis; or
c) performing services for the Policyholder as an independent contractor, including persons for whom income is reported on a 1099 form or subject to the terms of a leasing agreement between the Policyholder and a leasing organization.

End Stage Renal (Kidney) Failure means Diagnosis of chronic and end stage (irreversible) failure of both kidneys to function, as a result of which the need for regular (at least weekly) dialysis or transplant is recommended to sustain life. Diagnosis must be made by a board-certified or board-eligible Physician appropriately specialized for the involved organ(s). Renal failure caused by a traumatic event or surgical trauma is not included in this definition.

Evidence of Insurability means proof of good health acceptable to Us. This proof may be obtained through questionnaires, physical exams or written documentation, as required by Us.

Family means Your Spouse, former Spouse, children, parents, grandparents, grandchildren, brothers, sisters and the spouses (or domestic partners or equivalent) of such individuals, or Your Spouse's relatives of like degree.

First Enrollment Period means the 31-day period following the day the Employee or Dependent becomes eligible for insurance under the Policy or any Prior Plan.

Genetic Disorders means Diagnosis made during Childhood of any of the following: infantile onset ascending spastic paralysis; cystic fibrosis; Down syndrome; juvenile primary lateral sclerosis; muscular dystrophy; ostogenesis imperfecta (excluding type I); spinal muscular atrophy type I or II; or Vascular Ehlers-Danlos syndrome. Diagnosis must be made by a board-certified or board-eligible pediatrician or Physician appropriately specialized for the involved defect/disorder, and based on genetic testing. A prenatal diagnosis of one or more of these defects/disorders for an eligible Dependent child is included in this definition upon the live birth of the Dependent child. In the event of a prenatal diagnosis, the date of Diagnosis under the Policy for the defect/disorder(s) will be the date of birth of the Dependent child.

Guarantee Issue Amount means the amount of insurance We may issue without requiring Evidence of Insurability.

Health Screening Test means any of the following: abdominal aortic aneurysm ultrasound; blood test for triglycerides; bone marrow testing; bone density screening; breast ultrasound; CA 15-3 (blood test for breast cancer); CA 125 (blood test for ovarian cancer); carotid ultrasound; CEA (blood test for colon cancer); chest X-ray; colonoscopy; CT angiography; EKG; double contrast barium enema; fasting blood glucose test; flexible sigmoidoscopy; hemoccult stool analysis; mammography; pap smear; PSA (blood test for prostate cancer); serum cholesterol test (for HDL and LDL levels); SPEP (blood test for myeloma); stress test (on a bicycle or treadmill); or thermography.

Heart Attack (Myocardial Infarction) means Diagnosis of the death of a portion of the heart muscle (myocardium) due to inadequate blood supply that has resulted in all of the following evidence of acute myocardial infarction:

a) typical physical symptoms (characteristic chest pain, for example);
b) new and serial characteristic electrocardiographic (EKG) changes consistent with myocardial infarction; and
c) the characteristic rise of cardiac enzymes, biochemical markers or Troponins recorded at the following levels or higher:
    1. Troponin T > 1.0 ng/ml; or
    2. AccuTnl > 0.5 ng/ml or equivalent threshold with other Troponin I methods.

The evidence must show a definite acute myocardial infarction. Diagnosis must be made by a board-certified or board-eligible cardiologist. Diagnosis of other acute coronary syndromes (including but not limited to angina or established (old) myocardial infarction), any other disease or injury involving the cardiovascular system, or cardiac arrest not caused by a myocardial infarction are not included in this definition.

Heart Transplant/Placement on OPTN/UNOS List means Diagnosis of the need for transplantation of a healthy human heart, or inclusion on the Organ Procurement and Transplantation Network/United Network for Organ Sharing (OPTN/UNOS) waiting list for such a procedure, necessitated by the diagnosis of end-stage heart disease. Diagnosis must be made by a board-certified or board-eligible cardiologist. The transplant of any other organs, parts of organs, tissues or cells is not included in this definition.

Heart Valve Surgery means Diagnosis of the need for surgery requiring median sternotomy (surgery to divide the breastbone) to replace or repair one or more heart valves. Diagnosis must be made by a board-certified or board-eligible cardiologist. Evidence to support the necessity of the surgery is required.

Hospital means a facility that:

a) is accredited, approved, certified or licensed by the proper authority of the state in which it is located to provide care and treatment for injured or sick people on an inpatient basis;
b) is recognized as a general hospital by the Joint Commission;
c) provides 24-hour nursing service by Registered Nurses (RNs); and
d) has organized facilities and equipment for diagnosis and treatment of acute medical and surgical conditions on its premises or in facilities available to it on a prearranged basis.

A hospital does not include a facility or institution, or part thereof, which is licensed or used principally as a:

a) clinic (including dental, mental illness or substance abuse facilities), ambulatory medical center or urgent care center;
b) convalescent home, rest home, nursing home or home for the aged;
c) halfway house; or
d) rehabilitative, alternate care, extended care, skilled nursing or board and care facility.

Incapacitated means that a Dependent child, by reason of intellectual disability, developmental disability, mental illness or physical handicap, is continuously incapable of:

a) performing two or more Activities of Daily Living (ADLs), if younger than the age of 26; or
b) self-sustaining employment, if older than the age of 26.

Injury, Injuries means an accidental bodily injury that requires treatment by a Physician.

Insured Person(s) means You and/or Your Dependent(s) who are insured under the Policy.

Life Event means:

a) a change in Your legal marital status or domestic partnership (or equivalent);
b) a change in the number of Your Dependents.

Major Organ Transplant/Placement on OPTN/UNOS List means the diagnosis of the need for transplantation of a healthy, complete human liver, lung, pancreas, small intestine or large intestine, or inclusion on the Organ Procurement and Transplantation Network/United Network for Organ Sharing (OPTN/UNOS) waiting list for such a procedure, necessitated by the diagnosis of end-stage organ disease (organ failure). Diagnosis must be made by a board-certified or board-eligible Physician appropriately specialized for the involved organ(s). The need for organ transplant as a direct result of life-threatening cancer, or the transplant of any other organs, parts of organs, tissues or cells, is not included in this definition.

Our, We, Us means United of Omaha Life Insurance Company.

Partial Benefit means a Critical Illness for which the benefit payable is less than 100% of the CI Principal Sum, as shown in the CI Table in the Critical Illness Insurance Benefits section of the Policy.

Pathological Diagnosis means a Diagnosis of Cancer or Carcinoma in Situ (Non-Invasive Cancer) based upon a microscopic study of fixed tissue or preparations from the hemic (blood) system. Diagnosis must be made by a board-certified or board-eligible pathologist, and the Diagnosis of malignancy must conform with the standards set by the American Board of

Pathology or American College of Pathology. The date of Diagnosis under the Policy for Cancer or Carcinoma in Situ (Non-Invasive Cancer) is the day the tissue, preparation or culture are taken.

Physician means a legally qualified medical doctor licensed to practice medicine, prescribe drugs, perform surgery, or where required by state law, any other licensed practitioner of a healing art who is deemed to be the same as a legally qualified medical doctor. The physician must be acting within the scope of his/her license. A physician does not include the Insured Person or any Family member.

Plan Administrator means the person or entity designated as the plan administrator for the Policyholder's group critical illness insurance plan.

Policy means the group policy issued to the Policyholder by Us, including this Certificate.

Policy Anniversary means October 1 of each Policy Year.

Policy Effective Date means October 1, 2019.

Policy Year means the period commencing on the Policy Effective Date and ending on the next succeeding Policy Anniversary and, thereafter, each 12-month period commencing on the Policy Anniversary.

Pre-existing Condition means any Critical Illness for which an Insured Person received Treatment in the 3 months prior to:

a) the date the Insured Person became insured under the Policy or any Prior Plan; or
b) the date of any increase in benefits under the Policy.

Prior Plan means any similar insurance policy:

a) replaced by insurance under part or all of the Policy; and
b) in effect and maintained or sponsored by the Policyholder on the day before the Policy Effective Date.

Schedule means the section of the Certificate identified as the "Schedule."

Sickness means a disease, disorder or condition that requires treatment by a Physician.

Spouse means the person to whom You are legally married.

Stroke means Diagnosis of the death or permanent damage of brain tissue due to inadequate blood supply or hemorrhage within the skull resulting in permanent neurological deficit with persisting clinical symptoms, categorized with a score of 3 or higher on the modified Rankin Scale (mRS). Diagnosis must be made by a board-certified or board-eligible neurologist, and damage evidenced by computerized axial tomography (CAT scan) or magnetic resonance imaging (MRI) and examination demonstrating lasting neurological deficits. Transient ischaemic attack; traumatic or infection-caused injury to brain tissue or blood vessels; brain injury associated with hypoxia, anoxia or hypotension; vascular disease affecting the eye or optic nerve; chronic cerebrovascular insufficiency; and ischemic disorders of the vestibular system are not included in this definition.

Structural Congenital Defects means Diagnosis made during Childhood of any of the following: anal atresia; anencephaly; bilary atresia; cleft lip and/or palate; club foot; coractation; diaphragmatic hernia; gastroschisis; Hirschsprung's disease; hypoplastic left heart system; omphalocele; patent ductus arteriosis; pyloric stenosis; spina bifida; tetralogy of fallot; or transposition of the great arteries. Diagnosis must be made by a board-certified or board-eligible pediatrician or Physician appropriately specialized for the involved defect/disorder, and confirmed by diagnostic testing if applicable. A prenatal diagnosis of one or more of these defects/disorders for an eligible Dependent child is included in this definition upon the live birth of the Dependent child. In the event of a prenatal diagnosis, the date of Diagnosis under the Policy for the defect/disorder(s) will be the date of birth of the Dependent child.

Subsequent Enrollment Period means any period of up to 31 consecutive calendar days designated for enrollment under the Policy by the Policyholder and agreed to in writing by Our authorized representative in Our home office.

Treatment means medical advice, consultation, care or services (including diagnostic measures) received by an Insured Person, or the use of drugs or medicines by an Insured Person. For Cancer or Carcinoma in Situ (Non-Invasive Cancer), this definition does not include routine follow-up visits with a Physician to verify whether or not the cancer has returned, or maintenance drug therapy (ongoing hormonal therapy, immunotherapy or chemo-prevention therapy that is intended to decrease the risk of cancer reoccurrence following the full remission of a cancer.

Type 1 Diabetes means Diagnosis made during Childhood or Adolescence of diabetes that results from auto-immune destruction of insulin producing cells in the pancreas. Confirmation of the cause of low insulin production is required. Diagnosis must be made by a board-certified or board-eligible endocrinologist or Physician appropriately specialized for the involved condition, and based on blood tests.

Written Request means a request that is signed, dated and submitted to the Policyholder or Us. The request must be on a form We supply or be in a form and content acceptable to Us.

You, Your means the Employee who is insured under the Policy.

Group Voluntary Critical Illness Benefits

Hoover City Schools

Group Number: G000BJXW

United of Omaha Life Insurance Company

Home Office:
Mutual of Omaha Plaza
Omaha, Nebraska 68175

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UNITED OF OMAHA LIFE INSURANCE COMPANY
A MUTUAL *of* OMAHA COMPANY

YOUR GROUP VOLUNTARY ACCIDENT BENEFITS

FOR EMPLOYEES OF:

Hoover City Schools

CLASS(ES): All Eligible Employees

EFFECTIVE DATE: October 1, 2019

PUBLICATION DATE: August 26, 2019

NOTICE(S)

THE POLICY PROVIDES LIMITED BENEFITS. THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR HOSPITAL OR MEDICAL EXPENSE INSURANCE, A HEALTH MAINTENANCE ORGANIZATION (HMO) CONTRACT, OR MAJOR MEDICAL EXPENSE INSURANCE.

THE INSURANCE PROVIDED UNDER THE POLICY DOES NOT SATISFY THE INDIVIDUAL MANDATE OF THE ACA BECAUSE THE COVERAGE DOES NOT MEET THE REQUIREMENTS OF MINIMUM ESSENTIAL COVERAGE. CONSUMERS MAY BE LIABLE FOR A FEDERAL TAX PENALTY UNLESS THEY PURCHASE A HEALTH BENEFIT PLAN (OR PLANS) THAT PROVIDE MINIMUM ESSENTIAL COVERAGE.

THE POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. IT DOES NOT FULLY SUPPLEMENT FEDERAL MEDICARE HEALTH INSURANCE. IF YOU ARE ELIGIBLE FOR MEDICARE, REVIEW THE *GUIDE TO HEALTH INSURANCE FOR PEOPLE WITH MEDICARE*, AVAILABLE FROM US OR ONLINE AT WWW.MEDICARE.GOV.

PLEASE READ YOUR CERTIFICATE CAREFULLY. THIS CERTIFICATE DESCRIBES THE BENEFITS THAT ARE AVAILABLE TO YOU UNDER THE POLICY. THE POLICY ONLY PAYS BENEFITS FOR ACCIDENTAL INJURIES AND TREATMENT OF ACCIDENTAL INJURIES AS LISTED IN THE CERTIFICATE. THE POLICY IS ISSUED IN THE STATE OF ALABAMA AND PROVIDES ALL OF THE BENEFITS REQUIRED BY APPLICABLE ALABAMA LAW.

FRAUD WARNING

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Group Number: G000BJXW

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IMPORTANT NOTICE TO PERSONS ON MEDICARE

THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

This insurance pays limited benefits, if you meet the conditions listed in the policy, for treatment and conditions that result from an accidental injury. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

- any expense or services covered by the policy are also covered by Medicare; or
- it pays the fixed dollar amount stated in the policy and Medicare covers the same event

Medicare generally pays for most of all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice care
- outpatient prescription drugs if you are enrolled in Medicare Part D
- other approval items and services

BEFORE YOU BUY THIS INSURANCE

- ✓ Check the coverage in **all** health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company or at *www.medicare.gov*.
- ✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

NOTICE(S)

If You have any questions about or concerns with this insurance, please first contact the Policyholder or Your benefits administrator. If after doing so You still have a question or concern, You may contact Us at:

United of Omaha Life Insurance Company
Mutual of Omaha Plaza
Omaha, Nebraska 68175
Call Toll-Free: 1-800-948-9478
www.mutualofomaha.com

When contacting Us, please have Your Policy number available.

IF YOU ARE NOT SATISFIED WITH YOUR CERTIFICATE, YOU MAY RETURN IT TO US WITHIN 30 DAYS AFTER YOU RECEIVE IT, UNLESS A CLAIM HAS PREVIOUSLY BEEN RECEIVED BY US UNDER YOUR CERTIFICATE. WE WILL REFUND WITHIN 30 DAYS OF OUR RECEIPT OF THE RETURNED CERTIFICATE ANY PREMIUM THAT HAS BEEN PAID AND THE CERTIFICATE WILL THEN BE CONSIDERED TO HAVE NEVER BEEN ISSUED. YOU SHOULD BE AWARE THAT IF YOU ELECT TO RETURN THE CERTIFICATE FOR A REFUND OF PREMIUMS, LOSSES WHICH OTHERWISE WOULD HAVE BEEN COVERED UNDER YOUR CERTIFICATE WILL NOT BE COVERED.

TABLE OF CONTENTS

PAGE

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CERTIFICATE OF INSURANCE

UNITED OF OMAHA LIFE INSURANCE COMPANY

Home Office:
Mutual of Omaha Plaza
Omaha, Nebraska 68175

Capitalized terms used in this section have the meanings assigned to them in the Definitions section of this Certificate.

United of Omaha Life Insurance Company certifies that Group Policy Number GUDH-BJXW (the Policy) has been issued to Hoover City Schools (the Policyholder). The Policy provides Group Accident Insurance.

Insurance is provided for Employees of the Policyholder subject to the terms and conditions of the Policy. This Certificate is made a part of the Policy.

Please read this Certificate carefully. The benefits described in this Certificate are effective only if You and Your Dependent(s), if applicable, are eligible for the insurance, become insured and remain insured as described in this Certificate and according to the terms and conditions of the Policy.

If the provisions of this Certificate and those of the Policy do not agree, the provisions of the Policy will apply. The Policy is part of a contract between United of Omaha Life Insurance Company and the Policyholder, and may be amended, changed or terminated without Your consent or notice to You.

This Certificate replaces any certificate previously issued under the Policy.

The Policy is nonparticipating, therefore it will pay no dividends. The Policy is non contributory.

James T. Blackledge
Chief Executive Officer

Jay D. Vankat
Corporate Secretary

SCHEDULE

Capitalized terms used in this section have the meanings assigned to them in the Definitions section of the Policy.

CLASS(ES)

All Eligible Employees

ACCIDENT INSURANCE

Accident insurance offers financial protection for You and Your insured Dependent(s) by paying a benefit if You or an insured Dependent are Injured in an Accident. The benefit amount(s) payable is/are based on the type and amount of insurance in effect on the date the Accident occurs, subject to the definitions, limitations, exclusions and other provisions of the Policy.

You may elect insurance for Yourself and Your Dependent(s) under this Certificate for one of the following coverage options:

a) Yourself only;
b) You and Your Spouse;
c) You and Your Dependent child(ren); or
d) You, Your Spouse and Your Dependent child(ren).

Unless otherwise stated in this Certificate, the benefit amount payable is the same for You and Your insured Dependent(s). If You have questions regarding who is insured for accident insurance, You may contact the Policyholder.

Plan Type

This Certificate represents the accident insurance available under Full Plan 1M (AL-NC-CAT-NABM), as selected by the Policyholder. If You have questions regarding the plan type, You may contact the Policyholder.

Coverage Type

This Certificate provides insurance for Accidents that occur any time of day, regardless of whether You or Your insured Dependent(s) are working or not. This is known as "24-hour coverage" or "on and off-job coverage."

EXPRESS BENEFIT

If You or an insured Dependent are Injured as the result of an Accident, We will pay a benefit amount of $75 upon notification of the Accident. The benefit can be paid in a very short time frame and based on minimal information (compared to a typical Accident claim).

This benefit is payable once per Accident for each Insured Person that is Injured as a result of the Accident. This benefit is subject to all of the applicable definitions, limitations, exclusions and other provisions of the Policy.

BASIC BENEFITS

The basic benefits payable under this Certificate are organized into the following categories:

Category	Benefit Amount
Initial Care & Emergency	Up to $1,000
Specified Injuries	Up to $10,000
Hospital, Surgical & Diagnostic	Up to $400 per day and $1,000 for admission
Follow-Up Care	Up to $750

Within each category, benefits are payable up to the amount shown, depending on the type of Injury sustained or the type of medical Treatment that is received as the result of an Accident. The specific benefit amounts, conditions and limitations that are applicable to each Injury or Treatment are available in the applicable benefits section of this Certificate for each category.

(For example, specific information for the Initial Care & Emergency category can be located in the section titled “Initial Care & Emergency Benefits.”)

ADDITIONAL BENEFIT(S)

In addition to Basic Benefits, family care benefits (benefits for transportation, Lodging and Childcare) and a health screening benefit are available under this Certificate.

The specific benefit amounts, conditions and limitations that are applicable to the additional benefit(s) are available in the Additional Benefit(s) section of this Certificate.

CATASTROPHIC INSURANCE

In addition to Basic Benefits, benefits for catastrophic losses and Injuries are available under this Certificate.

Catastrophic insurance pays a benefit if You or an insured Dependent are in an Accident and experience a serious loss or Injury, such as death or dismemberment. The benefit amount payable is based on the amount of insurance that is in effect for You or an insured Dependent on the date the Accident occurs, subject to the definitions, limitations, exclusions and other provisions of the Policy.

Provided You have elected accident insurance, Your amount of catastrophic insurance is $25,000.

Provided You have elected accident insurance for Your Spouse, Your Spouse’s amount of catastrophic insurance is $10,000.

Provided You have elected accident insurance for Your Dependent child(ren), the amount of catastrophic insurance for Your Dependent child(ren) is $5,000.

The amount of catastrophic insurance is also referred to as the Principal Sum. The Principal Sum for You or Your Spouse reduces by 50% when You reach the age of 70. If You have questions regarding the amount of catastrophic insurance for You or Your Dependent(s), You may contact the Policyholder.

The specific conditions and limitations that are applicable to catastrophic insurance are available in the Catastrophic Benefits section of this Certificate.

GUARANTEE ISSUE AMOUNT(S) AND EVIDENCE OF INSURABILITY

All amounts of insurance under the Policy are guarantee issue. Evidence of insurability (proof of good health) is not required for any amount of insurance under the Policy.

Insurance under the Policy is only available if the total number of Employees insured under the Policy attains or remains above 10 Employees or 9% of the eligible Employees, whichever is greater. If the total number falls below the required level, insurance may be reduced, rescinded or terminated.

ELIGIBILITY

Capitalized terms used in this section have the meanings assigned to them in the Definitions section of this Certificate.

WHEN AN EMPLOYEE BECOMES ELIGIBLE FOR INSURANCE

An Employee who is Actively Working on the Policy Effective Date becomes eligible for insurance under the Policy on the Policy Effective Date.

An Employee who is hired after the Policy Effective Date becomes eligible for insurance under the Policy on the day the Employee begins Active Work.

The day on which an Employee becomes eligible for insurance under the Policy may not be the same as the day on which insurance begins. The When Insurance Begins provision describes the day on which insurance begins.

WHEN A DEPENDENT BECOMES ELIGIBLE FOR INSURANCE

A Dependent becomes eligible for insurance under the Policy on the later of:

a) the day You become eligible for insurance under the Policy; or
b) the day You acquire the Dependent;

provided You elect insurance for yourself under the Policy.

If both You and Your Spouse are eligible for insurance under the Policy as Employees of the Policyholder;

a) You or Your Spouse may also elect insurance as a Dependent of the other person under the Policy; and
b) both You and Your Spouse may elect insurance for Your Dependent child(ren) under the Policy.

The day on which a Dependent becomes eligible for insurance under the Policy may not be the same as the day on which insurance begins. The When Insurance Begins provision describes the day on which insurance begins.

CONTINUITY OF INSURANCE UPON TRANSFER OF INSURANCE CARRIER

If there is a conflict between this provision and any other provision of the Policy, this provision shall control.

If the Policy replaces a Prior Plan, the Policy will provide insurance for an Employee who:

a) was insured under the Prior Plan on the day before the Policy Effective Date;
b) is otherwise eligible under the Policy, but is not Actively Working on the Policy Effective Date due to:
    1. Injury or Sickness; or
    2. a leave of absence protected under:
        a. the federal Family and Medical Leave Act (FMLA) or Uniformed Services Employment and Reemployment Rights Act (USERRA) and any amendments thereto; or
        b. any other applicable federal or state law that allows for continuation of insurance in certain instances;
c) is not a retired Employee; and
d) is not insured under any provision of the Prior Plan.

The Policy will not provide insurance under this provision for any Employee who does not satisfy the criteria above unless approved in writing by Our authorized representative in Our home office.

Insurance under this provision is subject to uninterrupted payment of premium to Us when due.

If insurance is provided for the Employee, insurance may also be provided for any eligible Dependent(s).

We reserve the right to request any information We need from the Policyholder to determine whether the conditions necessary to be eligible for insurance under this provision have been satisfied.

Insurance under this provision will end on the earliest of:

a) the day the Employee returns to Active Work for the Policyholder or begins employment with any other employer;

b) the last day the Employee would have been insured under the Prior Plan, if the Prior Plan had not ended or terminated;
c) the day the Employee's insurance under the Policy ends for any reason shown in the When Insurance Ends provision;
d) the last day of the twelfth month following the Policy Effective Date; or
e) the last day of the time period allowed by FMLA, USERRA or applicable federal or state law that allows for continuation.

If an Employee is eligible for insurance under this provision, the Employee will not be eligible for insurance under any continuation provision in this Certificate.

WHEN INSURANCE BEGINS

An Employee must enroll for any insurance requiring an election by submitting a Written Request for insurance for the Employee and any Dependent(s). The Written Request must be submitted to the Policyholder no later than 31 days following the day the Employee or Dependent(s) become(s) eligible. If the Written Request for insurance is not submitted within the required time frame, the Employee and/or Dependent(s) may not enroll until a Subsequent Enrollment Period is offered.

An Employee will become insured on the first day of the month that coincides with or follows the latest of the day:
a) the Employee becomes eligible and is Actively Working; or
b) the Employee submits a Written Request to enroll for insurance, if required.

An eligible Dependent will become insured on the latest of the day:
a) the Employee becomes insured;
b) the Employee acquires the eligible Dependent; or
c) the Employee submits a Written Request to enroll the Dependent for insurance, if required.

Insurance for a Dependent child who became Incapacitated prior to reaching the age of 26 will begin in accordance with the above terms, provided the child otherwise meets the definition of Dependent.

Insurance for a newborn Dependent child begins at the moment of live birth. Insurance for a newly adopted newborn Dependent child begins with the date of placement into Your custody, or at the moment of live birth if a written agreement to adopt the child was previously entered into by You. If Dependent child insurance requires an election and Dependent child insurance for any other child(ren) is not already in effect under the Policy, a Written Request for insurance for any newborn or newly adopted Dependent child(ren) must be submitted to the Policyholder within 31 days following the day the Dependent child(ren) become(s) eligible in order to continue insurance beyond the 31-day period.

EXCEPTIONS TO WHEN INSURANCE BEGINS (DEFERRED EFFECTIVE DATE)

This provision does not apply if the Employee is eligible for insurance under the Continuity of Insurance Upon Transfer of Insurance Carrier provision. This provision also does not apply to any Dependent who was eligible and insured under any Prior Plan on the day before the Policy Effective Date.

Insurance for an Employee or Dependent who is:
a) confined in a Hospital as an inpatient;
b) confined in any institution or facility other than a Hospital; or
c) confined at home and under the care or supervision of a Physician;
on the day insurance is to begin will not take effect until the day after the Employee has completed one full day of Active Work or the Dependent is no longer confined.

Insurance for an Employee who is not Actively Working when insurance would otherwise begin will not take effect until the day after the Employee has completed one full day of Active Work.

In addition, insurance for a Dependent who is unable to perform two or more Activities of Daily Living (ADLs), whether or not confined, will not take effect until the day the Dependent has performed all ADLs for at least 15 consecutive days. This exception does not apply to any Incapacitated Dependent child.

Insurance for a newborn Dependent child, regardless of confinement, will begin in accordance with the When Insurance Begins provision, provided the child otherwise meets the definition of Dependent.

THE FIRST ENROLLMENT PERIOD

An Employee may elect insurance for him/herself and any Dependent(s) during the First Enrollment Period.

If an Employee does not elect insurance during the Employee's or Dependent's First Enrollment Period, future elections may only be made in accordance with the Subsequent Enrollment Periods provision, or as otherwise provided under the When Election Changes Are Permitted provision.

SUBSEQUENT ENROLLMENT PERIODS

An Employee may elect, drop, increase, decrease or change insurance for the Employee and any Dependent(s) during a Subsequent Enrollment Period.

WHEN ELECTION CHANGES ARE PERMITTED

An Employee may elect, drop, increase, decrease or change insurance as allowed by the Policyholder.

Life Events

If You experience a Life Event and You are currently insured under the Policy, You may submit a Written Request to change insurance within 31 days of the Life Event. If the Written Request is submitted more than 31 days after the date of a Life Event, You may not change insurance until a Subsequent Enrollment Period is offered.

An Employee who experiences a Life Event who previously declined insurance under the Policy may not enroll until a Subsequent Enrollment Period is offered.

CHANGES TO INSURANCE BENEFITS

Any allowable change in the benefits, class, plan type (as shown in Schedule) or amount of insurance for any Insured Person, whether requested by You or the Policyholder, or as a result of the terms of the Policy, will take effect on the first day of the month that follows the date of the request or the change.

If You are not Actively Working on the day any change in insurance would otherwise take effect, the change will become effective the first day of the month that follows the day after You return to Active Work.

REINSTATEMENT OF INSURANCE

You may be eligible to reinstate insurance that has ended in accordance with this provision. For any insurance requiring an election, You must submit a Written Request to reinstate insurance within 31 days of Your return to Active Work. If the Written Request is submitted more than 31 days after the date You return to Active Work, You may not re-enroll for insurance until a Subsequent Enrollment Period is offered. If insurance is reinstated for You, insurance may also be reinstated for any eligible Dependent(s).

Reinstated insurance will take effect on the first day of the month that coincides with or follows the date. If You are not Actively Working on the day the reinstated insurance would otherwise take effect, insurance will become effective on the day after You return to Active Work.

The following reinstatement option(s) is/are available:

Non-Payment of Premium or Voluntary Termination of Insurance

If insurance ended due to the non-payment of premium or voluntary termination of insurance by the Employee, the Employee may not re-enroll for insurance until a Subsequent Enrollment Period is offered.

Involuntary Reduction in Hours
If insurance ended because the Employee was no longer Actively Working due to an involuntary reduction of hours worked, insurance may be reinstated if the Employee returns to Active Work within 90 days from the date insurance ended.

Rehired Employee Due to Layoff or Termination
If insurance ended because the Employee was no longer Actively Working due to layoff or termination of employment with the Policyholder, insurance may be reinstated if the Employee is rehired and returns to Active Work within 90 days from the date insurance ended.

Rehired Employee Due to Leave of Absence
If insurance ended because the Employee was no longer Actively Working due to an approved leave of absence, insurance may be reinstated within 90 days from the date insurance ended upon return to Active Work. If insurance ended because the Employee was no longer Actively Working due to military leave, insurance may be reinstated upon return to Active Work within 31 days of discharge from active duty.

Transfer From Portability
If insurance was obtained under the Portability provision while an Employee was not Actively Working, insurance may be reinstated under the Policy. Any insurance provided through the Portability Policy will terminate upon reinstatement of insurance as an Actively Working Employee.

WHEN INSURANCE ENDS

Insurance for You and Your Dependent(s), if applicable, will end:

a) on the last day of the month in which You reach the age of 80;
b) on the last day of the month in which You are no longer eligible for insurance under the Policy;
c) on the last day of the month in which You begin active duty in the Armed Forces, National Guard or Reserves of any state or country (except for temporary active duty of 31 days or less);
d) on the day the Policy terminates; or
e) in accordance with the Grace Period provision.

Insurance for a Dependent will also end on the last day of the month in which the Dependent is no longer eligible for insurance under the Policy.

Insurance ending has no effect on benefits payable for any Accident that occurred by an Insured Person while insured under the Policy.

EXCEPTIONS TO WHEN INSURANCE ENDS

If insurance for You and Your Dependent(s), if applicable, would otherwise end, You or Your Dependent(s) may be able to continue insurance under one of the following provisions:

a) Continuation of Insurance for Layoff or Leave
b) Continuation of Insurance for Your Dependents in the Event of Your Death
c) Portability

CONTINUATION OF INSURANCE FOR LAYOFF OR LEAVE

If there is a conflict between this provision and any other provision of the Policy, this provision shall control.

You may be able to continue insurance from the day You cease to be Actively Working in the event of:

a) a temporary involuntary layoff; or
b) a leave of absence approved by the Policyholder due to any personal reason.

In addition, the federal Family and Medical Leave Act (FMLA) and Uniformed Services Employment and Reemployment Rights Act (USERRA) and any amendments thereto, as well as other applicable federal or state laws, may allow continuation of insurance in certain instances for leaves of absence, layoff or termination. Contact the Policyholder for additional information regarding any other continuation options that may be available.

Insurance may be continued for You and Your Dependent(s).

Any insurance continued under this provision will be subject to the following conditions:

a) insurance may not be continued beyond the earliest of:
    1. 12 weeks for Your temporary involuntary layoff;
    2. 12 weeks for Your leave of absence due to any personal reason; or
    3. the time period allowed by FMLA, USERRA or applicable federal or state law that allows for continuation; and
b) We continue to receive premium payment when due (premiums must be paid by You or on Your behalf).

Insurance under this provision will end on the last day of the month which coincides with or follows the earliest of the day:

a) the time period in a) in the preceding paragraph has been satisfied;
b) Your temporary involuntary layoff becomes permanent, if insurance is continued under this provision due to Your temporary involuntary layoff;
c) You return to Active Work;
d) You begin full-time employment with an employer other than the Policyholder; or
e) the Policy terminates.

Insurance under this provision will also end in accordance with the Grace Period provision.

If continued insurance under this provision ends and You have not returned to Active Work, You and Your Dependent(s) may be able to continue or obtain insurance under the Portability provision.

See the Options for Payment of Premium for Continued Insurance provision for premium payment options.

CONTINUATION OF INSURANCE FOR YOUR DEPENDENTS IN THE EVENT OF YOUR DEATH

If there is a conflict between this provision and any other provision of the Policy, this provision shall control.

When insurance under the Policy would otherwise end because of Your death, Your Dependent(s) may be able to continue insurance under this provision if we continue to receive timely premium payment when due (premiums must be paid by Your Dependent(s) or on Your Dependent(s) behalf).

Insurance under this provision will end on the earliest of the last day of the month which coincides with or follows the day:

a) that is 3 months from the date of Your death; or
b) the Policy terminates.

Insurance under this provision will also end in accordance with the Grace Period provision.

If continued insurance under this provision ends, Your Dependent(s) may be able to continue or obtain insurance under the Portability provision.

See the Options for Payment of Premium for Continued Insurance provision of this Certificate for premium payment options.

PORTABILITY

You have the right to continue receiving group accident insurance under this provision if You are under age 70 when insurance would otherwise end for any of the following applicable reasons:

a) You cease to be Actively Working and are not eligible for insurance under any other continuation provision in this Certificate;
b) Your employment, membership or association with the Policyholder ends; or
c) the Policy terminates and the Policyholder does not obtain a replacement policy with another insurance carrier within 31 days.

In addition to the above reasons, Your Spouse may be able to continue receiving insurance, including insurance for Dependent child(ren), under this provision if Your Spouse is under age 70 when insurance would otherwise end for any of the following reasons:

a) You enter active duty in the Armed Forces, National Guard or Reserves of any state or country for a period of more than 31 days;
b) divorce or legal separation of You and Your Spouse; or
c) Your death.

In the event Your Spouse continues to receive insurance under this provision, Dependent child(ren) may be insured under You or Your Spouse, but not both.

If You are eligible for insurance under this provision and are not eligible for insurance under any other continuation provision of the Policy (if applicable), You must elect insurance under this provision in order for Your Dependent(s) to be eligible**.**

If You continue to receive group accident insurance under this provision, You and Your Dependent(s) cannot continue insurance under any other continuation provision of the Policy (if applicable).

The Group Accident Insurance Portability Policy

The insurance continued under this provision is available under another group accident insurance policy (the "Portability Policy") issued by Us, as available at the time insurance under this provision is requested. If You or Your Spouse (if applicable) become insured under the Portability Policy, You or Your Spouse will receive a certificate of insurance that describes the terms and conditions of coverage under the Portability Policy.

The Portability Policy may not provide all the same benefits or have all the same terms and conditions that are included in the Policy. In addition, the premium rates charged for insurance under the Portability Policy may not be the same as the premium rates charged for insurance under the Policy. The benefits and premium rates of Our Portability Policy are described on Our portability request form. You may contact the Policyholder or Us to obtain Our portability request form.

We may change the benefits and conditions of the Portability Policy and associated premium rates at any time. We will provide notice of any change at least 31 days before the change is effective.

The continued group insurance coverage under the Portability Policy is available as a result of portability rights that arise solely from the Policy, as arranged for You as an employee welfare benefit subject to the Employee Retirement Income Security Act of 1974, as amended.

Notice of the Right to Continue Insurance Under this Provision

The portability period is the period of time that is 31 days from the date insurance under the Policy would otherwise end ("Portability Period"). When insurance under the Policy would otherwise end, notice of the right to continue insurance under this provision may be given. If notice is not given at least 15 days after the start of the Portability Period, an extension of the period of time in which to request continued insurance under this provision will be allowed. Any extension of the Portability Period will expire on the earlier of:

a) 15 days after notice has been received (if notice is received within 90 days after the start of the Portability Period); or
b) 60 days after the end of the Portability Period, even if notice is not received.

How to Request Continued Insurance Under this Provision

You or Your Spouse must submit a Written Request for insurance under this provision. The Written Request and the initial premium due must be submitted within the Portability Period.

PREMIUM PAYMENTS

Capitalized terms used in this section have the meanings assigned to them in the Definitions section of this Certificate.

PAYMENT OF PREMIUMS THROUGH PAYROLL DEDUCTION

You are responsible for the payment of premiums for insurance under the Policy. The premium owed by You equals the total premium for all Insured Person(s).

Premiums will be automatically deducted from Your paychecks by the Policyholder, then remitted to Us, as authorized by You during the enrollment process. Please contact the Policyholder for information regarding Your paycheck deductions.

Payment of premium does not guarantee eligibility for coverage.

OPTIONS FOR PAYMENT OF PREMIUM FOR CONTINUED INSURANCE

When insurance is continued We must receive premium payment when due for insurance to remain effective, unless otherwise stated or allowed in the Policy. Premium payment may be made in the following ways:

a) the Policyholder may pay the premiums; or
b) You may pay premium to the Policyholder who will then submit premium to Us.

Contact the Policyholder to determine which option is available to You.

Payment of premium does not guarantee eligibility for coverage.

GRACE PERIOD

All premiums must be paid within the grace period. There is a grace period of 60 days for payment of premiums. This means that, except for the initial premium, if premium is not paid on or before the date it is due, the premium must be paid in the 60-day period that follows. We will consider premium to be paid on the date We receive it.

Insurance will stay in force during the grace period, unless You or the Policyholder provides Us with written notice that insurance for any Insured Person will terminate during the grace period. If We receive such notice, insurance will terminate on the date requested.

If any premium due is not paid during the grace period, insurance will end on the last day of the grace period. If insurance ends, it may be reinstated as described in the Reinstatement of Insurance provision.

PREMIUMS AND PREMIUM CHANGES

The premium rate structure for accident insurance under the Policy is comprised of a monthly rate for each coverage option shown in the Schedule that applies to You and Your Dependent(s).

If You request a change in Your plan type (as shown in the Schedule) or the amount of insurance for any Insured Person, the Policyholder will provide You with notice of Your new premium amount upon request if You are responsible for the payment of premiums for insurance.

If there is a change in the amount of the premium for insurance for any Insured Person in accordance with the terms of the Policy, or a change in the plan type (as shown in the Schedule) or amount of insurance for any Insured Person as the result of a request of the Policyholder, the Policyholder will provide You with notice of the change at least 15 days prior to the date of the change if You are responsible for the payment of premiums for insurance.

Premium amounts will change if premium rates under the Policy are changed.

INITIAL CARE & EMERGENCY BENEFITS

Capitalized terms used in this section have the meanings assigned to them in the Definitions section of this Certificate. The benefits described in this section are subject to all of the applicable definitions, limitations, exclusions and other provisions of the Policy.

INITIAL CARE

If more than one form of Initial Care is received by an Insured Person for the same Accident, We will only pay the highest of the following benefits for the Insured Person:

a) Emergency Room Benefit;
b) Urgent Care Center Benefit; or
c) Initial Physician Office Visit Benefit.

We will reduce the amount payable for Initial Care by the amount paid for the Express Benefit for an Accident for an Insured Person.

Emergency Room Benefit

We will pay a benefit amount of $150 if an Insured Person receives Treatment in an Emergency Room for one or more Injuries sustained as the result of an Accident within 72 hours after the Accident. This benefit is payable once per Accident for each Insured Person.

Urgent Care Center Benefit

We will pay a benefit amount of $100 if an Insured Person receives Treatment in an Urgent Care Center for one or more Injuries sustained as the result of an Accident within 72 hours after the Accident. This benefit is payable once per Accident for each Insured Person.

Initial Physician Office Visit Benefit

We will pay a benefit amount of $75 if an Insured Person receives Treatment from a Physician or Medical Professional in such individual's office or clinic for one or more Injuries sustained as the result of an Accident within 30 days after the Accident. This benefit is payable once per Accident for each Insured Person.

EMERGENCY TRANSPORTATION

Ground Ambulance Benefit

We will pay a benefit amount of $200 if an Insured Person is transported by a licensed professional ambulance company to or from a Hospital or between medical facilities for Treatment of one or more Injuries sustained as the result of an Accident. The ambulance transportation must occur within 72 hours after the Accident. This benefit is payable once per Accident for each Insured Person.

Air Ambulance Benefit

We will pay a benefit amount of $1,000 if an Insured Person is transported by a licensed professional air ambulance company to or from a Hospital or between medical facilities for Treatment of one or more Injuries sustained as the result of an Accident. The ambulance transportation must occur within 72 hours after the Accident. This benefit is payable once per Accident for each Insured Person.

SPECIFIED INJURY BENEFITS

Capitalized terms used in this section have the meanings assigned to them in the Definitions section of this Certificate. The benefits described in this section are subject to all of the applicable definitions, limitations, exclusions and other provisions of the Policy.

If an Insured Person sustains both a Fracture and Dislocation (or multiple Fractures and Dislocations) as the result of the same Accident, the maximum amount payable for all Fractures and Dislocations under the Policy is up to 200% of the amount payable for the Fracture or Dislocation with the highest applicable Open Reduction or Closed Reduction benefit amount.

FRACTURES (BROKEN BONES)

Benefits

We will pay the applicable benefit amount shown in the Fracture Benefits Table if an Insured Person receives Closed Reduction (Non-surgical) or Open Reduction (Surgical) Treatment for a Fracture sustained as the result of an Accident. Treatment must occur by a Physician or Medical Professional within 90 days after the Accident.

If a Fracture is diagnosed as a Chip Fracture, We will pay 25% of the amount listed in the table for the Closed Reduction for the bone/bone group involved.

The maximum amount payable for all Fractures sustained by an Insured Person for the same Accident is up to 150% of the amount payable for the Fracture with the highest applicable Open Reduction or Closed Reduction benefit amount.

Fracture Benefits Table

Bone/Bone Group (From Head to Toe)	Open Reduction Amount	Closed Reduction Amount
Skull, depressed (Cranial bones)	$5,000	$2,500
Skull, non-depressed (Cranial bones)	$2,500	$1,250
Bones of face (Except nose and lower jaw)	$900	$450
Nose (Nasal bones)	$600	$300
Lower jaw (Mandible)	$900	$450
Shoulder blade (Scapula)	$900	$450
Collarbone (Clavicle)	$600	$300
Breastbone (Sternum)	$900	$450
Rib	$600	$300
Upper arm (Humerus)	$900	$450
Forearm (Radius and/or ulna)	$900	$450
Wrist (Carpals)	$900	$450
Hand (Metacarpals, except fingers)	$900	$450
Fingers (Phalanges)	$200	$100
Vertebral body (Except vertebral processes)	$2,500	$1,250
Vertebral process	$900	$450
Tail bone (Coccyx)	$600	$300
Pelvis (Except tail bone and hip bones)	$2,500	$1,250
Hip bones (Illium, ischium and/or pubis)	$5,000	$2,500
Thigh (Femur)	$2,500	$1,250
Knee cap (Patella)	$900	$450
Lower leg (Tibia and/or fibia)	$2,500	$1,250
Ankle (Talus)	$900	$450
Foot (Metatarsals and calcaneus, except toes)	$900	$450
Toes (Phalanges)	$200	$100

Limitations

If an Insured Person sustains:

a) multiple Fractures to the same bone/bone group as a result of the same Accident, only the applicable Open Reduction or Closed Reduction benefit for the bone/bone group is payable; or

b) a Fracture:
    1. that is treated with both Open Reduction and Closed Reduction as a result of the same Accident, only the benefit for the Open Reduction of the Fracture is payable;
    2. to the bones of the face and the nose (Nasal bones) as a result of the same Accident, only the highest applicable Open Reduction or Closed Reduction benefit is payable;
    3. to a vertebral body and a vertebral process of the same vertebrae as a result of the same Accident, only the highest applicable Open Reduction or Closed Reduction benefit is payable; or
    4. to the tail bone (Coccyx), pelvis or hip bones (Illium, ischium and/or pubis) as a result of the same Accident, only the highest applicable Open Reduction or Closed reduction benefit is payable.

If We have paid a benefit for a Fracture previously sustained by an Insured Person, any new claim for that same Fracture will be payable only if the subsequent Fracture is the result of a separate and distinct Accident that occurred after the previous Fracture was completely healed.

DISLOCATIONS (SEPARATED JOINTS)

Benefits

We will pay the applicable benefit amount shown in the Dislocation Benefits Table if an Insured Person receives Closed Reduction (Non-surgical) or Open Reduction (Surgical) Treatment for a Dislocation sustained as the result of an Accident. Treatment must occur by a Physician or Medical Professional within 90 days after the Accident.

If a Dislocation is diagnosed as an Incomplete Dislocation, or if Treatment of a Dislocation occurs by a Physician or Medical Professional without the use of Anesthesia, We will pay 25% of the amount listed in the table for the Closed Reduction for the joint/joint group involved.

The maximum amount payable for all Dislocations sustained by an Insured Person for the same Accident is up to 150% of the amount payable for the Dislocation with the highest applicable Open Reduction or Closed Reduction benefit amount.

Dislocation Benefits Table

Joint/Joint Group (From Head to Toe)	Open Reduction Amount	Closed Reduction Amount
Lower jaw (Temporomandibular)	$1,200	$600
Shoulder (Glenohumeral)	$1,200	$600
Collarbone and breastbone (Sternoclavicular)	$1,200	$600
Elbow	$1,200	$600
Wrist (Radiocarpal and/or intercarpal)	$1,200	$600
Hand (Carpometacarpal and/or intrametacarpal)	$1,200	$600
Fingers (Interphalangeal and/or metacarpophalangeal)	$300	$150
Hip	$6,000	$3,000
Kneecap (Patella)	$3,000	$1,500
Ankle (Talocalcaneal and/or talocalcaneonavicular	$1,800	$900
Foot (Tarsometatarsal and/or intermetatarsal)	$1,800	$900
Toes (Interphalangeal and/or metatarsalphalangeal)	$300	$150

Limitations

If an Insured Person sustains a Dislocation:

a) that is treated with both Open Reduction and Closed Reduction as a result of the same Accident, only the benefit for the Open Reduction of the Dislocation is payable;
b) to the wrist (radiocarpal and/or intercarpal) and hand (carpometacarpal and/or intrametacarpal) joints/joint groups as a result of the same Accident, only the highest applicable Open Reduction or Closed Reduction benefit is payable; or
c) to the ankle (talocalcaneal and talocalcaneonavicular) and foot (tarsometatarsal and/or intermetatarsal) joints/joint groups as a result of the same Accident, only the highest applicable Open Reduction or Closed Reduction benefit is payable.

If We will pay/have paid a benefit for a Dislocation previously sustained by an Insured Person, any new claim for that same Dislocation will be payable only if the subsequent Dislocation is the result of a separate and distinct Accident that occurred after the previous Dislocation was completely healed.

LACERATION BENEFIT

We will pay the applicable benefit amount shown in the Laceration Benefits Table if an Insured Person receives Treatment to repair one or more Lacerations sustained as the result of an Accident with an appropriate Laceration Repair Method. The benefit amount is based on the total length of all Lacerations that require repair with a Laceration Repair Method.

Treatment must occur by a Physician or Medical Professional within 72 hours after the Accident. This benefit is payable once per Accident for each Insured Person.

Laceration Benefits Table

Total Length of All Lacerations	Benefit Amount
Less than 2 inches	$50
2 inches to 6 inches	$300
Greater than 6 inches	$600

If no Laceration is severe enough to require a Laceration Repair Method for repair, We will pay a benefit of 50% of the lowest benefit amount shown in the table above.

BURNS

Burn Benefit

We will pay the applicable benefit amount shown in the Burn Benefits Table if an Insured Person receives Treatment for burns sustained as the result of an Accident. The benefit amount is based on the severity of the Burn (Burn type), as diagnosed by a Physician or Medical Professional. If more than one type of Burn is sustained, only the highest applicable benefit amount is payable.

Treatment must occur by a Physician or Medical Professional within 72 hours after the Accident. This benefit is payable once per Accident for each Insured Person.

Burn Benefits Table

Severity of Burn (Burn Type)	Benefit Amount
Second degree burns which cover less than or equal to 9% of the total body surface area	$125
Second degree burns which cover 10% to 36% of the total body surface area	$250
Second degree burns which cover greater than 36% of the total body surface area	$1,000
Third degree burns which cover less than 18% of the total body surface area	$1,500
Third degree burns which cover 18% to 36% of the total body surface area	$5,000
Third degree burns which cover greater than 36% of the total body surface area	$10,000

Skin Graft Benefit

If an Insured Person receives a Skin Graft for a Burn for which a benefit is payable under the Policy, We will pay a Skin Graft benefit of 25% of the payable Burn benefit. This benefit is payable once per Accident for each Insured Person.

DENTAL CARE

Crown or Filling Repair Benefit

We will pay a benefit amount of $200 if an Insured Person sustains an Injury as the result of an Accident to one or more natural teeth which requires repair by placement of a crown or filling. Treatment must occur by a Dentist within 30 days after the Accident. This benefit is payable once per Accident for each Insured Person.

Extraction Benefit

We will pay a benefit amount of $75 if an Insured Person sustains an Injury as the result of an Accident to one or more natural teeth which results in extraction of the damaged tooth/teeth.

Treatment must occur by a Dentist within 30 days after the Accident. This benefit is payable once per Accident for each Insured Person.

HOSPITAL, SURGICAL & DIAGNOSTIC BENEFITS

Capitalized terms used in this section have the meanings assigned to them in the Definitions section of this Certificate. The benefits described in this section are subject to all of the applicable definitions, limitations, exclusions and other provisions of the Policy.

HOSPITAL

Admission Benefit

We will pay a benefit amount of $1,000 for the first time an Insured Person is Confined to a Hospital for Treatment of one or more Injuries sustained as the result of an Accident. The Confinement must begin within 90 days after the Accident. This benefit is payable once per Accident for each Insured Person.

We will not pay this benefit for Treatment in an Emergency Room, Outpatient Treatment, a stay of less than 20 hours in an Observation Unit or other observation area of a Hospital, or Treatment at a Rehabilitation Facility.

Daily Confinement Benefit

We will pay a benefit amount of $200 per day of Confinement if an Insured Person is Confined to a Hospital for Treatment of one or more Injuries sustained as the result of an Accident. The Confinement must begin within 90 days after the Accident. This benefit is payable for up to 365 days per Accident for each Insured Person. This benefit is only payable for one Hospital Confinement at a time, even if the Confinement is the result of more than one Accident.

We will not pay this benefit for Treatment in an Emergency Room, Outpatient Treatment, Treatment at a Rehabilitation Facility, or during the first 15 days of Confinement for an Insured Person Confined to an Intensive Care Unit.

Intensive Care Unit Confinement Benefit

We will pay a benefit amount of $400 per day of Confinement if an Insured Person is Confined to an Intensive Care Unit (ICU) for Treatment of one or more Injuries sustained as the result of an Accident. The Confinement must begin within 30 days after the Accident. This benefit is payable for up to 15 days per Accident for each Insured Person. This benefit is only payable for one ICU Confinement at a time, even if the Confinement is the result of more than one Accident.

This benefit is not payable if an Insured Person is Confined to any Hospital unit that does not meet the definition in the Policy of an Intensive Care Unit. We will not pay this benefit and the Daily Confinement Benefit concurrently.

Rehabilitation Facility Confinement Benefit

If an Insured Person is transferred to a Rehabilitation Facility for Treatment of one or more Injuries sustained as the result of an Accident immediately after a period of Confinement for which a Daily Confinement Benefit is payable, We will pay a benefit amount of $100 per day for the Insured Person's Confinement as a resident inpatient in a Rehabilitation Facility. The Insured Person's Confinement in the Rehabilitation Facility must begin within 365 days after the Accident. This benefit is payable for up to 30 days per Accident for each Insured Person.

This benefit is only payable for one Rehabilitation Facility Confinement at a time, even if the Confinement is the result of more than one Accident. We will not pay this benefit and the Daily Confinement Benefit concurrently.

SURGICAL

If any surgery listed below occurs concurrently with an Open Reduction for a Fracture or Dislocation of the same bone/bone group or joint/joint group as a result of the same Accident, only the highest applicable benefit is payable.

Exploratory Surgery or Arthroscopic Debridement Benefit

We will pay a benefit amount of $150 if an Insured Person undergoes Exploratory Surgery or Arthroscopic Debridement for one or more Injuries sustained as the result of an Accident. An Exploratory Surgery must occur by a Physician within 365 days after the Accident. An Arthroscopic Debridement must occur by a Physician within 365 days after the Accident. This benefit is payable once per Accident for each Insured Person.

We will reduce the benefit amount payable for any surgery listed below if this benefit was previously paid for the same Injury(ies) for an Accident for an Insured Person.

Abdominal, Cranial or Thoracic Surgery Benefit
We will pay a benefit amount of $1,500 if an Insured Person undergoes abdominal, cranial or thoracic surgery for the repair of one or more internal Injuries sustained as the result of an Accident. The surgery must occur by a Physician within 365 days after the Accident. This benefit is payable once per Accident for each Insured Person.

We will not pay this benefit for the repair of a hernia. No Exploratory Surgery Benefit, Arthroscopic Surgery Benefit or Brain Injury Diagnosis Benefit is payable if this benefit is payable for the same injury(ies). If abdominal, cranial or thoracic surgery occurs concurrently with an Open Reduction for a Fracture or Dislocation of the same bone/bone group or joint/joint group as a result of the same Accident, only the highest applicable benefit is payable.

Herniated Disc Surgery Benefit
We will pay a benefit amount of $600 if an Insured Person undergoes surgery to repair one or more Herniated Discs sustained as the result of an Accident. Initial Treatment must occur by a Physician or Medical Professional within 30 days after the Accident and surgery must occur by a Physician within 365 days after the Accident. This benefit is payable once per Accident for each Insured Person.

No Exploratory Surgery Benefit or Arthroscopic Surgery Benefit is payable if this benefit is payable for the same injury(ies).

Torn Knee Cartilage (Meniscus) Surgery Benefit
We will pay a benefit amount of $500 if an Insured Person undergoes surgery to repair torn knee cartilage (meniscus) sustained as the result of an Accident. Initial Treatment must occur by a Physician or Medical Professional within 30 days after the Accident and surgery must occur by a Physician within 365 days after the Accident. This benefit is payable once per knee per Accident for each Insured Person.

No Exploratory Surgery Benefit or Arthroscopic Surgery Benefit is payable if this benefit is payable for the same injury(ies). If an Insured Person undergoes surgery to repair torn knee cartilage (meniscus) and undergoes surgery to repair one or more ligaments, rotator cuffs or tendons as a result of the same Accident, the maximum amount payable for the surgeries is equal to 200% of the highest applicable benefit amount.

Ligament, Rotator Cuff or Tendon Surgery Benefit
We will pay a benefit amount of $500 if an Insured Person undergoes surgery to repair one or more torn, ruptured or severed ligaments, rotator cuffs or tendons sustained as the result of an Accident. Initial Treatment must occur by a Physician or Medical Professional within 30 days after the Accident and surgery must occur by a Physician within 365 days after the Accident. This benefit is payable once per Accident for each Insured Person.

No Exploratory Surgery Benefit or Arthroscopic Surgery Benefit is payable if this benefit is payable for the same injury(ies). If an Insured Person undergoes surgery to repair one or more ligaments, rotator cuffs or tendons and undergoes surgery to repair torn knee cartilage (meniscus) as a result of the same Accident, the maximum amount payable for the surgeries is equal to 200% of the highest applicable benefit amount.

Eye Procedure Benefit
We will pay a benefit amount of $300 if an Insured Person undergoes a procedure to remove a foreign object or surgery for an eye Injury sustained as the result of an Accident. The surgery or procedure must occur by a Physician or Medical Professional within 90 days after the Accident. This benefit is payable once per eye per Accident for each Insured Person.

We will not pay this benefit for an Injury that is limited to the Eyelid or for an eye examination (with or without Anesthesia). No Exploratory Surgery Benefit or Arthroscopic Surgery Benefit is payable if this benefit is payable for the same injury(ies).

Blood Products Benefit
We will pay a benefit amount of $300 if an Insured Person receives a transfusion of one or more Blood Products for Treatment of an Injury sustained as the result of an Accident. The transfusion must occur within 90 days after the Accident. This benefit is payable once per Accident for each Insured Person.

We will not pay this benefit for platelet or plasma infusions.

Pain Management (Epidural Anesthesia) Benefit
We will pay a benefit amount of $100 if an Insured Person receives Epidural Anesthesia for Treatment of an Injury sustained as the result of an Accident. The Anesthesia must be administered within 90 days after the Accident. This benefit is payable once per Accident for each Insured Person.

DIAGNOSTIC

X-Ray Benefit
We will pay a benefit amount of $50 if an Insured Person undergoes an X-Ray for Treatment of one or more Injuries sustained as the result of an Accident. The X-Ray must occur within 90 days after the Accident. This benefit is payable once per Accident for each Insured Person.

Diagnostic Exam Benefit
We will pay a benefit amount of $200 if an Insured Person undergoes a Diagnostic Exam for Treatment of one or more Injuries sustained as the result of an Accident. The exam must occur within 90 days after the Accident. This benefit is payable once per Accident for each Insured Person.

Brain Injury Diagnosis Benefit
We will pay a benefit amount of $150 if an Insured Person is diagnosed with a Brain Injury sustained as the result of an Accident. The diagnosis must occur by a Physician or Medical Professional within 30 days after the Accident and be confirmed by a Diagnostic Exam. This benefit is payable once per Accident for each Insured Person.

We will reduce the benefit amount payable for cranial surgery if this benefit was previously paid for the same Injury(ies) for an Accident for an Insured Person.

FOLLOW-UP CARE BENEFITS

Capitalized terms used in this section have the meanings assigned to them in the Definitions section of this Certificate. The benefits described in this section are subject to all of the applicable definitions, limitations, exclusions and other provisions of the Policy.

FOLLOW-UP TREATMENT

Physician Follow-Up Office Visit Benefit

We will pay a benefit amount of $75 if an Insured Person receives Follow-Up Treatment for one or more Injuries sustained as the result of an Accident from a Physician or Medical Professional in such individual's office or clinic. The first Follow-Up Treatment must occur within 60 days after the Accident or within 30 days after the Insured Person is no longer Confined as a result of the Accident.

All Follow-Up Treatment must occur within 365 days after the Accident. This benefit is payable up to 2 times per Accident for each Insured Person.

We will not pay this benefit:

a) if any form of Initial Care was not received by the Insured Person for the same Accident;
b) for Follow-Up Treatment received on the same day that an Insured Person received any form of Initial Care for the same Accident; or
c) while an Insured Person is Confined.

Therapy Services Benefit

We will pay a benefit amount of $25 if an Insured Person receives Therapy for one or more Injuries sustained as the result of an Accident from a Therapist in such individual's office or clinic. The first Therapy visit must occur within 365 days after the Accident or within 30 days after the Insured Person is no longer Confined as a result of the Accident.

All Therapy visits must occur within 365 days after the Accident. This benefit is payable up to 6 times per Accident for each Insured Person.

We will not pay this benefit:

a) if any form of Initial Care was not received by the Insured Person for the same Accident;
b) for Therapy received on the same day that an Insured Person received any form of Initial Care for the same Accident; or
c) while an Insured Person is Confined.

MEDICAL DEVICE BENEFIT

We will pay a benefit amount of $100 if an Insured Person sustains an Injury as the result of an Accident which requires a Medical Device to assist the Insured Person with personal locomotion or mobility. The Medical Device must be prescribed by a Physician or Medical Professional and be received within 365 days after the Accident. This benefit is payable once per Accident for each Insured Person.

Proof of the expense incurred for the purchase of a Medical Device for an Insured Person must be submitted with the claim.

PROSTHETIC DEVICE(S) BENEFIT

We will pay a benefit amount of $750 if an Insured Person sustains an Injury as the result of an Accident and receives a Prosthetic Device after the Injury results in the loss of limb, hand, foot or sight of an eye. The Prosthetic Device must be prescribed by a Physician for functional use and be received within 365 days after the Accident. This benefit is payable up to 2 times per Accident for each Insured Person.

We will not pay this benefit for more than one Prosthetic Device for the same body part, or for the replacement of a Prosthetic Device for which We will pay/have paid a benefit for an Insured Person for the same Accident.

ADDITIONAL BENEFITS

Capitalized terms used in this section have the meanings assigned to them in the Definitions section of this Certificate. The benefits described in this section are subject to all of the applicable definitions, limitations, exclusions and other provisions of the Policy.

FAMILY CARE

Transportation Benefit

We will pay a benefit amount of $300 per round trip for travel by an Insured Person to a Hospital or other medical facility more than 100 miles away from the Insured Person's primary residence for Treatment (including Follow-Up Treatment) of one or more Injuries sustained as the result of an Accident. Treatment must be prescribed by a Physician and the same or similar Treatment must not be available within 100 miles of the Insured Person's primary residence. This benefit is payable for up to 3 round trips per Accident within 365 days after the Accident.

We will also pay a benefit amount of $300 if an Insured Person is Confined for Treatment of one or more Injuries sustained as the result of an Accident that occurred more than 200 miles away from the Insured Person's primary residence and is brought home (to the Insured Person's primary residence). Transportation to the Insured Person's primary residence must occur within 48 hours following discharge from the Hospital or Rehabilitation Facility, within 365 days after an Accident. This benefit is payable once per Calendar Year per Insured Person.

Mileage is measured as the distance from the Insured Person's primary residence to the facility at which the Treatment occurs. We will not pay this benefit if either the Ground Ambulance Benefit or Air Ambulance Benefit is payable for the same trip.

Lodging Benefit

We will pay a benefit amount of $125 per night of Lodging for which an expense is incurred if an adult Family member or adult companion accompanies an Insured Person who is Confined more than 100 miles away from the Insured Person's primary residence for Treatment of one or more Injuries sustained as the result of an Accident. This benefit is payable for up to 30 nights of Lodging per Accident within 365 days after the Accident.

This benefit is only payable for a Confinement for which We will pay a Daily Confinement Benefit, Intensive Care Unit Confinement Benefit or Rehabilitation Facility Confinement Benefit for the Insured Person. Only one benefit is payable per night of Lodging. Proof of the expense incurred by the adult companion for Lodging must be submitted with the claim. Mileage is measured as the distance from the Insured Person's primary residence to the Hospital or medical facility in which the Insured Person is Confined.

Childcare Benefit

We will pay a benefit amount of $20 per day for Childcare if an Insured Person is Confined for Treatment of one or more Injuries sustained as the result of an Accident and incurs expense for one or more Dependent children attending a Childcare Center. This benefit is payable for up to 30 days of Childcare per Dependent child per Accident within 365 days after the Accident.

A Dependent child does not have to be insured under the Policy for this benefit to be payable. This benefit is only payable for a Confinement for which We will pay a Daily Confinement Benefit or Intensive Care Unit Confinement Benefit for the Insured Person. Proof of the expense incurred by the Insured Person for Childcare must be submitted with the claim.

HEALTH SCREENING BENEFIT

We will pay a health screening benefit of $50 for each Insured Person who has a Health Screening Test performed while insurance under the Policy is in force. This benefit is payable once per calendar year for each Insured Person.

CATASTROPHIC BENEFITS

Capitalized terms used in this section have the meanings assigned to them in the Definitions section of this Certificate. The benefits described in this section are subject to all of the applicable definitions, limitations, exclusions and other provisions of the Policy.

The Principal Sum is the amount of catastrophic insurance in effect for the Insured Person on the date of the Accident.

ACCIDENTAL DEATH

Basic Accidental Death Benefit

We will pay a benefit amount equal to 100% of the Principal Sum if an Insured Person dies as the result of an Accident. Death must occur within 365 days after the Accident. This benefit is payable once under the Policy for each Insured Person.

If one or more Catastrophic Benefits have been previously paid under the Policy for an Accident for an Insured Person, We will reduce the amount payable under this benefit by the amount paid for the previous Catastrophic Benefit(s) unless otherwise indicated in a benefit provision included in this Catastrophic Benefits section of this Certificate.

Common Carrier Accidental Death Benefit

We will pay a benefit amount equal to 300% of the Principal Sum if an Insured Person dies as the result of an Accident that occurs while a fare-paying passenger on a Common Carrier. Death must occur within 365 days after the Accident. This benefit is payable once under the Policy for each Insured Person.

We will not pay this benefit if an Insured Person was an operator or member of the crew on the Common Carrier conveyance at the time of the Accident. If this benefit is payable under the Policy for an Insured Person, We will not pay the Basic Accidental Death Benefit for that Insured Person.

If one or more Catastrophic Benefits have been previously paid under the Policy for an Accident for an Insured Person, We will reduce the amount payable under this benefit by the amount paid for the previous Catastrophic Benefit(s) unless otherwise indicated in a benefit provision included in this Catastrophic Benefits section of this Certificate.

Exposure & Disappearance

An Insured Person will be presumed to have died, for the purposes of the Basic Accidental Death Benefit or Common Carrier Accidental Death Benefit, if after the forced landing, stranding, sinking or wrecking of a vehicle:

a) the Insured Person disappears;
b) the Insured Person's body is not found; and
c) a valid death certificate is issued by a court of appropriate jurisdiction.

Transportation of Remains Benefit

We will pay for expenses reasonably incurred for the preparation and transportation of remains, up to a maximum of $5,000, if an Insured Person dies as the result of an Accident and the death occurs more than 100 miles away from the Insured Person's primary residence. We must be contacted prior to the preparation and transportation of the remains to pre-authorize the services.

The Insured Person's bodily remains or ashes must be transported to a mortuary or funeral home within 30 miles of the Insured Person's primary residence by a duly licensed company that provides mortuary transport services. This benefit is payable once under the Policy for each Insured Person. This benefit amount is payable in addition to any other applicable benefits under the Policy.

Proof of the expenses incurred must be submitted with the claim. This benefit does not include the transportation expense of anyone accompanying the body or remains, visitation expenses or funeral expenses. In no event will the total amount paid under all group insurance policies issued by Us exceed the actual expense for the preparation and transportation of remains of an Insured Person. We will not pay this benefit if a same or similar benefit is payable under a third-party service contracted by Us.

DISMEMBERMENT & PARALYSIS

Benefits

We will pay the applicable benefit amount shown in the Dismemberment & Paralysis Benefits Table below if an Insured Person sustains one or more Injuries as the result of an Accident that results in Dismemberment and/or Paralysis. The Dismemberment or Paralysis must occur within 365 days after the Accident.

The maximum amount payable for all losses shown in the table sustained by an Insured Person for the same Accident is 100% of the Principal Sum.

Dismemberment & Paralysis Benefits Table

Loss	Benefit
Loss of Both Hands, Loss of Both Feet, Loss of Entire Sight of Both Eyes or any combination of two or more of these losses	100% of the Principal Sum
Loss of Speech and Loss of Hearing (Both ears)	100% of the Principal Sum
Loss of One Hand, Loss of One Foot, Loss of Entire Sight of One Eye or Loss of Hearing (Both ears)	50% of the Principal Sum
Loss of Thumb and Index Finger of the Same Hand	25% of the Principal Sum
Loss of Multiple Fingers or Loss of Multiple Toes	10% of the Principal Sum
Quadriplegia (Paralysis of both upper and both lower limbs)	100% of the Principal Sum
Triplegia (Paralysis of three limbs)	75% of the Principal Sum
Hemiplegia (Paralysis of an upper and a lower limb)	50% of the Principal Sum
Paraplegia (Paralysis of both lower limbs)	50% of the Principal Sum
Uniplegia (Paralysis of a limb)	25% of the Principal Sum

Limitations

If more than one loss shown in the Dismemberment & Paralysis Benefits Table is sustained by an Insured Person for the same Accident, We will pay only the highest applicable benefit. If a benefit was paid under the Policy for an Insured Person for any Dismemberment or Paralysis and the Insured Person later sustains a more severe loss shown in the table as a result of the same Accident, We will reduce the amount payable for the subsequent, more severe loss by the amount paid previously under this benefit.

REASONABLE MODIFICATION(S) BENEFIT

We will pay for expenses reasonably incurred for Home Alteration and/or Vehicle Modification, up to a maximum of 10% of the Principal Sum, if an Insured Person sustains one or more Injuries as the result of an Accident for which a Dismemberment or Paralysis benefit is payable under the Policy for:

a) Loss of Both Hands, Loss of Both Feet, Loss of Entire Sight of Both Eyes or any combination of 2 or more of these losses;
b) Loss of Speech and Loss of Hearing (Both ears);
c) Loss of One Hand, Loss of One Foot, Loss of Entire Sight of One Eye or Loss of Hearing (Both ears); or
d) Quadriplegia, triplegia, hemiplegia or paraplegia.

A Physician must certify that any modification is needed to accommodate a physical disability of the Insured Person. A modification must be made by someone experienced in such adaptations, and must be in compliance with any requirements established by the appropriate government authority. The expense for any modification cannot exceed the usual level of charges for similar alterations and/or modifications in the location where the expense is incurred.

The expense for any modification must be incurred within 365 days after the Accident. This benefit is payable once per Accident for each Insured Person. This benefit amount is payable in addition to any other applicable benefits under the Policy.

Proof of the expenses incurred must be submitted with the claim. In no event will the total amount paid under all group insurance policies issue by Us exceed the actual expense for the Home Alteration and/or Vehicle Modification for an Insured Person.

COMA BENEFIT

We will pay a benefit amount equal to 50% of the Principal Sum if an Insured Person sustains one or more Injuries as the result of an Accident that results in a Coma. The Insured Person must become Comatose within 30 days after the Accident and remain Comatose for 15 or more consecutive days. The Coma must be diagnosed by a Physician and be confirmed by an electroencephalogram (EEG). This benefit is payable once per Accident for each Insured Person.

EXCLUSIONS

Capitalized terms used in this section have the meanings assigned to them in the Definitions section of this Certificate.

We will not pay any benefits under the Policy for any loss or claim which does not result from an Accident or occurs more than 365 days after an Accident.

We will also not pay any benefits under the Policy for an Accident that:

a) results from any bodily infirmity, Sickness, or medical or surgical Treatment thereof;
b) results from cosmetic surgery or procedures;
c) results, whether an Insured Person is sane or insane, from:
    1. an intentionally self-inflicted Injury or Sickness; or
    2. suicide or attempted suicide;
d) occurs in consequence of an Insured Person's being voluntarily intoxicated or under the influence of any controlled substance or alcohol (as defined by the laws of the state in which the Accident occurred), unless administered on the advice of a Physician;
e) results from an Insured Person's intentional or voluntary use of poison, gas or fumes, whether by ingestion, injection, inhalation or absorption, including self-infliction of carbon monoxide poisoning emanating from a motor vehicle;
f) results from an Insured Person's voluntary participation in a riot, commission of a felony, participation in illegal activities or participation in an illegal occupation;
g) occurs while an Insured Person is incarcerated or imprisoned;
h) results from an act of declared or undeclared war or armed aggression;
i) occurs while an Insured Person is operating, learning to operate, riding as a passenger, boarding, departing or jumping from any aircraft (including those that are not motor driven, such as a hot air balloon), unless riding as a fare-paying passenger in a commercial aircraft on a regularly-scheduled flight or while Traveling on Business of the Policyholder;
j) occurs while an Insured Person is riding in or on any motor vehicle or aircraft engaged in racing, endurance tests, off-road activities (for motor vehicles), acrobatic tricks or stunts (for motor vehicles), or acrobatic or stunt flying (for aircraft);
k) occurs while an Insured Person is practicing for, participating in or officiating any semi-professional or professional competitive athletic contest for which any type of compensation or remuneration is received by the Insured Person;
l) occurs while an Insured Person is engaged in skydiving, scuba diving, parachuting, hang gliding, bungee jumping, sail gliding, parasailing, parakiting, mountain climbing, base jumping, rock climbing or other similar high risk activities or extreme sports; or
m) occurs while an Insured Person is on active duty or training in the Armed Forces, National Guard or Reserves of any state or country and for which any governmental body or its agencies are liable.

PAYMENT OF CLAIMS

Capitalized terms used in this section have the meanings assigned to them in the Definitions section of this Certificate.

NOTICE OF CLAIM AND CLAIM FORMS

Before benefits are paid, We must be given written proof of claim as described in the Proof of Claim section below.

As an option, notice of claim may be made to Us within 20 days from the date of the Accident or subsequent Injury or Treatment, or as soon as reasonably possible. The notice should include:

1. The Policyholder's name and the Policy number or group number.
2. The Insured Person's name and mailing address.
3. Your name, mailing address and relationship to the Insured Person, if You are not the Insured Person for whom the claim is being filed.
4. The Claimant's name and mailing address, if the Claimant is other than You or the Insured Person.

Failure to give notice within this time frame shall not invalidate nor reduce any claim.

If notice of claim is given to Us, within 15 days We will provide the requested or necessary claim form(s), instructions and assistance to You, the Insured Person, or the beneficiary, or to the Policyholder for delivery to You, the Insured Person, or the beneficiary. A claim form can also be obtained at any time through Our website.

If We do not provide the requested or necessary form(s) within 15 days, written proof of claim may be submitted that includes the nature, date, cause and extent of the loss for which claim is made, in addition to the information listed previously in this section.

HOW TO OBTAIN PLAN BENEFITS

Forward the completed claim form to:
United of Omaha Life Insurance Company
Mutual of Omaha Plaza
Omaha, Nebraska 68175

CLAIM ASSISTANCE

For assistance with filing a claim or an explanation of how a claim was paid, contact:
United of Omaha Life Insurance Company
Mutual of Omaha Plaza
Omaha, Nebraska 68175
Call Toll-Free: 1-800-775-8805

PROOF OF CLAIM

We must be given written proof of claim within 90 days from the date of the Accident or subsequent Injury or Treatment for an Insured Person. Failure to furnish such proof within this time period shall not invalidate nor reduce any claim if:

a) it was not reasonably possible to give proof within that 90-day period; and
b) proof is furnished as soon as reasonably possible, but not later than one year after the Accident or subsequent Treatment, except in the absence of legal capacity.

We may require supporting information which may include, but is not limited to, clinical records, charts x-rays, and other diagnostic aids.

We may occasionally require an Insured Person to be examined by a Physician of Our choice to assist in determining whether benefits are payable. We will pay for these examinations. We will not require more than a reasonable number of examinations. Where not prohibited by law, We may also require an autopsy. We will pay for this autopsy.

PAYMENT OF CLAIMS

Benefits will be paid immediately after We receive acceptable proof of claim and confirm liability.

Unless You have assigned this insurance, benefits for any Insured Person will be paid to You, except benefits unpaid at Your death or payable due to Your death will be paid to:

a) Your designated beneficiary(ies); if none, then to
b) Your surviving Spouse; if none, then to
c) Your surviving natural and/or adopted child(ren), in equal shares; if none, then to
d) Your surviving parent(s), in equal shares; if none, then to
e) Your estate.

Any benefits paid to a minor may be paid to the legally appointed guardian of the minor. Any benefits paid by Us in good faith will discharge Our liability to the extent of the benefits payment.

Any benefits paid to a minor may be paid to the legally appointed guardian of the minor. Any benefits paid by Us in good faith will discharge Our liability to the extent of the benefits payment.

BENEFICIARY DESIGNATION

In the event of Your death, a beneficiary should be designated to receive any benefits under the Policy that are unpaid at the time of Your death. Beneficiary records will be kept by the Policyholder, Plan Administrator or the office where beneficiary records for the Policy are kept. The most current beneficiary designation in effect under a Prior Plan will be accepted as a beneficiary designation under the Policy until changed (if applicable).

Certain states are community property states. If You live in a community property state and You designate someone other than Your Spouse as a beneficiary, state law may require that Your Spouse consent to such designation. If You do not obtain Your Spouse's consent to the designation, then such designation may not be effective. Community property states as of the Policy Effective Date include: Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington and Wisconsin.

Your beneficiary may be changed at any time by You or Your assignee (if You have assigned this insurance). To make a change, a Written Request should be provided to the Policyholder, Plan Administrator or to the office where beneficiary records for the Policy are kept. If You do not know where the records are kept, then the Written Request may be sent to Us. When received by the Policyholder or Us, the change will take effect as of the date the Written Request is signed. The change will not apply to any payments or other action taken by Us before the Written Request was received.

RIGHT OF ASSIGNMENT

The rights provided to You under the Policy for insurance are owned by You, unless You have previously assigned these rights to someone else, or You assign Your rights to an assignee. You should consult with a legal counsel prior to making an assignment.

We will recognize an assignee as the owner of the rights assigned only when:

a) the assignment is in writing and acceptable to Us; and
b) a signed or certified copy of the assignment has been received and approved by Us.

The assignment will not apply to any payments or other action taken by Us before the assignment was received and recorded in Our home office. We are not responsible for any legal, tax or other implications of any assignment.

FACILITY OF PAYMENT

In the event benefits under the Policy become payable to You or any person who is not legally competent to claim or receive benefits, a minor, or Your estate, We may pay an amount of up to $500 to any of the following:

a) a person related to You by blood or marriage;
b) a person or entity that has incurred expenses related to Your last illness or death;
c) the person who has assumed the care and support of You or any beneficiary;

d) a personal or legal representative of Your estate

Any benefits paid by Us in good faith will discharge Our liability to the extent of the benefits payment.

MODE OF PAYMENT

Benefits for each claim will be paid by Us in one lump sum, unless otherwise indicated in any benefit provision of this Certificate.

REFUND TO US

If it is found that We paid more benefits than We should have paid under the Policy, We will have the right to a refund from You or the recipient of benefits.

We also have a right to a refund for any payments due to:
a) fraud or misrepresentation;
b) any error We make in processing a claim;
c) You or Your agent's failure to provide complete information; or
d) an Insured Person not being eligible for coverage.

You or the recipient of benefits must reimburse Us in full. We will determine the method by which the repayment is to be made, including without limitation, reducing or withholding any benefits payable to You, Your survivor(s) or Your estate under this or any other group insurance policy issued by Us. We will credit any such payments to the refund until the refund is fully recovered.

If it is found that We paid less benefits than We should have paid under the Policy, We will make additional payment(s), as necessary.

AUTHORITY TO INTERPRET POLICY

By purchasing the Policy, the Policyholder grants Us the discretion and the final authority to construe and interpret the Policy. This means that We have the authority to decide all questions of eligibility and all questions regarding the amount and payment of any Policy benefits within the terms of the Policy as interpreted by Us. Benefits under the Policy will be paid only if We decide, in Our discretion, that a person is entitled to them. In making any decision, We may rely on the accuracy and completeness of any information furnished by the Policyholder, an Insured Person or any other third party. Our interpretation of the Policy as to the amount of benefits and eligibility shall be binding and conclusive on all persons.

The Policyholder further grants Us the authority to delegate to third parties, including, without limitation, Mutual of Omaha Insurance Company and any third party administrator with whom We have contracted to provide claims administration and other administrative services, the discretionary authority granted in the Policy. The Policyholder expressly grants such third party the full discretionary authority granted to Us under this Policy.

You or the claimant (in the event of Your death) have the right to request a review of Our decision. If, after exercising the Policy's review procedures, the claim for benefits is denied or ignored, in whole or in part, You or the claimant may file suit and a court will review Your or the claimant's eligibility or entitlement to benefits under the Policy.

CLAIM REVIEW AND APPEAL PROCEDURES

Capitalized terms used in this section have the meanings assigned to them in the Definitions section of this Certificate.

NOTICE: In addition to the requirements described in this document, applicable state laws may contain requirements for claims review and appeal procedures. To the extent that any requirement in this document is inconsistent with any state law requirement, the requirement that is most favorable to the person insured under the Policy shall prevail. If You have any questions, please contact Us.

CLAIM REVIEW PROCEDURES

Once We receive information necessary to evaluate the claim, We will make a decision within the time periods set forth below. In the event an extension is necessary due to matters beyond Our control, We will notify the Claimant of the extension and the circumstances requiring the extension.

Except when the Claimant voluntarily agrees to provide Us with additional time, extensions are limited as set forth below. If an extension is necessary due to the Claimant's failure to submit complete information, We will notify the Claimant of the additional information required. Such notice of incomplete information will be sent within the time periods set forth below.

In order for Us to continue processing the claim, the missing information must be provided to Us within the time periods set forth below. The Claimant may contact Us at any time for additional details about the processing of the claim.

INITIAL CLAIM DECISION

The period of time within which a claim decision will be made begins at the time the claim is filed, without regard to whether all the information necessary to make a claim decision accompanies the filing. The applicable time periods are shown below:

a) initial claim decision period: 45 days unless additional information is requested as set forth below;
b) extension period: 30 days; and
c) maximum number of extensions: 2.

If additional information is needed, We will notify the Claimant within 10 days of Our receipt of the claim. Once the Claimant receives Our request for additional information, the Claimant will be given no less than 45 days to submit the additional information to Us. We will make Our determination within 15 days of Our receipt of the additional information. If We do not receive the additional information within the specified time period, We will make Our determination based upon the available information.

CLAIM DENIALS

If a request for a claim is denied, in whole or in part, the Claimant will receive notice of the denial, which will include:

a) the specific reason(s) for the denial;
b) reference to the specific Policy provisions on which the denial is based;
c) a description of the appeal procedures and time limits applicable to such procedures, including the right to request an appeal within 60 days and the right to bring a civil action following the appeal process; and
d) any other information which may be required under state or federal laws and regulations.

Additionally, if an internal rule, guideline, protocol or other similar criterion was relied upon in making the Adverse Benefit Determination, the Claimant has the right to request information about such internal rule, guideline, protocol or other similar criterion that was used in making the Adverse Benefit Determination, free of charge.

OPPORTUNITY TO REQUEST AN APPEAL

The Claimant shall have a reasonable opportunity to appeal a claim review decision. As part of the appeal, there will be a full and fair review of the claim review decision.

The Claimant will have no later than 60 days from the Claimant's receipt of notification of Our claim review decision to submit a request for an appeal. The request for an appeal should include:

1. The Policyholder's name and the Policy number or group number.
2. The Insured Person's name and mailing address.
3. The name and mailing address of the Claimant filing the appeal, if different from the Insured Person.
4. The nature of the appeal.

The request for an appeal can be submitted in any manner and should include any additional information that may have been omitted from Our review or that should be considered by Us. The notification regarding Our claim review decision will include instructions on how and where to submit an appeal.

By requesting an appeal, the Claimant has authorized Us, or anyone designated by Us, to review any and all records (including, but not limited to, medical records) which We determine may be relevant to the appeal.

RESPONSE TO APPEALS

We will respond no later than 45 days from Our receipt of the request for an appeal. However, if We determine that an extension is required, We will notify the Claimant in writing of the extension prior to the termination of the initial appeal period. In no event will the extension exceed 45 days from the end of the initial appeal period. The extension notice will indicate the special circumstances requiring the extension and the date by which We expect to render the appeal decision.

When We make Our determination, the Claimant will be provided with:

a) information regarding the decision; and
b) information regarding other internal or external appeal or dispute resolution alternatives, including any required state mandated appeal rights.

The period of time within which an appeal decision is required to be made will begin at the time an appeal is filed, without regard to whether all the information necessary to make an appeal decision accompanies the filing. If a period of time is extended as described above due to the Claimant's failure to submit information necessary to decide a claim, the period for making the appeal decision shall be "tolled" or suspended from the date on which the extension notice is sent until the earlier of:

a) the date on which We receive the response; or
b) the date established by Us in the notice of extension for the furnishing of the requested information.

STANDARD PROVISIONS

Capitalized terms used in this section have the meanings assigned to them in the Definitions section of this Certificate.

INSURANCE CONTRACT

The insurance contract consists of:

a) the Policy (of which this Certificate is made a part);
b) the Policyholder's signed application attached to the Policy; and
c) any signed application for You and Your Dependent(s) (if applicable).

Statements in an application are considered representations and not warranties. We will not use any statements in an Insured Person's application to deny a claim or to contest the validity of this insurance unless We provide You, Your beneficiary or Your authorized representative with a copy of that application.

CHANGES IN THE INSURANCE CONTRACT

The insurance contract may be changed (including reducing or terminating benefits or increasing premium costs) any time We and the Policyholder both agree to a change. No one else has the authority to change the insurance contract. A change in the insurance contract:

a) does not require the consent of any Insured Person or beneficiary; and
b) must be:
    1. in writing;
    2. made a part of the Policy; and
    3. signed by Our authorized representative in Our home office.

A change may affect any class of Insured Persons included in the Policy.

INCONTESTABILITY

We will not contest this Policy after it has been in force two years, except for nonpayment of premium.

LEGAL ACTIONS

No legal action can be brought until at least 60 days after We have been given written proof of claim. No legal action can be brought more than six years after the date written proof of claim is required, unless otherwise required by state law in Your state of residence.

CONFORMITY WITH STATE AND FEDERAL LAW

Any provision of the Policy which, on its effective date, is in conflict with the law of the federal government or the state in which an Insured Person resides on such date is hereby amended to conform to the minimum requirements of such law.

DEFINITIONS

The following capitalized terms have the meanings assigned in this section. These terms are used throughout the Policy.

Accident, Accidental means a sudden, unexpected and unforeseeable event which results in one or more Injuries that occurs after the effective date of insurance under the Policy for an Insured Person and while insurance is in effect for an Insured Person.

Actively Working, *Active Work* means an Employee is:

a) performing the normal duties of his or her regular job for the Policyholder on a regular and continuous basis 20 or more hours each week; and
b) receiving compensation from the Policyholder for work performed for the Policyholder.

An Employee will be considered to be actively working on any day that is a regular paid holiday or day of vacation, or regular or scheduled non-working day, provided the Employee was actively working on the last preceding regular work day.

Activities of Daily Living means the basic activities of daily living consisting of the following self-care tasks:

a) personal hygiene (bathing, grooming, shaving and oral care);
b) dressing and undressing (putting on and taking off all items of clothing and any necessary braces or artificial limbs);
c) eating (the ability to feed oneself);
d) transferring (from bed to chair, and back; from sitting to standing, and back);
e) continence (controlling bladder and bowel function);
f) toileting (the ability to use a restroom); and
g) moving around (as opposed to being bedridden).

Adverse Benefit Determination means a denial, reduction, or termination of a benefit or a failure to provide or make payment (in whole or in part) for a benefit. This includes, without limitation, any such denial, reduction or termination of a benefit, or failure to provide or make payment, that is based upon ineligibility for insurance under the Policy.

Ambulatory Medical Center means a licensed healthcare facility providing ambulatory (outpatient) surgical or medical treatment, other than a Hospital, Physician's office or clinic.

Anesthesia means a general or spinal anesthetic. Anesthesia does not include injection of local anesthetic or peripheral nerve blocks.

Arthroscopic Debridement means a minimally invasive surgical procedure performed to treat or repair an Injury through removal or modification of damaged cartilage or bone. Arthroscopic debridement includes cartilage shaving and trimming.

Basic Benefits means any benefit included in any of the benefit categories shown in the Basic Benefits section of the Schedule section of this Certificate.

Blood Products means whole blood, red blood cells, plasma, platelets or granulocytes.

Brain Injury means a traumatic brain injury (TBI) or a mild traumatic brain injury (MTBI), including cerebral contusions, cerebral lacerations, concussions or intracranial hemorrhage.

Burn means an Injury to flesh or skin caused by heat, electricity, chemicals, friction or radiation. A burn includes second and third degree burns in which damage penetrates to the dermis (underlying layers of the skin). A burn does not include a sunburn or a superficial (first degree) burn of the epidermis (the outer layer of the skin).

Calendar Year means the 12-month period beginning on January 1 of each year and ending on December 31 of the same year.

Catastrophic Benefits means any of the benefits shown in the Catastrophic Benefits section of this Certificate.

Certificate means this document that describes the benefits, terms, conditions, exclusions and limitations of the insurance provided under the Policy.

Childcare means care provided for one or more Dependent children on a regular basis for daily periods of less than 24 hours, whether the care is for daytime or nighttime hours. This care must be provided in a Childcare Center.

Childcare Center means a duly licensed independent childcare provider or duly licensed childcare facility that provides non-medical care for children in a group setting that is not owned or operated by the Insured Person or a member of the Insured Person's Family.

Chip Fracture means a fracture in which a fragment or piece of a bone is broken off near a joint at a place where a ligament is usually attached which is diagnosed as a chip fracture by a Physician or Medical Professional. Another term for chip fracture is "avulsion fracture." A chip fracture does not include a stress fracture or a hairline fracture.

Chiropractic Care means spinal manipulation services provided by a Chiropractor to correct a structural imbalance. Chiropractic care does not include massage therapy, care for chronic conditions or other injuries not related to structural imbalance.

Chiropractor means a duly licensed health care professional focused on the diagnosis and treatment of neuromuscular disorders, with an emphasis on treatment through manual adjustment and/or manipulation of the spine. The chiropractor must be acting within the scope of his/her license. A chiropractor does not include the Insured Person or any Family member.

Claimant means the person who submits a claim for benefits for any Insured Person under the Policy, including the authorized representative of such person.

Closed Reduction means a medical procedure to restore a broken bone or dislocated joint to the correct alignment without surgery. Closed reduction includes immobilization.

Coma, Comatose means an Insured Person is in a profound stupor or state of complete and total unconsciousness with no reaction to external stimuli, response to internal needs, and a Glasgow Coma Score of eight (8) points or less, for which intubation is required for respiratory assistance. A coma does not include a medically induced coma or a coma that is the result of any alcohol or drug use.

Common Carrier means a method of common public transport with defined published routes, time schedules and rates approved by regulators. A common carrier includes public airlines, railroads, subways, trolleys, boats and bus lines. A common carrier does not include taxis, limousines, any privately chartered mode of transportation or any mode of transportation owned, operated or leased for or by the Policyholder.

Confined, Confinement means the assignment to a bed as a resident inpatient on the advice of or as prescribed by a Physician with a charge for room and board in a:

a) Hospital or an Observation Unit (or other observation area of a Hospital) for a period of at least 20 consecutive hours; or
b) a Rehabilitation Facility.

Dentist means a person who is:

a) licensed to practice dentistry under the law of the jurisdiction in which the dental procedure is performed; and
b) operating within the scope of his or her license.

Dependent means a citizen, permanent resident or lawful resident of the United States who is:

a) Your Spouse;
b) Your natural born or legally adopted child;
c) Your stepchild;
d) a child that You or Your Spouse are required to provide insurance for under the terms of a:
    1. Qualified Medical Child Support Order (QMCSO), National Medical Support Notice or equivalent; or
    2. decree, judgment or order issued by a court of competent jurisdiction; or
e) any other child who lives with You in a regular parent/child relationship and who qualifies as Your "dependent" as defined in the United States Internal Revenue Code.

A dependent does not include:

a) anyone who is a member of the Armed Forces, National Guard or Reserves of any state or country on active duty (except for temporary duty of 31 days or less);
b) Your divorced, legally separated or former Spouse;
c) Your Spouse after You reach the age of 80;

d) a child who has reached the age of 26 unless the child is Incapacitated;
e) Your child if the child has been legally adopted by another person; or
f) a child placed in Your home by a social service agency which retains control over the child.

Diagnostic Exam means any of the following:
a) bone scintigraphy;
b) computerized tomography (CT) scan;
c) electroencephalogram (EEG);
d) magnetic resonance imaging (MRI); or
e) single photon emission computed tomography (SPECT) scan.

A diagnostic exam does not include an X-Ray.

Dislocation means a complete, abnormal separation of a joint which is diagnosed as a dislocation by a Physician or Medical Professional and is confirmed by an X-Ray or appropriate Diagnostic Exam. The dislocations covered under the Policy are shown in the Dislocations section of the Specified Injury Benefits section of this Certificate. Another term for dislocation is "luxation."

Dismemberment means the removal of a body part by trauma, prolonged constriction, or surgery (amputation).

Emergency Room means a specified area within a Hospital that is designated for the emergency care of Injuries. This area must:
a) be staffed and equipped to handle trauma;
b) be under the direct supervision of a Physician;
c) provide treatment by Physicians and/or Medical Professionals; and
d) provide care 7 days per week, 24 hours per day.

An Urgent Care Center is not an emergency room.

Employee means a person who is:
a) a citizen or permanent resident of the United States; or
b) lawfully and legally able to work in the United States pursuant to applicable federal and state laws; and
c) performing work for the Policyholder at:
    1. the Policyholder's usual place of business;
    2. an alternative work site at the direction of the Policyholder; or
    3. a location to which the employee must travel to perform the job.

An employee does not include a person:
a) who resides outside the United States for a period in excess of 12 consecutive months unless written approval has been received from Our authorized representative in Our home office;
b) working for the Policyholder on a seasonal or temporary basis; or
c) performing services for the Policyholder as an independent contractor, including persons for whom income is reported on a 1099 form or subject to the terms of a leasing agreement between the Policyholder and a leasing organization.

Epidural Anesthesia means a form of regional anesthesia involving the injection of drugs through a catheter placed into the epidural space. Epidural anesthesia does not include spinal anesthesia, the injection of local anesthetic or peripheral nerve blocks.

Exploratory Surgery means surgery performed for diagnostic purposes, without repair and without the intent of treating a condition or Injury.

Express Benefit means the benefit identified in the Express Benefit section of the Schedule.

Eyelid means the moveable fold of skin and muscle that can be closed over the exposed portion of an eyeball.

Family means Your Spouse, former Spouse, children, parents, grandparents, grandchildren, brothers, sisters and the spouses (or domestic partners or equivalent) of such individuals, or Your Spouse's relatives of like degree.

First Enrollment Period means the 31-day period following the day the Employee or Dependent becomes eligible for insurance under the Policy or any Prior Plan.

Follow-Up Treatment means ongoing Treatment or physical evaluation which occurs after Initial Care has been received by the Insured Person.

Fracture means a break in a bone that can be detected by an X-Ray or similar diagnostic exam which is diagnosed as a fracture by a Physician or Medical Professional. The fractures covered under the Policy are shown in the Fractures section of the Specified Injury Benefits section of this Certificate. A fracture does not include a stress fracture or a hairline fracture.

Health Screening Test means any of the following: abdominal aortic aneurysm ultrasound; blood test for triglycerides; bone marrow testing; bone density screening; breast ultrasound; CA 15-3 (blood test for breast cancer); CA 125 (blood test for ovarian cancer); carotid ultrasound; CEA (blood test for colon cancer); chest X-Ray; colonoscopy; CT angiography; EKG; double contrast barium enema; fasting blood glucose test; flexible sigmoidoscopy; hemoccult stool analysis; mammography; pap smear; PSA (blood test for prostate cancer); serum cholesterol test (for HDL and LDL levels); SPEP (blood test for myeloma); stress test (on a bicycle or treadmill); or thermography.

Herniated Disc means a tear in the outer, fibrous ring (annulus fibrosus) of an intervertebral disc (discus intervertebralis) enabling the inner portion (nucleus pulposus) to herniate or extrude through the damaged outer rings. A herniated disc does not include a bulging disc.

Home Alteration means internal or external structural modifications to an Insured Person's primary residence, such as widening of doorframes, replacement doors, ramps, stairs or hand rails, or modifications to walkways.

Hospital means a facility that:

a) is accredited, approved, certified or licensed by the proper authority of the state in which it is located to provide care and treatment for injured or sick people on an inpatient basis;
b) is recognized as a general hospital by the Joint Commission;
c) provides 24-hour nursing service by Registered Nurses (RNs); and
d) has organized facilities and equipment for diagnosis and treatment of acute medical and surgical conditions on its premises or in facilities available to it on a prearranged basis.

A hospital does not include a facility or institution, or part thereof, which is licensed or used principally as a:

a) clinic (including dental, mental illness or substance abuse facilities), Ambulatory Medical Center or Urgent Care Center;
b) convalescent home, rest home, nursing home or home for the aged;
c) halfway house; or
d) rehabilitative, alternate care, extended care, skilled nursing or board and care facility.

Incapacitated means that a Dependent child, by reason of intellectual disability, developmental disability, mental illness or physical handicap, is continuously incapable of:

a) performing two or more Activities of Daily Living (ADLs), if younger than the age of 26; or
b) self-sustaining employment, if older than the age of 26.

Incomplete Dislocation means an incomplete, abnormal separation or misalignment of a joint which is diagnosed as an incomplete dislocation by a Physician or Medical Professional and is confirmed by an X-Ray or appropriate Diagnostic Exam. Another term for incomplete dislocation is "subluxation" or "partial dislocation."

Initial Care means any of the benefits shown in the Initial Care section of the Initial Care and Emergency Benefits section of this Certificate.

Injured means the occurrence of an Injury.

Injury, Injuries means a bodily injury that is the direct result of an Accident which requires treatment by a Physician or Medical Professional. An injury must be independent of bodily infirmity, Sickness or medical or surgical treatment thereof, and all other causes. An injury includes an infection that is the natural result of an Accidental wound and Accidental food poisoning.

Insured Person(s) means You and/or Your Dependent(s) who are insured under the Policy and this Certificate.

Intensive Care Unit (ICU) means a place which is a specifically designated area of a Hospital that provides the highest level of medical care and:

a) is restricted to patients who are critically ill or injured and who require intensive comprehensive observation and care;
b) is separate and apart from the surgical recovery room and from rooms, beds and wards customarily used for patient Confinement;
c) is permanently equipped with special lifesaving equipment and medical apparatus for the care of the critically ill or injured;
d) is under constant and continuous observation by a specially trained nursing staff assigned exclusively to the unit on a 24 hour basis; and
e) has a Physician assigned to the unit on a full-time basis.

An intensive care unit may include Hospital units with the following (or similar) names: intensive care unit, critical care unit, neonatal intensive care unit, burn unit or transplant unit. An intensive care unit is not any of the following step-down units: a progressive care unit, an intermediate care unit, a private monitored room, a sub-acute intensive care unit, a modified/moderate care unit, an Observation Unit or any facility that does not satisfy the requirements of this definition.

Laceration means a cut or tear of the skin or flesh.

Laceration Repair Method means sutures (stitches), tissue adhesives (glue), staples or skin-closure strips.

Life Event means:

a) a change in Your legal marital status or domestic partnership (or equivalent);
b) a change in the number of Your Dependents.

Lodging means a duly licensed establishment, such as a hotel, inn, lodge, motel or other facility that provides sleeping accommodations to the general public in exchange for a fee that is not owned or operated by the Insured Person or a member of the Insured Person's Family.

Loss of a Thumb and Index Finger of the Same Hand means Severance of the thumb and index finger of the same hand at or proximal to the metacarpophalangeal joints (the joints that connect the fingers and the hand).

Loss of Both Feet, Loss of One Foot means Severance of the foot or both feet above the ankle joint. Loss of a foot includes the Severance of an entire leg or Severance of any part of a leg that includes an entire foot.

Loss of Both Hands, Loss of One Hand means Severance of at least four whole fingers from one or both hands. Loss of a hand includes the Severance of an entire arm or Severance of any part of an arm that includes an entire hand.

Loss of Entire Sight of Both Eyes, Loss of Entire Sight of One Eye means total and permanent loss of sight of one or both eyes which cannot be corrected by any means, or Severance of one or both eyes.

Loss of Hearing means total and permanent loss of hearing in both ears which cannot be corrected by any means.

Loss of Multiple Fingers means the Severance of more than one finger at or proximal to the first interphalangeal joint at which the finger is attached to the hand. Loss of multiple fingers does not include Loss of a Thumb and Index Finger of the Same Hand.

Loss of Multiple Toes means the Severance of more than one toe at or proximal to the first interphalangeal joint at which the toe is attached to the foot.

Loss of Speech means total and permanent loss of audible voice communication which cannot be corrected by any means.

Medical Device means a device or appliance that is intended by its manufacturer to assist a person with personal locomotion or mobility due to a malfunctioning part of the body, including (but not limited to) crutches, a cane, a wheelchair, a walker, a back brace or a leg brace.

Medical Professional means a person who is duly licensed to provide Treatment, such as a physician's assistant (PA), nurse practitioner (NP/APRN) or registered nurse (RN). The medical professional must be acting within the scope of his/her license. A medical professional does not include the Insured Person or any Family member.

Observation Unit means a specified area within a Hospital, apart from an Emergency Room, where a patient can be monitored by a Physician or Medical Professional following Outpatient Treatment or Treatment in an Emergency Room.

This area must:

a) be under the direct supervision of a Physician;
b) provide treatment by Physicians and/or Medical Professionals; and
c) provide care 7 days per week, 24 hours per day.

Occupational Therapy means the Treatment provided by an occupational Therapist of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those tasks required by the person's occupation. Occupational therapy does not include diversional, recreational or vocational therapies (such as arts, crafts or hobbies).

Open Reduction means a medical procedure to restore a broken bone or dislocated joint to the correct alignment with surgery.

Our, We, Us means United of Omaha Life Insurance Company.

Outpatient Treatment means Treatment, including surgery, received by an Insured Person at a Hospital or appropriately licensed Ambulatory Medical Center for which there is no charge for room and/or board.

Paralysis means total and permanent loss of use of a limb without Severance. This loss must be determined by a Physician to be complete and irreversible. Forms of paralysis include quadriplegia, triplegia, hemiplegia, paraplegia and uniplegia.

Physical Therapy means Treatment provided by a physical Therapist through physical means; hydrotherapy, heat or similar modalities; physical agents; or bio-mechanical and neuro-physiological principles and devices. Such therapy is given to relieve pain, restore function and to prevent disability following an Injury or loss of a body part.

Physician means a legally qualified medical doctor licensed to practice medicine, prescribe drugs, perform surgery, or where required by state law, any other licensed practitioner of a healing art who is deemed to be the same as a legally qualified medical doctor. The physician must be acting within the scope of his/her license. A physician does not include the Insured Person or any Family member.

Plan Administrator means the person or entity designated as the plan administrator for the Policyholder's group accident insurance plan.

Policy means the group policy issued to the Policyholder by Us, including this Certificate.

Policy Anniversary means October 1 of each Policy Year.

Policy Effective Date means October 1, 2019.

Policy Year means the period commencing on the Policy Effective Date and ending on the next succeeding Policy Anniversary and, thereafter, each 12-month period commencing on the Policy Anniversary.

Prior Plan means any similar insurance policy:

a) replaced by insurance under part or all of the Policy; and
b) in effect and maintained or sponsored by the Policyholder on the day before the Policy Effective Date.

Prosthetic Device means an artificial device that replaces a missing body part, such as a limb or eye. A prosthetic device does not include hearing aids, dental aids (including dentures/false teeth), eye glasses, cosmetic prostheses (such as wigs) or joint replacements (such as an artificial hip or knee).

Rehabilitation Care Services means coordinated multidisciplinary physical restorative services (the combined use of medical, social, educational and vocational services) to enable an Insured Person who is disabled by an Injury to achieve the highest possible functional ability. Services are provided by or under the supervision of Physicians and/or Medical Professionals experienced in rehabilitative medicine.

Rehabilitation Facility means an appropriately licensed facility that provides Rehabilitation Care Services on an inpatient basis. A rehabilitation facility may be a unit within a Hospital if the unit is specifically designated for Rehabilitation Care

Services and is separate and apart from the beds and wards customarily used for patient Confinement. A rehabilitation facility does not include:

a) a rest home or home for the aged;
b) a hospice care facility;
c) a place for alcoholics or drug addicts; or
d) an assisted living facility.

A rehabilitation facility also does not include a nursing home, an extended care facility or a skilled nursing facility, unless an Insured Person is receiving Rehabilitation Care Services at such home or facility.

Schedule means the section of the Certificate identified as the "Schedule."

Severance, Severed means the complete separation and Dismemberment of a body part from the body.

Sickness means a physical or mental disease, illness, infection, disorder or condition, including pregnancy and any drug or alcohol disorder, which is not caused by an Accident. Sickness does not include an infection that is the natural result of an Accidental wound.

Skin Graft means a surgical procedure by which skin, skin stem cells or skin substitute is placed over a Burn to permanently replace damaged or missing skin, regenerate damaged or missing skin, or provide a temporary wound covering.

Speech Therapy means Treatment and assistance provided by a speech Therapist for disorders related to speech, language, cognitive communication, voice, swallowing and fluency.

Spouse means the person to whom You are legally married.

Subsequent Enrollment Period means any period of up to 31 consecutive calendar days designated for enrollment under the Policy by the Policyholder and agreed to in writing by Our authorized representative in Our home office.

Therapist means a person who is duly licensed to practice occupational, physical or speech therapy. An occupational therapist must possess the designation of "Occupational Therapist Registered (OTR)." A physical therapist must practice according to the code of ethics of the American Physical Therapy Association. A speech therapist must practice according to the code of ethics of the American Speech-Language-Hearing Association. The therapist must be acting within the scope of his/her license. A therapist does not include the Insured Person or any Family member.

Therapy means ongoing Chiropractic Care, Occupational Therapy, Physical Therapy or Speech Therapy which occurs after Initial Care has been received by the Insured Person.

Traveling on Business of the Policyholder means any trip made by You on assignment by or with authorization of the Policyholder for the purpose of furthering the business of the Policyholder. If this trip is made on a private aircraft, then the aircraft must:

a) have a current and valid Federal Aviation Administration of the United States (FAA) standard airworthiness certificate; and
b) be operated by a person holding a current and valid FAA pilot's certificate authorizing such person to operate the aircraft.

Treatment means medical advice, consultation, care or services (including diagnostic measures) received by an Insured Person, or the use of drugs or medicines by an Insured Person.

Urgent Care Center means a licensed, free-standing healthcare facility providing immediate, short-term medical care without an appointment, other than a Hospital, Emergency Room, Physician's office or clinic.

Vehicle Modification means modification to or installation of assistive devices for one motor vehicle (not including a motorized wheelchair or scooter).

Written Request means a request that is signed, dated and submitted to the Policyholder or Us. The request must be on a form We supply or be in a form and content acceptable to Us.

X-Ray means electromagnetic radiation that differentially penetrates structures within the body and creates images of the structures.

You, Your, Yourself means the Employee who is insured under the Policy and this Certificate.

Group Voluntary Accident Benefits

Hoover City Schools

Group Number: G000BJXW

United of Omaha Life Insurance Company

Home Office:
Mutual of Omaha Plaza
Omaha, Nebraska 68175