MUTUAL of OMAHA

PLAN OF INSURANCE

Policyholder Name: 2nd Adventure Payroll Services
3006 Brownells Pkwy
Grinnell, IA 50112

Policy Number: GMDC-CMKF

Effective Date: January1, 2025

Eligibility: All active full-time (30+ hours per week) employees of the Policyholder domiciled in the United States and their eligible dependents.

Employee means a citizen or permanent resident of the United States, or a person who is authorized to work in the United States pursuant to the Immigration and Nationality Act and related rules and regulations.

Dependents of enrolled Employees may also be insured, provided the requirements for eligibility are met, Spouse or Children coverage is applied for, and the proper premium paid.

No eligible person may be covered more than once under this Memorandum of Coverage. If they are covered as an Employee, they cannot also be covered as a dependent of another Employee.

Premiums:

Monthly per $1,000 Principal Sum	
Employee Only	$0.024
Employee & Family	$0.024

The following riders are attached to and made a part of this Memorandum of Coverage:

Guaranty Association Notice	
Claim Review & Appeal Procedures	0KW5M

Mutual of Omaha
3300 Mutual of Omaha Plaza | Omaha, NE 68175

MEMORANDUM OF COVERAGE

Insurance benefits are underwritten by Mutual of Omaha Insurance Company under Master Policy GMDC-CMKF issued to the Direct Marketer's Insurance Trust. This Memorandum of Coverage along with the Certificate of Insurance describes the benefits payable under the policy.

This coverage goes into effect on the Effective Date shown on the Plan of Insurance. The initial term ends on the first renewal date. This coverage may be renewed for additional terms with our consent. Each term begins and ends at 12:01 a.m., Standard Time, at the main office of the Accountholder.

GENERAL PROVISIONS

Eligibility: Persons within the class or classes stated in the Plan of Insurance are eligible for insurance under this Memorandum of Coverage.

Effective Date of Individual Coverage: Each eligible person who makes written application will become insured under this Memorandum of Coverage on the Certificate Date specified in the Schedule.

Certificate: We will issue a certificate for each Insured. The certificate will state the terms of insurance.

Premiums: The premiums for the plan of coverage provided under this Memorandum of Coverage are stated on the Plan of Insurance.

The Initial Premium for each person to be insured is due on the effective date of his or her coverage. Renewal Premiums are due on the first day of each certificate renewal term. We have the right to adjust premiums. We will give the Accountholder at least 60 days' advance written notice and each Insured at least 30 days' advance written notice of any premium change.

Entire Contract; Changes: This Memorandum of Coverage and any attached papers constitute the entire contract of insurance. Any statements made by the Accountholder or an Insured shall, in the absence of fraud, be deemed a representation and not a warranty. No statement made by an Insured shall avoid his or her insurance or reduce benefits unless contained in a written application signed by that person. Any change of this Memorandum of Coverage requires written consent of an executive officer of ours.

Coverage and Individual Provisions: The coverage and individual provisions for this coverage are in the Certificate of Insurance and any attached rider(s). A copy of the certificate and any attached rider(s) when attached to this Memorandum of Coverage is (are) made a part of it.

Underwritten by Mutual of Omaha Insurance Company • Home Office: Omaha, Nebraska

CLAIM REVIEW
AND APPEAL PROCEDURES
(As Federally Mandated)

For the employer-employee accidental death and/or dismemberment policy under which you are insured, this provision is effective the later of:

(a) the effective date of the Policy; or
(b) the date required by Federal law.

Definitions

Capitalized terms have the same meaning as shown in the Policy.

For the purposes of this provision the following term has the following meaning:

Adverse Benefit Determination means a denial, reduction or termination of, or a failure to provide or to make payment (in whole or in part) for a benefit, including any such denial, reduction, termination of, or failure to provide or make payment (in whole or in part) that is based upon the Insured Person's ineligibility for insurance under the Policy.

Claim Review Procedures

Once We receive information necessary to evaluate the claim, We will make a decision within the time periods set forth below. Please refer to the Payment of Claims provision of the Policy.

In the event an extension is necessary due to matters beyond Our control, We will notify the person submitting the claim of the extension and the circumstances requiring the extension. Extensions are limited as set forth below.

If an extension is necessary due to failure to submit complete information, We will notify the person submitting the claim 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.

We may contact the person submitting the claim at any time for additional details about the processing of the claim.

Claim Review Decisions

(a) Initial review: We will notify the person submitting the claim of Our claim decision within 45 days after Our receipt of the claim, 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 person submitting the claim within 30 days of Our receipt of the claim. Once Our request for additional information is received, the person submitting the claim will have 45 days to submit the additional information to Us. We will have a total of 105 days (which includes an additional 30-day extension, if necessary, due to circumstances beyond Our control) to process the claim. If We do not receive the additional information within the specified time period, We will make Our determination based on the available information.

Claim Denials

If a claim is denied or partially denied, the person submitting the claim will receive a written or electronic 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) if applicable, a description of any additional material or information necessary to complete the claim and the reason We need the material or information;
(d) a description of the appeal procedures, including the right to request an appeal within 180 days and the right to bring a civil action following the appeal process; and
(e) any other information which may be required under state or federal laws and regulations.

Opportunity To Request An Appeal

The person submitting the claim may appeal Our claim review decision in accordance with this Claim Review and Appeal Procedures provision. As part of the appeal, We will perform a full and fair review of the decision.

The request for an appeal can be written, electronically or orally submitted to Us and should include any additional information that the person submitting the claim believes may have been omitted from Our review that should be considered by Us.

The request for an appeal should include:

(a) the name of the person for whom the claim has been submitted;
(b) the name of the person filing the appeal;
(c) the policy number; and
(d) the nature of the appeal.

We will establish and maintain procedures for hearing, researching, recording and resolving any appeal. The notification of Our claim review decision will include instructions on how and where to submit an appeal.

The person submitting the claim will:

(a) have 180 days from receipt of notification to submit a request for an appeal;
(b) be provided the opportunity to submit written comments, documents, records and other information relating to the claim; and
(c) be provided, upon request and free of charge, reasonable access to and copies of documents, records and other information relevant to the claim.

In reviewing the appeal We will consider all comments, documents, records and other information submitted by the person submitting the claim relating to the claim, without regard to whether such information was submitted or considered in the claim decision.

Request for an appeal authorizes Us, or anyone designated by Us, to review records relevant to the claim.

Our Response To An Appeal

Once We receive a request for an appeal, We will respond within 45 days, unless additional information is requested. If additional information is requested, the following extensions apply:

(a) extension period: 45 days; and
(b) maximum number of extensions: one.

We will have a total of 90 days to process the appeal.

When We make Our decision, the person submitting the claim will be provided with:

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

NOTICE OF PROTECTION PROVIDED BY

IOWA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This notice provides a brief summary of the Iowa Life and Health Insurance Guaranty Association Act (the "Association" and the protection it provides for policyholders. This safety net was created under Iowa law, located at Iowa Code Chapter 508C, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that Your life, annuity, health insurance company or health maintenance organization becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Iowa law, with funding from assessments paid by other insurance companies.

The basic protections provided by the Association are:

a) Life Insurance
   1. $300,000 in death benefits
   2. $100,000 in net cash surrender and withdrawal values

b) Health Insurance
   1. $500,000 for health benefit plans (see definition below)
   2. $300,000 in disability income protection insurance benefits
   3. $300,000 in long-term care insurance benefits
   4. $100,000 in other types of health insurance benefits, including net cash surrender and withdrawal values

c) Annuities
   1. $250,000 in the present value of annuity benefits, including net cash surrender and withdrawal values

The maximum amount of protection for each individual, regardless of the number of policies or contacts, is $350,000. Special rules may apply with regard to health benefit plans.

"Health benefit plan" is defined in the applicable Iowa law and generally includes hospital or expense policies, contracts or certificates, or HMO subscriber contracts that provide comprehensive forms of coverage for hospitalization or medical services, but excludes policies that provide coverages for limited benefits (such as dental-only or vision-only insurance), Medicare Supplement insurance, disability income insurance and long-term care insurance.

Note: Certain policies and contracts may not be covered or fully covered. If coverage is available, it will be subject to substantial limitations and exclusions. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements under Iowa law.

Benefits provided by a long-term care rider to a life insurance policy or annuity contract shall be considered the same type of benefits as the base life insurance policy or annuity contract to which the long-term rider relates.

To learn more about the Association and the protections it provides, as well as those relating to group contracts or retirement plans, please visit the Association's website at **www.ialifega.org**, or contact:

Iowa Life and Health Insurance Guaranty Association
700 Walnut Street, Suite 1300
Des Moines, IA 50309
(515) 248-5712

Iowa Insurance Division
1963 Bell Ave, Suite 100
Des Moines, IA 50315
(515) 654-6600

Information about the financial condition of insurers is available from a variety of sources, including financial rating agencies such as AM Best Company, Fitch Ratings Inc., Moody's Investors Service, and S&P Global Ratings**.**

The Association is subject to the supervision of the Commissioner of the Iowa Insurance Division. Persons who desire to file a complaint to allege a violation of the laws governing the Association may contact the Iowa Insurance Division. State law provides that any suit against the Association shall be brought in the Iowa District Court in Polk County, Iowa.

Insurance companies and agents are not allowed by Iowa law to use the existence of the Association or its coverage to encourage You to purchase any form of insurance or HMO coverage. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and Iowa law, then Iowa law will control.