UNITED OF OMAHA LIFE INSURANCE COMPANY
A MUTUAL *of* OMAHA COMPANY

YOUR GROUP VOLUNTARY CRITICAL ILLNESS BENEFITS

FOR EMPLOYEES OF:

ACME Truck Line, Inc.

CLASS(ES): All Eligible Employees

EFFECTIVE DATE: January 1, 2025

PUBLICATION DATE: December 20, 2024

NOTICE(S)

THE POLICY PROVIDES LIMITED BENEFITS. THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.

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. THE POLICY IS ISSUED IN THE STATE OF LOUISIANA AND PROVIDES ALL OF THE BENEFITS REQUIRED BY APPLICABLE LOUISIANA 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.

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 conditions listed in the policy for one of the specified 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 when:

- any expenses 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 or 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 approved 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
3300 Mutual of Omaha Plaza
Omaha, Nebraska 68175
Call Toll-Free: 1-800-775-8805
www.mutualofomaha.com

When contacting us, please have your Policy Group 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.

FOR RESIDENTS OF FLORIDA

THE BENEFITS OF THE POLICY PROVIDING YOUR COVERAGE ARE GOVERNED PRIMARILY BY THE LAW OF A STATE OTHER THAN FLORIDA.

FOR RESIDENTS OF MARYLAND

THE GROUP INSURANCE POLICY PROVIDING COVERAGE UNDER THIS CERTIFICATE WAS ISSUED IN A JURISDICTION OTHER THAN MARYLAND AND MAY NOT PROVIDE ALL OF THE BENEFITS REQUIRED BY MARYLAND LAW.

FOR RESIDENTS OF NORTH CAROLINA

THE BENEFITS OF THE POLICY PROVIDING YOUR COVERAGE ARE GOVERNED PRIMARILY BY THE LAW OF A STATE OTHER THAN NORTH CAROLINA. PLEASE READ YOUR POLICY CAREFULLY.

FOR RESIDENTS OF VERMONT

THIS POLICY OR CERTIFICATE IS NOT SUBJECT TO REGULATION BY VERMONT.

TABLE OF CONTENTS

PAGE

CERTIFICATE OF INSURANCE

UNITED OF OMAHA LIFE INSURANCE COMPANY

Home Office:
3300 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-BHPR (the Policy) has been issued to ACME Truck Line, Inc. (the Policyholder).

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

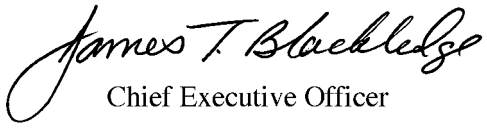
Please read this Certificate carefully. The benefits described in this Certificate are effective only if you and your Dependents, if applicable, are eligible for the insurance, become insured and remain insured as described in this Certificate and according to the terms and conditions of the Policy.

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 may include access to certain third party goods and services selected by the Policyholder that are related to the benefits provided to you under this Policy and are made available to you and to your dependents. We are not responsible for the provision of goods or services by our affiliates or third parties. We are also not liable to the Policyholder or you for the failure to provide or the negligent provision of such goods or services by our affiliates or third parties.

The Policy is nonparticipating; therefore, it will pay no dividends.



Chief Executive Officer

Corporate Secretary

SCHEDULE

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, conditions, limitations, exclusions and other provisions 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 insurance from $10,000 to $20,000, in increments of $5,000.

Your amount of critical illness insurance is also referred to as your Principal Sum.

If you have questions regarding the amount of your critical illness insurance, you may contact the Policyholder.

CRITICAL ILLNESS INSURANCE FOR YOUR SPOUSE

Provided you have elected some amount of insurance, you may elect to have your Spouse insured for an amount of critical illness insurance from $5,000 to $10,000, in increments of $5,000, provided the amount elected does not exceed 100% of your Principal Sum.

Any amount of critical illness insurance for your Spouse is the Spouse's Principal Sum.

CRITICAL ILLNESS INSURANCE FOR YOUR DEPENDENT CHILDREN

Provided you have elected some amount of critical illness insurance, the amount of critical illness insurance for your Dependent child(ren) is 50% of your Principal Sum.

Any amount of critical illness insurance for your Dependent children will be rounded to the next higher multiple of $1,000, if not already an even multiple of $1,000. Any amount of critical illness insurance for a Dependent child is the Dependent child's Principal Sum.

If you have questions regarding the amount of critical illness insurance for your Dependents, you may contact the Policyholder.

GUARANTEE ISSUE AMOUNTS

Guarantee issue is only available if the total number of Employees insured under the Policy attains or remains above 10 Employees or 21% of the eligible Employees, whichever is greater. If the total number falls below the required level, the Guarantee Issue Amounts may be reduced or rescinded.

Guarantee Issue Amount For You (The Employee)

Your Guarantee Issue Amount is $20,000. Any amount of insurance in excess of this amount requires Evidence of Insurability, regardless of the amount of insurance you were insured for under a Prior Plan.

Guarantee Issue Amount For Your Spouse

The Guarantee Issue Amount for your Spouse is $10,000. Any amount of insurance in excess of this amount requires Evidence of Insurability, regardless of the amount of insurance your Spouse was insured for under a Prior Plan.

Guarantee Issue Amount For Your Dependent Children

The Guarantee Issue Amount for each Dependent child is 50% of your Principal Sum. Any amount of insurance in excess of this amount requires Evidence of Insurability, regardless of the amount of insurance your Dependent child was insured for under a Prior Plan.

Insurance for you and your Dependents 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 you or your Spouse becomes eligible;
b) any amount of insurance elected in excess of a Guarantee Issue Amount for you or your Spouse;
c) any increase in the amount of insurance after the initial election of insurance for you or your Spouse, unless during a Subsequent Enrollment Period or as otherwise stated or allowed in the Policy;
d) you or your Spouse if you or your Spouse were eligible for insurance under a Prior Plan but did not elect such insurance; or
e) you or your Spouse if your or your Spouse's 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 is required for all amounts of insurance issued under the Policy for whom insurance is elected within 31 days after the date the Dependent children become(s) eligible, if the Dependent child insurance requires an election and Dependent child insurance for any other children is not already in effect under the Policy.

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, conditions, exclusions, and other provisions of this Certificate.

CRITICAL ILLNESS INSURANCE BENEFITS

INITIAL BENEFIT

Critical Illness benefits are payable if an Insured Person is Diagnosed with a covered Critical Illness. We will pay the applicable Initial Benefit amount shown in the Critical Illness Benefits Table if:

a) the diagnosis occurs on or after the Policy Effective Date; and
b) the diagnosis is a covered Critical Illness as defined in the Definitions section of this Certificate.

The amount of critical illness insurance for each Insured Person, also referred to as the Principal Sum, is provided in the Schedule section of this Certificate.

SUBSEQUENT BENEFIT

Once an Initial Benefit has been paid for a Critical Illness for an Insured Person, benefits remain payable under the Policy for any other Critical Illness for the Insured Person. The date of Diagnosis for a Subsequent benefit must have a Benefit Separation Period of at least 30 days from the date of Diagnosis of the most recent Critical Illness for the Insured Person.

In the event an Insured Person is diagnosed with any other Critical Illness within the 30-day Benefit Separation Period, the Critical Illness is subject to the following:

a) if the Benefit Percentage we paid for the previous Critical Illness is less than the Subsequent Benefit Percentage, we will pay the difference in the two amounts; or
b) if the Benefit Percentage we paid for the previous Critical Illness is equal to or greater than the Subsequent Benefit Percentage, no additional Principal Sum benefits are payable.

Subsequent benefit payments are subject to the POLICY BENEFIT MAXIMUM provision in this section of this Certificate.

REOCCURRENCE BENEFIT

Once an Initial Benefit has been paid for a Critical Illness for an Insured Person, a Reoccurrence benefit is payable, with no limit to the number of Reoccurrences, unless otherwise specified in the Critical Illness Benefits Table in this section of this Certificate.

A Reoccurrence benefit for an Insured Person is only payable if the Reoccurrence Separation Period is at least 90 days without Treatment.

The Reoccurrence Separation Period does not apply to Skin Cancer.

Reoccurrence benefit payments are subject to POLICY BENEFIT MAXIMUM provision in this section of this Certificate.

ADVANCED CONDITION

If a benefit is paid for a Critical Illness and an Insured Person is later Diagnosed with an Advanced Condition of the same Critical Illness for which a higher benefit is payable, we will pay the difference in the two amounts for the Insured Person without regard to the Reoccurrence Separation Period or Benefit Separation Period.

Advanced Condition payments are subject to POLICY BENEFIT MAXIMUM provision in this section of this Certificate.

MULTIPLE CRITICAL ILLNESS LIMITATION

If more than one Critical Illness is incurred by an Insured Person in the same 24 hour period, only the highest applicable benefit is payable.

Benefit payments are subject to any POLICY BENEFIT MAXIMUM provision in this section of this Certificate.

POLICY BENEFIT MAXIMUM

For each Insured Person, the total amount of Critical Illness benefits payable under the Policy is limited to 1000% of the Insured Person's Principal Sum in effect.

The Policy Benefit Maximum does not apply to Skin Cancer and Additional Benefits.

If the Critical Illness benefits paid for an Insured Person reach the Policy 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 the Policy Benefit Maximum and the terms and conditions of the Eligibility section of this Certificate.

CRITICAL ILLNESS BENEFITS TABLE

Critical Illness Benefits	Initial Benefit	Reoccurrence Benefit
Autoimmune Disorders		
Addison's Disease	25% of the Principal Sum	None
Diabetes Type I	100% of the Principal Sum	None
Inflammatory Bowel Disease	25% of the Principal Sum	None
Systemic Lupus Erythematosus (SLE)	50% of the Principal Sum	None
Cancer & Benign Tumor Diagnoses		
Benign Brain Tumor or Benign Spinal Cord (Intradural) Tumor	100% of the Principal Sum	100% of the Initial Benefit amount
Bone Marrow/Stem Cell Donor	25% of the Principal Sum	100% of the Initial Benefit amount
Bone Marrow/Stem Cell Recipient	100% of the Principal Sum	100% of the Initial Benefit amount
Cancer (Invasive)	100% of the Principal Sum	100% of the Initial Benefit amount
Carcinoma in Situ (Non-Invasive Cancer)	25% of the Principal Sum	100% of the Initial Benefit amount
Skin Cancer	$500	$500, limited to 1 reoccurrence per Calendar Year and limited to a total of 5 reoccurrences while insured under the Policy
Vascular & Pulmonary Conditions		
Acute Respiratory Distress Syndrome (ARDS)	25% of the Principal Sum	100% of the Initial Benefit amount
Aneurysm	25% of the Principal Sum	100% of the Initial Benefit amount
Coronary Artery Disease (Major)	25% of the Principal Sum	100% of the Initial Benefit amount
Coronary Artery Disease (Minor)	25% of the Principal Sum	100% of the Initial Benefit amount
Heart Attack (Myocardial Infarction)	100% of the Principal Sum	100% of the Initial Benefit amount
Sudden Cardiac Arrest	100% of the Principal Sum	None
Neurological Movement Disorders		
Alzheimer's Disease	100% of the Principal Sum	None
Amyotrophic Lateral Sclerosis (ALS)	100% of the Principal Sum	None
Dementia	100% of the Principal Sum	None
Huntington's Disease	100% of the Principal Sum	None
Multiple Sclerosis (MS)	100% of the Principal Sum	None
Muscular Dystrophy	100% of the Principal Sum	None
Myasthenia Gravis	100% of the Principal Sum	None
Parkinson's Disease	100% of the Principal Sum	None
Neurological Brain & Skull Conditions		

Bone Flap/Skull Defect	100% of the Principal Sum	100% of the Initial Benefit amount
Stroke	100% of the Principal Sum	100% of the Initial Benefit amount
Transient Ischemic Attack (TIA) or Reversible Ischemic Neurologic Deficit (RIND)	10% of the Principal Sum	100% of the Initial Benefit amount
Organ Conditions		
Major Organ Failure	100% of the Principal Sum	100% of the Initial Benefit amount
End Stage Renal Failure	100% of the Principal Sum	None
Infectious Conditions		
Coronaviruses (including Covid-19)	25% of the Principal Sum	100% of the Initial Benefit amount
Infectious Diseases	25% of the Principal Sum	100% of the Initial Benefit amount
Occupational Diagnosis		
Occupational Human Immunodeficiency Virus (HIV)	100% of the Principal Sum	None
Occupational Hepatitis B, C, or D	100% of the Principal Sum	None
Functional Loss		
Coma	100% of the Principal Sum	100% of the Initial Benefit amount
Loss of Hearing	100% of the Principal Sum	None
Loss of Sight in Both Eyes	100% of the Principal Sum	None
Loss of Sight in One Eye	50% of the Principal Sum	None
Loss of Speech	100% of the Principal Sum	None
Paralysis	100% of the Principal Sum	None

ADDITIONAL BENEFITS TABLE

Additional Benefits	Benefits Amount
Health Screening Benefit	$75

ADDITIONAL BENEFITS LIMITS

Health Screening Benefit

We will pay the health screening benefit amount listed in the Additional Benefits Table per day for each Insured Person who has a Health Screening Test performed. This benefit is payable 1 day per Calendar Year for each Insured Person, for a combined maximum of 6 health screening benefits per Calendar Year for all Insured Persons.

EXCLUSIONS

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, conditions, limitations, exclusions, and other provisions of this Certificate.

EXCLUSIONS

We will not pay benefits for any Critical Illness or Additional Benefit that:

a) was diagnosed prior to the Policy Effective Date;
b) result from elective or cosmetic surgery or procedures or resulting complications. Reconstructive surgery related to a Critical Illness is eligible for coverage;
c) result from an intentionally self-inflicted Injury or Sickness, or attempted suicide;
d) result from an Insured Person's:
    1. voluntary use of illegal drugs;
    2. intentional taking of over the counter medication not in accordance with recommended dosage and warning instruction;
    3. intentional misuse of prescription drugs; or
    4. excessive or harmful use of alcohol and/or alcoholic drinks; or
e) result 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) result from an Insured Person's Participation in a Riot, commission of a felony, participation in illegal activities or participation in an illegal occupation;
g) occur while an Insured Person is incarcerated or imprisoned following the Insured Person's conviction of a crime;
h) result from an act of declared or undeclared war or armed aggression; or
i) occur 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.

In addition, we will not pay benefits for:

a) any Critical Illness or Additional Benefit not included in this Certificate; or
b) a Critical Illness that is Diagnosed by you or a member of your Family.

ELIGIBILITY

Capitalized terms used in this section have the meanings assigned to them in the Definitions section of this Certificate.

WHEN YOU BECOME ELIGIBLE FOR INSURANCE (ELIGIBILITY WAITING PERIOD)

If you complete the 60 day Eligibility Waiting Period on or before the Policy Effective Date, you become eligible for insurance on the Policy Effective Date.

If you are not eligible for insurance on the Policy Effective Date, or if you are hired after the Policy Effective Date, you become eligible for insurance the day after you complete the 60 days Eligibility Waiting Period.

The day you become eligible for insurance may not be the same as the day your insurance begins. The WHEN YOUR INSURANCE BEGINS provision describes the day your insurance begins.

WHEN A DEPENDENT BECOMES ELIGIBLE FOR INSURANCE

Provided you elect insurance for you, your Dependents become eligible for insurance on the later of:

a) the day you become eligible for insurance; or
b) the day you acquire the Dependent.

If both you and your Spouse are eligible for and elect insurance under the Policy as Employees:

a) neither you nor your Spouse may elect insurance as a Dependent of the other person; and
b) both you and your Spouse may elect insurance for your Dependent children.

In order to insure a Dependent child, you must insure all of your Dependent children.

The day a Dependent becomes eligible for insurance may not be the same as the day insurance begins. The WHEN YOUR DEPENDENT'S INSURANCE BEGINS provision describes the day when insurance begins.

WHEN YOUR INSURANCE BEGINS

You must enroll for any insurance requiring an election by submitting a Written Request for insurance. The Written Request must be submitted to the Policyholder no later than 31 days after the day you become eligible. If the Written Request for insurance is not submitted within the required time frame, you must provide Evidence of Insurability.

You 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) you become eligible and are Actively Working; or
b) your Written Request is properly completed and signed, if required.

You must provide Evidence of Insurability if it is required. You become insured for any amount of insurance that requires Evidence of Insurability, including any amount in excess of the Guarantee Issue Amount for you and your Dependents on the first day of the month that follows the day we approve Evidence of Insurability.

WHEN YOUR DEPENDENT'S INSURANCE BEGINS

You must enroll your Dependents for any insurance requiring an election by submitting a Written Request for insurance. The Written Request must be submitted to the Policyholder no later than 31 days after the day your Dependent becomes eligible. If the Written Request for insurance is not submitted within the required time frame, your Dependents must provide Evidence of Insurability.

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

a) you become insured, unless otherwise agreed to by our authorized representative in our home office;

b) you acquire the eligible Dependent; or
c) your Written Request to enroll the Dependent for insurance is properly completed and signed, if required.

Your Dependents must provide Evidence of Insurability if it is required. Your Dependents become insured for any amount of insurance that requires Evidence of Insurability, including any amount in excess of the Guarantee Issue Amount, on the first day of the month that coincides with or follows the day we approve Evidence of Insurability.

Insurance for a Dependent child who became Incapacitated prior to reaching the age of 26 begins 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 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, provided the child otherwise meets the definition of Dependent. Insurance for a child placed in your custody following execution of an act of voluntary surrender begins on the date the act of voluntary surrender becomes irrevocable. If Dependent child insurance requires an election and Dependent child insurance for any other child is not already in effect, a Written Request for insurance for any newborn or newly adopted Dependent child must be submitted to the Policyholder within 31 days after the day the Dependent child becomes eligible in order to continue insurance beyond the 31-day period.

EXCEPTIONS TO WHEN YOUR INSURANCE BEGINS

This provision does not apply if you are eligible for insurance under the CONTINUITY OF INSURANCE UPON TRANSFER OF INSURANCE CARRIER provision.

If you are:
a) not Actively Working due to Injury or Sickness;
b) confined in a Hospital as an inpatient;
c) confined or assigned to a bed as a resident inpatient 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 would otherwise begin, insurance will not take effect until the day after you are released by your Physician and you return to Active Work.

If you are not Actively Working when insurance would otherwise begin for reasons other than those listed above, insurance will not take effect until the day you return to Active Work.

EXCEPTIONS TO WHEN YOUR DEPENDENT'S INSURANCE BEGINS

This provision does not apply to any Dependent who was eligible and insured under any Prior Plan on the day before the Policy Effective Date.

If your Dependent is:
a) confined in a Hospital as an inpatient;
b) confined or assigned to a bed as a resident inpatient 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, insurance will not take effect until the day after your Dependent is no longer confined.

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 your 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 YOUR DEPENDENT'S INSURANCE BEGINS provision, provided the child otherwise meets the definition of Dependent.

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 controls.

If the Policy replaces a Prior Plan, the Policy will provide insurance for you and any Dependents if you:

a) were insured under the Prior Plan on the day before the Policy Effective Date;
b) are otherwise eligible, but 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) are not receiving or eligible to receive benefits under the Prior Plan;
d) are not insured under any provision of the Prior Plan;
e) are not a retired Employee; and
f) are approved by our authorized representative in our home office for insurance under this provision.

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 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 section of this Certificate and all other terms and conditions of the Policy.

If insurance is provided for you, insurance may also be provided for your Dependents.

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 you return to Active Work for the Policyholder or begin employment with any other employer;
b) the last day you would have been insured under the Prior Plan, if the Prior Plan had not ended or terminated;
c) the day your insurance 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 you are eligible for insurance under this provision, you will not be eligible for insurance under any continuation 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 Dependents may be able to obtain insurance under the PORTABILITY provision.

FIRST ENROLLMENT PERIOD

You may elect insurance for you and any Dependents during the First Enrollment Period.

If you do not elect insurance during your or any 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

You may elect, drop, increase, decrease or change insurance for you and any Dependents during a Subsequent Enrollment Period.

WHEN ELECTION CHANGES ARE PERMITTED

You may elect, drop, increase, decrease or change insurance as allowed by the Policyholder. Any election of or increase in insurance for you or your Dependents will require Evidence of Insurability unless otherwise stated or allowed in the Policy.

Life Events

Within 31 days after the date of a Life Event, you may submit a Written Request to change insurance.

If you experience a Life Event and you are currently insured, insurance for you and any Dependents may be issued up to the Guarantee Issue Amount without Evidence of Insurability. We will require 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.

If you experience a Life Event and previously declined insurance, you may not enroll until a Subsequent Enrollment Period is offered.

ANNUAL INCREASE OPTION

You may elect or increase insurance for you and/or your Dependents during a Subsequent Enrollment Period.

You may submit a Written Request to increase the amount of insurance for you and/or your Dependents, provided the new amount of insurance does not exceed the maximum benefit amount for you and/or your Dependents shown in the Schedule section of this Certificate.

You may increase your amount of insurance by up to your Guarantee Issue Amount, in increments as shown in the Schedule section of this Certificate.

You may increase your Spouse's amount of insurance by up to your Spouse's Guarantee Issue Amount, in increments as shown in the Schedule section of this Certificate. Your Spouse's total amount of insurance, including any requested increase, may not exceed your Spouse's maximum benefit amount and may not exceed 100% of Your Principal Sum.

Your Dependent child's amount of insurance will be equal to 50% 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 to the next higher multiple of $1,000.

If you previously declined insurance under the Policy, you may submit a Written Request to elect insurance for you and/or your Dependents. You may request an amount of insurance up to your Guarantee Issue Amount for you, in increments as shown in the Schedule section of this Certificate. You may elect up to your Spouse's Guarantee Issue Amount for your Spouse, in increments as shown in the Schedule section of this Certificate. The requested amount of insurance may not exceed 100% of the Employee's Principal Sum.

Your Dependent child's amount of insurance will be equal to 50% of your new amount of insurance. Any amount of insurance for your Dependent child will be rounded to the next higher multiple of $1,000, if not already an even multiple of $1,000.

CHANGES TO INSURANCE BENEFITS

Any allowable change in the benefits, 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, unless otherwise stated or allowed in the Policy.

For any increase in insurance, we will use the Policyholder's records and/or the premium we receive to verify that the amount of insurance requested is the appropriate insurance amount the Insured Person is eligible for 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 becomes effective the first day of the month that follows the day you return to Active Work.

If your Dependent is:

a) confined in a Hospital as an inpatient;
b) confined or assigned to a bed as a resident inpatient 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 any increase in insurance would otherwise take effect, the increase becomes effective the first day of the month that follows the day your Dependent is no longer confined.

In addition, any increase in 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 first day of the month that follows the day your Dependent has performed all ADLs for at least 15 consecutive days.

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 your last day of Active Work. If insurance is reinstated for you, insurance may also be reinstated for any Dependents.

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 coincides with or 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 becomes effective on the day you return to Active Work.

Non-Payment of Premium or Voluntary Termination of Insurance

If insurance ends because you do not pay premium or you voluntarily terminate insurance, you may not re-enroll for insurance until a Subsequent Enrollment Period is offered.

Involuntary Reduction in Hours

If insurance ends because you are no longer Actively Working due to an involuntary reduction of hours worked insurance may be reinstated without satisfying another Eligibility Waiting Period if you return to Active Work within 90 days from the date insurance ended.

Rehired Employee Due to Layoff or Termination

If insurance ends because you are no longer Actively Working due to layoff or termination of employment with the Policyholder, insurance may be reinstated without satisfying another Eligibility Waiting Period if you are rehired and return to Active Work within 90 days from the date insurance ended. All other Policy provisions apply.

Rehired Employee Due to Leave of Absence

If insurance ends because you are no longer Actively Working due to an approved leave of absence, insurance may be reinstated within 90 days from the date insurance ended without satisfying another Eligibility Waiting Period upon return to Active Work. If insurance ends because you are no longer Actively Working due to military leave, insurance may be reinstated upon return to Active Work within 31 days of your discharge from active duty without satisfying another Eligibility Waiting Period. All other Policy provisions apply.

Transfer From Portability

If insurance is obtained under the PORTABILITY provision while you are not Actively Working, insurance may be reinstated up to the amount of insurance that was in effect under the PORTABILITY Policy without satisfying another Eligibility Waiting Period if you are rehired and return to Active Work. Any insurance provided through the PORTABILITY policy will terminate upon reinstatement of insurance as an Actively Working Employee.

WHEN INSURANCE ENDS

Insurance ends:

a) for all Insured Persons on the last day of the month in which you are no longer Actively Working;
b) on the last day of the month in which a Dependent is no longer eligible for insurance under the Policy;
c) on the last day of the month in which your Dependent child reaches the age of 26;
d) on the date that benefits paid for you or any Dependents reach the Policy Benefit Maximum;

e) on the last day of the month in which 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), unless otherwise allowed in the Policy;
f) the day the Policy terminates; or
g) in accordance with the GRACE PERIOD provision.

If insurance under the Policy ends, it will not affect benefits otherwise payable for a claim incurred while an Insured Person was insured under the Policy.

EXCEPTIONS TO WHEN INSURANCE ENDS

If insurance for you and/or your Dependents would otherwise end, you and/or your Dependents may be able to continue insurance under one of the following provisions:
a) CONTINUATION OF INSURANCE FOR LAYOFF, LEAVE OR FURLOUGH
b) CONTINUATION OF INSURANCE FOR YOUR DEPENDENTS IN THE EVENT OF YOUR DEATH
c) PORTABILITY

CONTINUATION OF INSURANCE FOR LAYOFF, LEAVE OR FURLOUGH

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

You may be able to continue insurance for you and your Dependents from the day you cease to be Actively Working in the event of:
a) a temporary involuntary layoff;
b) a temporary furlough; or
c) 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. Contact the Policyholder for additional information regarding any other continuation options that may be available.

Any insurance continued under this provision is 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 temporary furlough;
    3. 12 weeks for your leave of absence due to any personal reason; or
    4. 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 receive verification of the approved layoff, leave or furlough from the Policyholder upon request; and
d) we continue to receive premium payment when due (premiums must be paid by you or on your behalf).

Insurance under this provision ends 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 or furlough becomes permanent;
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 also ends 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 Dependents may be able to continue or obtain insurance under the PORTABILITY provision.

See the OPTIONS FOR PAYMENT OF PREMIUM FOR APPROVED CONTINUATION OF INSURANCE provision in the Premium Payments section of this Certificate 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 Dependents may be able to continue insurance under this provision, subject to the following conditions if we continue to receive premium payment when due (premiums must be paid by your Dependents or on your Dependents behalf).

The amount of insurance for any Insured Person may not be increased while insured under this provision. See the OPTIONS FOR PAYMENT OF PREMIUM FOR APPROVED CONTINUATION OF INSURANCE provision in the Premium Payments section of this Certificate for premium payment options.

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 Dependents may be able to continue or obtain insurance under the PORTABILITY provision.

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 group insurance, including insurance for each Dependent child, 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, each Dependent child 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 Dependents 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 may not exceed the amount in effect under the Policy on the day insurance ended.

If you continue to receive group insurance under this provision, you and your Dependents cannot continue insurance under any other continuation provision of the Policy (if applicable).

Notice of the Right to Continue Group Insurance Under this Provision

The portability period is the period of time that is 60 days from the date insurance would otherwise end (Portability Period). When insurance 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 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; 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 this provision. The Written Request and the initial premium due must be submitted within the Portability Period.

The Group Critical Illness Insurance Portability Policy

The 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 become insured under the Portability Policy, you or your Spouse will receive a certificate of insurance that describes the terms and conditions of insurance 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 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.

PREMIUM PAYMENTS

Capitalized terms used in this section have the meanings assigned to them in the Definitions section of this Certificate.

PAYMENT OF PREMIUM THROUGH PAYROLL DEDUCTION

You are responsible for the payment of premium for insurance under the Policy. The premium owed by you equals the total premium for all Insured Persons.

Premium is automatically deducted from your pay by the Policyholder, then remitted to us, as authorized by you during the enrollment process. Please contact the Policyholder for information regarding your deductions.

Payment of premium does not guarantee eligibility for coverage.

OPTIONS FOR PAYMENT OF PREMIUM FOR APPROVED CONTINUATION OF 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 premium; 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

There is a grace period of 45 days for payment of premium. 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 45-day grace period that follows. We consider premium to be paid on the date we receive it.

Insurance will stay in force during the grace period as long as premium is paid before the end of the grace period. If we receive written notice requesting cancellation of insurance on a current or future date, the grace period will not apply. Coverage will end on the cancellation date specified in such notice, as long as the full premium has been paid up to that date.

If premium is not paid by the end of the grace period, insurance will end the day after the last day of the grace period.

PREMIUM AND PREMIUM CHANGES

The premium for insurance under the Policy is a monthly rate for each coverage option shown in the Schedule section of this Certificate that applies to you and your Dependents.

If you request a change in your plan type (as shown in the Schedule section of this Certificate) 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 section of this Certificate) 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 premium for insurance.

Premium amounts will change if:

a) you reach the age of the next higher age band in the premium rate structure for the Policy; or
b) premium rates under the Policy change.

CLAIMS PROVISIONS

Capitalized terms used in this section have the meanings assigned to them in the Definitions section of this Certificate.

CLAIM FORMS

Before benefits are considered, we must be given written proof of claim. 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 loss occurs or as soon as reasonably possible. If we do not provide a claim form within 15 days of the request, written proof of claim may be submitted that includes the nature, date, cause and extent of the loss for which the claim is made.

PROOF OF LOSS

Written proof of claim must be given to us within 90 days from the date of Diagnosis of a Critical Illness for an Insured Person. If it is not reasonably possible to give us proof within the required time, we will not reduce or deny a claim for this reason if the proof is supplied as soon as reasonably possible.

We may require supporting information which may include, but is not limited to, clinical records, charts, x-rays, and other diagnostic aids.

Unless otherwise stated, in the event of death an autopsy confirmation or death certificate identifying a Critical Illness as the sole or primary cause of death will be accepted as proof of Diagnosis.

INDEPENDENT EXAMINATION AND AUTOPSY

We may require an Insured Person to be examined by a Physician as we direct to assist in determining whether benefits are payable. You may not impose any conditions on an examination such as pre-approval of the examiner, attendance of a third party or audio/video recording of the examination.

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 reducing benefits that are payable. 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.

HOW TO OBTAIN PLAN BENEFITS

Forward the completed claim form to:
United of Omaha Life Insurance Company
3300 Mutual of Omaha Plaza
Omaha, Nebraska 68175
Call Toll-Free: 1-800-775-8805

CLAIM ASSISTANCE

For assistance with filing a claim or an explanation of how a claim was paid, contact:
United of Omaha Life Insurance Company
3300 Mutual of Omaha Plaza
Omaha, Nebraska 68175
Call Toll-Free: 1-800-775-8805

CLAIM REVIEW AND APPEAL PROCESS

Claim Review Procedures

Once we receive information necessary to evaluate the claim, we will make a decision within the time periods stated 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 stated 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 within the time periods stated below.

In order for us to continue processing the claim, the missing information must be provided to us within the time periods stated 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, regardless to whether all the information necessary to make a claim decision accompanies the filing. The applicable time periods are:

a) initial claim decision period: 45 days unless additional information is requested;
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 and the Claimant will be given no less than 45 days to submit the additional information to us. If we do not receive the additional information within the specified time period, we will make our determination based upon the available information.

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 claim decision will 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 stated by us in the notice of extension for providing the requested information.

Claim Denials

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

a) the specific reasons 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 and the right to bring a civil action following the appeal process; and
d) any other information that 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 when the Claimant receives notification of our claim review decision to submit a request for an appeal.

The request 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 must be submitted to us in writing or electronically stating the reasons the Claimant believes the claim denial was incorrect. The Claimant should also include any additional information, documents or other materials that

might allow us to change our original decision. Requests for an appeal may be submitted to us at our Omaha, Nebraska address shown in the CLAIMS ASSISTANCE provision.

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) that we may determine to 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, regardless 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.

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 we expect to make the appeal decision.

If a period of time is extended as described above due to the Claimant's failure to submit information necessary to decide an appeal, the period for making the appeal decision will 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 stated by us in the notice of extension for providing the requested information.

Notice

If the administration of the Policy is subject to the Employee Retirement Income Security Act of 1974 (ERISA), the claimant may contact the U.S. Department of Labor, Employee Benefits Security Administration (EBSA) for further review of a claim or to ask questions about the claimant's rights under ERISA.

PAYMENT OF CLAIMS

Benefits will be paid immediately after we receive acceptable written proof of claim and any other required supporting information, but no later than 30 days after receipt of such notice or supporting information.

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 children, in equal shares; if none, then to
d) your surviving parents, 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. 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.

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. 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 communicated to us by the Policyholder.

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 $250 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; or
d) a personal or legal representative of your estate.

MODE OF PAYMENT

Benefits for each claim will be paid by us in one lump sum, unless otherwise indicated in any benefit provision in 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 the repayment is to be made, including without limitation, reducing or withholding any benefits payable to you, your survivors 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 payments, as necessary.

POLICYHOLDER LEGAL AND TAX RESPONSIBILITY

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.

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 (which includes this Certificate);
b) riders, endorsements, and amendments to the Policy or Certificate, if any;
c) the Policyholder's signed application attached to the Policy; and
d) any signed application for you or your Dependents (if applicable).

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 for two years during an Insured Person's lifetime, except for nonpayment of premium.

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 legal representative with a copy of that application.

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 one year after the date written proof of loss is required, unless otherwise required by state law in your state of residence.

DEFINITIONS

The defined terms used in this Certificate and Policy are shown in this section. With the exception of our, we, us, you and your, we have capitalized these terms wherever they appear to make them easier for you to find.

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

Accident means an external, sudden, unexpected, unforeseeable and unintended event definite as to time and place, resulting in one or more Injuries that occurs while insurance is in effect for an Insured Person. Accident does include bacterial infection that is the natural and foreseeable result of an accidental Injury or food poisoning.

Actively Working, Active Work means you are:

a) performing the normal duties of your job for the Policyholder on a regular and continuous basis 30 or more hours each week; and
b) receiving compensation from the Policyholder for work performed for the Policyholder.

You 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 you were actively working on the last preceding regular work day.

Activities of Daily Living (ADLs) 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 one's self);
d) transferring (from bed to chair and back; from sitting to standing and back);
e) continence (controlling bladder and bowel function); and
f) toileting (the ability to use a restroom).

Acute Respiratory Distress Syndrome (ARDS) means a Diagnosis of acute respiratory failure that results in inadequate oxygenation due to aspiration, infection or Injury. In the absence of clinical heart failure, evidence of infiltrates in both lungs may be present with the confirmation of an acute lung injury through blood testing, chest x-ray, examination of sputum, or a combination of these.

Addison's Disease means a Diagnosis of adrenal insufficiency where the adrenal glands do not produce sufficient steroid hormones, cortisol, and aldosterone. Diagnosis must be confirmed by blood or urine tests or medical imaging. This definition does not include adrenal insufficiency resulting from prolonged corticosteroid treatment.

Additional Benefit means any benefit shown in the Additional Benefits Table in the Benefits section of this Certificate.

Advanced Condition means a Diagnosis the same Critical Illness that has progressed from its original state to one that is more severe.

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, which is based upon ineligibility for insurance under the Policy.

AJCC TNM Stage means a method for determining the prognosis of Cancer based upon the thickness of the tumor (T), the extent of spread to the lymph nodes (N) and the presence of metastasis (M).

Alzheimer's Disease means a Diagnosis of a neurological disorder characterized by a decline in memory retention and intellectual capacity, where cognitive testing indicates considerable loss in abilities such as the ability to remember, reason, and perceive; and to understand, express, and give effect to ideas, which is supported by neuroradiological imaging, such as computerized axial tomography (CAT scan), magnetic resonance imaging (MRI), or positron emission tomography (PET) of the brain. This definition does not include a diagnosis of Alzheimer's disease that occurred prior to the Insured Person's effective date of coverage under the Policy.

Amyotrophic Lateral Sclerosis (ALS) means a Diagnosis of a neurological disease in the nervous system where the nerve cells in the brain and spinal cord are affected, causing loss of muscle control.

Aneurysm means a Diagnosis of a weakening in the walls of an artery which cause a balloon-like bulge to form in the blood vessel in the aorta, brain, carotid arteries, renal arteries, or any Dissecting Aneurysm or Ruptured Aneurysm for which a Physician recommends Surgery. This definition does not include an aneurysm caused by trauma.

Antibiotic-Resistant Bacteria Infection means any of the following: carbapenem-resistant enterobacteriaceae (CRE) infection, clostridium difficile (C. difficile) infection, methicillin-resistant staphylococcus aureus (MRSA) infection, streptococcus pneumoniae infection (also known as pneumococcus), and vancomycin-resistant enterococci (VRE) infection.

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 April 1, 2024 and the Policy Anniversary is January 1, the Insured Person will reach the attained age of 50 on January 1, 2025.

Benefit Percentage means the percentage that is applied to the Principal Sum to determine the amount of critical illness benefits payable under the Policy.

Benefit Separation Period means the period of time that must elapse between the date of Diagnosis of a Critical Illness for an Insured Person in order for a benefit to be payable for a Subsequent Critical Illness.

Benign Brain Tumor or Benign Spinal Cord (Intradural) Tumor means a Diagnosis of a benign Brain Tumor or benign Spinal Cord (Intradural) Tumor as confirmed by a neurological exam, neuroradiological exam, or pathological examination of tissue (biopsy or Surgical excision). This definition does not include angiomas, aneurysms, germinomas, pituitary adenomas, tumors of the skull, or tumors resulting from Cowden disease, Neurofibromatosis I or II, Tuberous sclerosis, or Von Hippel Lindau disease.

Binet Clinical Stage means a method for determining the prognosis of chronic lymphocytic leukemia based on how many areas of lymphoid tissue are affected.

Bone Flap/Skull Defect means a Diagnosis of the need for a Craniectomy or Cranioplasty, as recommended by a Physician, due to a Sickness, or Injury to prevent or reduce brain damage or death, to prevent permanent neurological deficits, or to restore brain function or independent living. This definition does not include a Bone Flap/Skull Defect benefit if done solely for cosmetic purposes.

Bone Marrow/Stem Cell Donor means a living person, of sound health, that is at least the legal age of adulthood as defined by the state in which they reside, donates harvested bone marrow, or stem cells through an apheresis procedure for the purpose of transplantation to another person for the replacement of damaged or diseased bone marrow.

Bone Marrow/Stem Cell Recipient means the Diagnosis of the need, as recommended by a Physician, for an autologous or allogeneic transplant of bone marrow or stem cells necessitated by the compromised ability of the bone marrow to produce blood cells appropriately. This definition does not include the recommendation for a transplant of any other organs, parts of organs, tissues, or cells.

Brain Tumor means a tumor located in the brain, cranial nerves, meninges within the skull, or central nervous system.

Breslow Thickness means a method for determining the prognosis of melanoma based on the thickness of the tumor.

Calendar Year means the 12-month period beginning on January 1 of each year and ending on December 31 of the same year.

Cancer means the presence of a malignant tumor or collection of malignant cells as evidenced by histopathological confirmation.

Cancer (Invasive) means a Diagnosis of any malignant tumor or neoplasm with histopathological confirmation, characterized by the uncontrolled growth of malignant cells and invasion of tissue beyond the initial tissue. Diagnosis must be confirmed by a Pathological Diagnosis or Clinical Diagnosis. Cancer (Invasive) includes but is not limited to:

a) any malignant tumor classified higher than AJCC TNM Stage T1N0M0;
b) a malignant Brain Tumor or malignant Spinal Cord (Intradural) Tumor;
c) leukemia, lymphoma, prostate cancer, sarcoma, multiple myeloma and any breast cancer including Stage 0 or In Situ; or
d) malignant melanoma or other skin malignancies that have been histologically classified as having caused invasion beyond the epidermis (the outer layer of skin) with:

1. a Clark's level III or greater;
2. Breslow's depth of 0.75mm or greater; or
3. AJCC TNM stage II or greater.

This definition does not include:

a) pre-malignant tumors or polyps;
b) any Skin Cancer, unless there's metastasis; or
c) any Carcinoma in Situ (Non-Invasive Cancer).

Carcinoma in Situ (Non-Invasive Cancer) means a 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 confirmed by a Pathological Diagnosis or Clinical Diagnosis. Carcinoma in Situ (Non-Invasive Cancer) includes, but is not limited to:

a) a malignant tumor classified as AJCC TNM Stage T1N0M0 or less 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.

This definition does not include:

a) pre-malignant tumors or polyps;
b) any prostate cancer;
c) breast cancer including Stage 0 or In Situ; or
d) any Skin Cancer.

Cerebral Palsy (CP) means a Diagnosis made during Childhood of Cerebral Palsy, which is a group of non-progressive disorders affecting muscle control characterized by issues with movement and the ability to maintain balance and posture, resulting in physical limitations attributed to abnormal development of or damage to the motor control centers of the brain. Other conditions such as intellectual disability, muscle or joint problems, seizures, or issues with vision, hearing, or speech can accompany Cerebral Palsy (CP).

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

Claimant means the person who submits a claim for benefits for any Insured Person, including the authorized representative of such person.

Clark Level means a method for determining the prognosis of melanoma based on the penetration level of the tumor into the skin.

Clinical Diagnosis means a Diagnosis based on the study of symptoms and diagnostic test results. We will accept a Clinical Diagnosis only 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.

The date of Diagnosis is the day the diagnostic test is completed which indicates the presence of Cancer.

Coma means the Diagnosis of a profound stupor or state of complete and total unconsciousness with no response to internal needs or reaction to external stimuli for a continuous period of 3 days or more as the result of a Injury or Sickness. This definition does not include a medically induced coma or a coma resulting from any Substance Use Disorder, or stroke.

Confined, Confinement means the assignment to a bed as a resident inpatient in a medical or treatment facility, including an Observation Unit, on the advice of or as prescribed by a Physician with a charge for room and board. Charge for room and board does not apply to confinement in a Veteran's Administration Hospital or other federal government-operated Hospital.

Coronary Artery Disease (Major) means the Diagnosis of coronary artery disease for which a Physician recommends Surgery that requires a median Sternotomy to correct the narrowing or blockage of one or more coronary arteries.

Coronary Artery Disease (Minor) means the Diagnosis of coronary artery disease for which a Physician recommends a minimally invasive Surgical Procedure to repair the narrowing or blockage of one or more coronary arteries. This definition includes atherectomy, balloon angioplasty, laser angioplasty, stent placement, and thrombectomy (angiojet).

Coronaviruses (including Covid-19) means a Diagnosis of an acute serious upper-respiratory tract infection characterized by fever, chills, cough, and shortness of breath, for which a Physician recommends an Insured Person be Hospital Confined for a minimum of 24 hours, and for which an Insured Person receives a positive Coronavirus test. This definition includes a Diagnosis of SARS coronavirus (SARS-CoV), SARS-CoV-2 (Covid-19), Middle East respiratory syndrome (MERS), or variant strains thereof.

Craniectomy means brain Surgery to remove part of the skull bone (a bone flap) to access the brain to reduce swelling, pressure, bleeding, or drain abscesses to prevent permanent neurological deficits.

Cranioplasty means Surgical repair of a bone defect in the skull resulting from a previous illness, Injury or an operation where the scalp is lifted to restore the contour of the skull with the original skull piece or a custom contoured graft made from material such as titanium plate or mesh, synthetic bone substitute, solid biomaterial, to prevent further injury or complication, and to reduce or resolve neurological deficits.

Critical Illness means any benefits shown in the Critical Illness Benefits Table in the Benefits section of this Certificate.

Dementia means a Diagnosis of a progressive neurological condition characterized by a decline in memory retention and intellectual capacity, resulting in the Insured Person's inability to independently perform two or more Activities of Daily Living (ADLs), with the expectation of continued deterioration in the Insured Person's abilities.

Dependent means a citizen, permanent resident or lawful resident of the United States who is:

a) your Spouse;
b) your natural born, legally adopted or foster child; your stepchild; or child of your domestic partner, civil union partner or equivalent;
c) your grandchild, if the grandchild is in your legal custody and lives with you;
d) a child that you or your Spouse are required to provide insurance for under the terms of a 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 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) an unborn or stillborn child;
f) your child if another person has legally adopted the child; or
g) a child placed in your home by a social service agency which retains control over the child.

Diabetes Type I means a Diagnosis of a form of diabetes mellitus for which a Physician recommends continuous insulin therapy for at least 2 months resulting from autoimmune, genetic, or infectious destruction of insulin-producing cells in the pancreas. Diagnosis must be confirmed by blood testing. This definition does not include Diabetes Type II, gestational diabetes, and prediabetes.

Diabetes Type II means a Diagnosis of a form of diabetes mellitus resulting from a functional impairment in the body's regulation of sugar which is complicated by the body's inadequate production or utilization of insulin for which a Physician recommends Prescription Medication to control blood sugar levels. Diagnosis must be confirmed by blood testing. This definition does not include Diabetes Type I, gestational diabetes, and prediabetes.

Diagnosis, Diagnoses, or Diagnosed means the Diagnosis of a Critical Illness that:

a) occurs after the Policy Effective Date and while the Insured Person is covered under the Policy;
b) is documented by a Physician that, where applicable, specializes in a particular field of medicine related to the Critical Illness; and
c) is supported, when applicable, by:

1. medical records;
2. objective clinical findings, including physical examination;
3. laboratory, imaging or pathological investigations;
4. any diagnostic requirements stated in this Certificate; and
5. medically accepted criteria that is consistent for the Diagnosis of the Critical Illness.

This definition does not include flare-ups from any illness that was diagnosed prior to the Insured Person's effective date of coverage under the Policy.

Dissecting Aneurysm means a condition where a tear or split develops in a layer of an artery wall causing bleeding into and along the layers of the artery wall.

Dismemberment means the removal of a body part by trauma, prolonged constriction, or surgery (amputation).

Eligibility Waiting Period means a continuous period of Active Work that you must satisfy before becoming eligible for insurance as described in the WHEN YOU BECOME ELIGIBLE FOR INSURANCE (ELIGIBILITY WAITING PERIOD) provision.

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 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 Failure means the Diagnosis of chronic and end-stage (irreversible) functional failure of both kidneys, which necessitates regular (at least weekly) dialysis or for which a transplant is recommended to sustain life. This definition does not include renal failure caused by a traumatic event or Surgical trauma.

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 Spouse, former Spouse, children, parents, grandparents, grandchildren, brothers, sisters and the spouses (or domestic partners, civil union partners or equivalent) of such individuals.

First Enrollment Period means the 31-day period following the day you or your Dependents become eligible for insurance under the Policy or any Prior Plan.

Genetic Disorders means a Diagnosis made during Childhood that includes any of the following: cystic fibrosis, down syndrome, infantile onset ascending spastic paralysis; Fragile X; hemophilia a, b, or c; juvenile primary lateral sclerosis; osteogenesis imperfecta (excluding type I); spinal muscular atrophy type I or II; or Vascular Ehlers-Danlos syndrome. Diagnosis must be confirmed by genetic testing. A prenatal Diagnosis of one or more Genetic Disorders is included in this definition upon the live birth of a Dependent child. In the event of a prenatal diagnosis, the date of Diagnosis under the Policy will be the Dependent child's date of birth. Once a Genetic Disorders benefit has been paid for a specific disorder listed in this definition, no additional benefit is payable for that same disorder.

Guarantee Issue Amount means the maximum amount of insurance we may issue under the Policy without requiring Evidence of Insurability. The Guarantee Issue Amount is shown in the Schedule section of this Certificate.

Health Screening Test includes, but is not limited to, the following health screenings or preventative tests administered by a Physician or Medical Professional to detect diseases or conditions in an Insured Person or to evaluate an Insured Person's overall health:

a) abdominal aortic aneurysm screenings;
b) angiogram/angiography (arteriogram);
c) annual/routine dental, health, hearing, physical, sports physical, vision and/or well women exams;
d) basic and/or comprehensive metabolic screening;
e) body mass index (BMI) assessment and health assessment;
f) bone density screening;
g) cancer preventative care and health screenings such as physical exams and testing, blood chemistry profiles, imaging studies, and/or biopsies[or any other cancer screening test that is generally medically accepted;
h) carotid doppler ultrasounds, magnetic resonance angiography and computed tomography;
i) vascular ultrasounds;
j) lower extremity arterial ultrasounds;
k) chest x-ray;
l) child and adolescent age-appropriate history, measurement, sensory screenings, developmental/behavioral screenings, physical exams and procedures, oral health, anticipatory guidance and/or immunizations and vaccinations;
m) coronaviruses;
n) diabetes health screenings;
o) domestic violence health screening;
p) echocardiogram (ECHO) and/or electrocardiogram (EKG/ECG/cardiac event/Holter monitoring);
q) exercise, pharmacologic (nuclear) and/or radiological stress test;
r) genetic testing;
s) hepatitis screenings;
t) immunizations and vaccinations for adults;
u) lipoprotein profile (HDL, LDL and triglycerides);
v) mental health consultation/evaluation for depression and anxiety;
w) neurological health screening;
x) neurological imaging studies and health screenings (CT, MRI, PET, SPET, EEG, EMG, ENG, myelography, thermography, ultrasounds, spinal/lumbar puncture and X-ray);
y) novel virus testing;
z) polysomnography (PSG);
aa) prenatal/perinatal care health screenings, ultrasounds, monitoring, tests and/or vaccines;
bb) sexually transmitted diseases or blood borne infection screening; and
cc) substance induced related mental health screening.

Health System Facility means a Hospital or other facilities which are owned, operated or controlled by the Policyholder.

Heart Attack (Myocardial Infarction) means the Diagnosis of damage or death to a portion of the heart muscle (myocardium) due to in inadequate blood supply. Diagnosis must be supported by the characteristic rise of cardiac enzymes or biochemical markers consistent with myocardial infarction; and at least one of the following clinical findings:

a) electrocardiogram (EKG) changes that illustrate new ischemia;
b) typical physical symptoms (characteristic chest pain, for example);
c) imaging evidence of new regional wall motion abnormality or new loss of viable myocardium; or
d) angiographic evidence consistent with limitation of coronary artery flow.

This definition does not include a diagnosis of other acute coronary syndromes such as angina, established (old) myocardial infarction, other diseases or injuries involving the cardiovascular system, or cardiac arrest not caused by a myocardial infarction.

Hospital means a facility that is accredited, approved, certified or licensed as a general hospital by the proper authority of the state in which it is located to provide Treatment for the condition causing confinement. A hospital does not include a facility or institution or part thereof which is licensed or used principally as:

a) a clinic;
b) a convalescent home;
c) a rest home or home for the aged;
d) a nursing home;
e) a halfway house; or
f) a board and care facility.

Huntington's Disease means a Diagnosis of a genetic disorder where the nerve cells in the brain progressively degenerate over time resulting in physical impairment, cognitive decline, and mental disturbances where symptoms are present and documented, and genetic testing confirms the presence of the huntingtin gene mutation. This definition does not include a diagnosis of Huntington's Disease that occurred prior to the Insured Person's effective date of coverage under the Policy.

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

Initial Benefit means the initial benefit Principal Sum payable for a Critical Illness as shown in the Critical Illness Benefits Table in the Benefits section of this Certificate.

Injury, Injuries means bodily harm that:

a) is a direct result of an Accident requiring treatment by a Physician or Medical Professional;
b) is independent of bodily infirmity, Sickness or medical or Surgical treatment and all other causes; and
c) occurs while insurance is in effect for an Insured Person.

Infectious Diseases means a Diagnosis of an infectious or contagious disease for which a Physician recommends an Insured Person be Hospital Confined for a minimum of 72 consecutive hours and has symptoms of one of the following Diagnoses: anthrax, Antibiotic-Resistant Bacteria Infection, Avian influenza H5N1, botulism, bovine spongiform encephalopathy (mad cow disease), brucellosis, Candida auris, cholera, diphtheria, Ebola virus disease, encephalitis, Escherichia coli, H1N1, hantavirus pulmonary syndrome, hepatitis A, legionnaires disease, leptospirosis, Meningitis, Mosquito-Borne Disease, necrotizing fasciitis, osteomyelitis, pertussis (Whooping Cough), pneumococcal disease, polio(myelitis), rabies, sepsis, Surgical site infection, tetanus, Tick-Borne Disease, tuberculosis, or typhoid fever. This definition does not include any diagnosed disease not listed in this definition.

Inflammatory Bowel Disease means a Diagnosis of a disease that causes chronic inflammation or ulcers in the digestive tract, for which a Physician recommends Prescription Medication or Surgery to reduce symptoms. This definition includes a diagnosis of Crohn's disease and ulcerative colitis. Diagnosis must be confirmed by intestinal endoscopy or medical imaging.

Insured Persons means you and/or your Dependents who are insured under the Policy.

Life Event means:

a) a change in your legal marital status (or domestic partnership, civil union partnership or equivalent);
b) a change in the number of your Dependents; or
c) a significant cost or coverage change under any employer or group sponsored critical illness plan or medical plan under which you or your Dependents are covered; or
d) Policyholder requested language.

Loss of Hearing means a Diagnosis of hearing loss due to Injury or Sickness in both ears where it has been determined an Insured Person has lost the ability to hear sounds at or below 70 decibels. This definition does not include hearing loss that can be corrected to above 70 decibels using any hearing aid, procedure, or device.

Loss of Sight in Both Eyes means a Diagnosis of vision loss due to Injury or Sickness in both eyes where the best corrected visual acuity is 6/60 (metric acuity) or 20/200 (Snellen chart or E chart acuity) or less, or the field of vision is less than 20 degrees.

Loss of Sight in One Eye means a Diagnosis of vision loss due to Injury or Sickness in one eye where the best corrected visual acuity is 6/60 (metric acuity) or 20/200 (Snellen chart or E chart acuity) or less, or the field of vision is less than 20 degrees.

Loss of Speech means a Diagnosis of the loss of audible voice communication due to Injury or Sickness. This definition does not include speech loss that could be totally or partially restored using a device or implant.

Major Organ Failure means a Diagnosis of organ failure for which a Physician recommends a partial or full transplantation of a healthy human heart, 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).

Medical Professional means a person who is duly licensed to provide Treatment, such as a physician's assistant (PA), nurse practitioner (NP/APRN), licensed practical nurse (LPN), or registered nurse (RN). The Medical Professional must be acting

within the scope of his/her license. This definition does not include the Insured Person or a member of the Insured Person's Family.

Meningitis means any of the following: amoebic, bacteria, fungal, parasitic, or viral.

Mosquito-Borne Disease means any of the following: chikungunya fever (also known as chikungunya virus infection), malaria, Severe Dengue, West Nile fever, Zika fever (also known as Zika virus disease) and yellow fever.

Multiple Sclerosis (MS) means a Diagnosis of a chronic neurological disease where the immune system attacks the protective layer of fatty tissue surrounding the nerve fibers in the brain and spinal cord resulting in symptoms including vision changes, issues with motor function, increased fatigue, and cognitive impairments that have been present and documented for a minimum of 90 days. Diagnosis must be confirmed by a neurological exam demonstrating functional impairments, imaging studies of the brain or spine cord to look for the characteristic lesions consistent of MS, or analysis of cerebrospinal fluid consistent with Multiple Sclerosis (MS).

Muscular Dystrophy means a Diagnosis of a group of neuromuscular diseases that cause progressive skeletal muscle weakness and death of muscle cells and tissue as a result of abnormal gene mutations that affect the production of proteins necessary to form healthy muscle. Diagnosis must be confirmed by electromyography and a muscle biopsy or genetic testing.

Myasthenia Gravis means a Diagnosis of a chronic neuromuscular disease where the communication between nerves and muscles begins to break down causing weakness in the muscles that support movement in the arms and legs and enable breathing. Diagnosis must be confirmed by two of the following:

a) positive edrophonium test;
b) the presence of antibodies that affect muscle receptor sites positively detected in a blood test;
c) abnormal electrodiagnostic study result;

and for which a Physician recommends Prescription Medication or immunotherapy to reduce symptoms. This definition does not include ocular myasthenia gravis.

Observation Unit means a specified area within a Hospital, apart from an emergency room, where a patient can be monitored. This area must:

a) be under the direct supervision of a Physician;
b) provide Treatment by Physicians or Medical Professionals; and
c) provide Treatment 7 days per week, 24 hours per day.

Occupational Hepatitis B, C, or D means a Diagnosis of hepatitis B, C, or D that is the result of an accidental exposure to contaminated bodily fluids, caused by an accidental needle stick or sharp injury or by mucous membrane exposure to blood or bloodstained bodily fluid, which occurs during the usual course of the Insured Person's occupation, and is reported to the Employer within 48 hours after the incident. Proof of occupational exposure requires a negative hepatitis B, C, or D test within 5 days of the incident and a subsequent positive hepatitis B, C, or D test within 180 days of the incident. This definition does not include any diagnosis of hepatitis B, C, or D that is the result of drug use, sexual transmission, or any hepatitis B, C, or D that is not directly related to occupational and accidental exposure.

Occupational Human Immunodeficiency Virus (HIV) means a Diagnosis of human immunodeficiency virus (HIV) that is the result of accidental exposure to HIV-contaminated body fluids, caused by an accidental needle stick or sharp injury or by mucous membrane exposure to blood or bloodstained bodily fluid, which occurs during the usual course of the Insured Person's occupation, and is reported to the Employer within 48 hours after the incident. Proof of occupational exposure requires a negative HIV test within 5 days of the incident and a subsequent positive HIV test within 270 days of the incident. This definition does not include any diagnosis of HIV that is the result of drug use, sexual transmission, or any diagnosis of HIV that is not directly related to occupational and accidental exposure.

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

Paralysis means a Diagnosis of complete and irreversible loss of the use of 2 or more limbs without Severance for which the expectation is the loss will last for a continuous period of 60 days or more as the result of damage to the spinal cord or brain caused by a Injury or Sickness. This definition does not include paralysis resulting from a Stroke.

Parkinson's Disease means a Diagnosis of a neurodegenerative disease where part of the brain is damaged, causing the brain to produce inadequate levels of dopamine that the brain uses to control movement resulting in symptoms including slow movement, tremors, stiffness, difficulty with speech, facial expressions, muscular rigidity, unsteady gait, and/or rapid and

persistent blinking. Diagnosis must be confirmed by neurological examination, cognitive testing, and neuroradiological imaging.

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.

Pathological Diagnosis means a diagnosis of 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 College of Pathology. The date of Diagnosis for Cancer is the day the tissue, preparation, or culture is taken.

Physician means a legally qualified medical doctor licensed to practice medicine, prescribe drugs, perform surgery, or any other licensed healthcare provider deemed 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 a member of the Insured Person's Family.

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.

Policyholder means ACME Truck Line, Inc..

Policy Anniversary means January 1 of each Policy Year.

Policy Benefit Maximum means the maximum percentage amount eligible for payment for an Insured Person under the Policy and any Prior Plan (if applicable). The policy benefit maximum is shown in the Benefits section of this Certificate.

Policy Effective Date means January 1, 2025.

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.

Prescription Medication means a generic, brand name, or specialty pharmaceutical substance that legally requires a medical prescription to be dispensed and is prescribed by a Physician or Medical Professional.

Principal Sum means an Insured Person's amount of critical illness insurance available as shown in the Schedule section of this Certificate.

Prior Plan means any similar insurance policy:

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

Rai Stage means a method for determining the prognosis of chronic lymphocytic leukemia based on blood cell counts.

Reoccurrence means an Insured Person is Diagnosed with the same Critical Illness for which an Initial Benefit has been previously paid under the Policy.

Reoccurrence Separation Period means the period of time that must elapse between the initial date of Diagnosis of a Critical Illness and the subsequent date of Diagnosis of the same Critical Illness for an Insured Person.

Ruptured Aneurysm means a condition where an aneurysm bursts and causes internal bleeding.

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

Severe Dengue means dengue hemorrhagic fever or dengue shock syndrome.

Sickness means a physical or mental disease, illness, infection, disorder, or condition that requires Treatment by a Physician or Medical Professional while insurance is in effect for an Insured Person.

Skin Cancer means a Diagnosis of the abnormal growth of cells within the tissues of the skin. This definition includes the diagnosis of basal cell carcinoma, squamous cell carcinoma, Merkel cell carcinoma of the skin, ocular melanoma, or non-melanoma. Diagnosis must be confirmed by a Pathological Diagnosis. This definition does not include pre-cancerous skin conditions.

Spinal Cord (Intradural) Tumor means tumor located within the spinal cord, covering the spinal cord (dura), central nervous system, or vertebrae (vertebral tumor).

Spouse means the person to whom you are legally married.

Sternotomy means a Surgical Procedure that creates access to your heart or other body parts by dividing the breastbone.

Stroke means a Diagnosis of death or permanent damage of brain tissue due to inadequate blood supply or hemorrhage within the skull resulting in clinical evidence of neurological impairment for a period of at least 30 days following the event. Diagnosis must be confirmed by neuroradiological imaging including computerized axial tomography (CAT scan) or magnetic resonance imaging (MRI), or other imaging test. This definition does not include Transient Ischemic Attack (TIA); 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.

Subsequent means a diagnosis of a different Critical Illness for which a benefit is payable or was paid previously under the Policy.

Subsequent Enrollment Period means any period designated for enrollment by the Policyholder and agreed to in writing by our authorized representative in our home office.

Substance Use Disorder means any condition or disease, regardless of its cause, listed in the most recent edition of the International Classification of Diseases or Controlled Substances Act as an alcohol or drug-related condition or disease.

Sudden Cardiac Arrest means a Diagnosis of an internal electrical disturbance of the heart that disrupts pumping that stops blood flow resulting in abrupt loss of heart function. This definition does not include Heart Attack (Myocardial Infarction) or any sudden cardiac arrest occurring during any clinical procedure or Surgical Procedure.

Surgery, Surgical, or Surgical Procedure means a medical procedure involving an incision in the Insured Person's skin or tissue that is intended to be explorative, reparative, or curative.

Systemic Lupus Erythematosus (SLE) means a Diagnosis of an autoimmune disease characterized by chronic inflammation that causes joint pain and swelling due to the body's immune system attacking healthy tissue and organs. Diagnosis must be indicated by at least 2 of the following:

a) abnormal levels of protein in the urine;
b) discoid rash;
c) hematologic (blood) disorder;
d) immunologic (immune system) disorder;
e) inflammation of the linings of the heart and/or lungs;
f) malar rash;
g) non-erosive arthritis;
h) oral ulcers;
i) photosensitivity;
j) positive antinuclear antibodies (ANA);
k) renal (kidney) disorder; or
l) seizures and/or psychosis.

This definition does not include discoid lupus and drug-induced lupus.

Systemic Sclerosis (Scleroderma) means the Diagnosis of an autoimmune, connective tissue, and rheumatic disease caused by an overproduction of collagen leading to the hardening and tightening of the skin and connective tissue, resulting in diffuse skin thickening extending beyond the face and fingers for which a Physician recommends Prescription Medication or Therapy to reduce symptoms.

Tick-Borne Disease means any of the following: anaplasmosis; babesiosis; borrelia miyamotoi disease; borrelia mayonii disease; Bourbon virus; Colorado tick fever; ehrlichiosis; Heartland virus; Lyme disease (formally borreliosis); Powassan virus; rickettsia parkeri rickettsiosis; Rocky Mountain spotted fever (RMSF); southern tick-associated rash illness (STARI); tickborne relapsing fever; and tularemia.

Transient Ischemic Attack (TIA) or Reversible Ischemic Neurologic Deficit (RIND) means a Diagnosis of a new acute ischemic event resulting from a temporary blockage of blood supply to the brain resulting in a brief episode of neurological dysfunction with no evidence of an acute infarction as confirmed by medical imaging.

*Treatmen*t 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 (Invasive) 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. The prenatal Diagnosis of a Critical Illness for a newborn child, as defined in this section of this Certificate, is not considered Treatment.

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 may be eligible or insured under the Policy.

ADDITIONAL SUMMARY PLAN DESCRIPTION INFORMATION

The Employee Retirement Income Security Act of 1974 (ERISA) requires that certain information be furnished to eligible participants in an employee benefits plan. The employee benefits plan maintained by the Policyholder shall be referred to herein as the "Plan."

This document, in conjunction with your Certificate, is your ERISA Summary Plan Description for the insurance benefits described herein.

Contributions are made solely by participants. Contributions are based on the amount of insurance premiums necessary to provide Plan coverage.

The benefits under the Plan are fully insured by us under a group insurance policy issued by us. Benefits under the Policy are guaranteed to the extent all Policy provisions are met and subject to all terms and conditions of the Policy (including, but not limited to, all exclusions, limitations and exceptions in the Policy). Our home office is located at 3300 Mutual of Omaha Plaza, Omaha, Nebraska 68175.

EMPLOYER IDENTIFICATION NUMBER AND PLAN NUMBER

The Employer Identification Number (EIN) is: 72-0540787
The Plan Number is: 501

PLAN ADMINISTRATOR

The Plan is provided through and administered by:

ACME Truck Line, Inc.
200 Westbank Expressway
Gretna, LA 70053
Phone: (504) 368-2510

AGENT FOR SERVICE OF LEGAL PROCESS

The agent for service of legal process upon the Plan is:

ACME Truck Line, Inc.
200 Westbank Expressway
Gretna, LA 70053
Phone: (504) 368-2510

In addition, service of process may be made upon the Plan Administrator (if different from the Agent for Service of Legal Process).

PLAN YEAR

Each 12-month period beginning on January 1 is a "plan year" for the purposes of accounting and all reports to the U.S. Department of Labor and other regulatory bodies.

STATEMENT OF ERISA RIGHTS

As a participant in the Plan, You are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

a) Receive Information About Your Plan and Benefits

1. Examine, without charge, at the Plan Administrator's office and at other specified locations all documents governing the Plan, including insurance contracts and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
2. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.
3. Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

b) Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate Your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of You and other Plan participants and beneficiaries. No one, including Your employer or any other person, may fire You or otherwise discriminate against You in any way to prevent You from obtaining a benefit or exercising Your rights under ERISA.

c) Enforce Your Rights

If Your claim for a benefit is denied or ignored, in whole or in part, You have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps You can take to enforce the above rights. For instance, if You request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, You may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay You up to $110 a day until You receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If You have a claim for benefits which is denied or ignored, in whole or in part, You may file suit in a state or Federal court. In addition, if You disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, You may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if You are discriminated against for asserting Your rights, You may seek assistance from the U.S. Department of Labor, or You may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If You are successful the court may order the person You have sued to pay these costs and fees. If You lose, the court may order You to pay these costs and fees, for example, if it finds Your claim is frivolous.

d) Assistance with Your Questions

If You have any questions about Your Plan, You should contact the Plan Administrator. If You have any questions about this statement or about Your rights under ERISA, or if You need assistance in obtaining documents from the Plan Administrator, You should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in Your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about Your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

PLAN DISCLOSURES

You are entitled to request from the Plan Administrator, without charge, information applicable to the Plan's benefits and procedures. In addition, Your Certificate includes, as applicable, a description of:

a) eligibility requirements;
b) when insurance ends;
c) state or federal continuation rights; and
d) claims procedures.

PLAN CHANGES

The persons with authority to change, including the authority to terminate, the Plan on behalf of the Policyholder are the Policyholder's Board of Directors or other governing body, or any person or persons authorized by resolution of the Board or other governing body to take such action. Please refer to the provision in Your Certificate entitled "Changes in the Insurance Contract" for information about how the Policy can be changed. The Policyholder's benefits area is authorized to apply for and accept the Policy and any changes to the Policy on behalf of the Policyholder.

Group Voluntary Critical Illness Benefits

ACME Truck Line, Inc.

Group Number: G000BHPR

United of Omaha Life Insurance Company

Home Office:
3300 Mutual of Omaha Plaza
Omaha, Nebraska 68175