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

YOUR GROUP VOLUNTARY CRITICAL ILLNESS BENEFITS

FOR EMPLOYEES OF:

Legacy Transportation Services Inc.

CLASS(ES): All Eligible Employees

EFFECTIVE DATE: January 1, 2023

PUBLICATION DATE: February 2, 2023

NOTICE(S)

THE POLICY PROVIDES LIMITED BENEFITS. THIS IS A SUPPLEMENT TO HEALTH INSURANCE. IT IS NOT A SUBSTITUTE FOR ESSENTIAL HEALTH BENEFITS OR MINIMUM ESSENTIAL COVERAGE AS DEFINED IN FEDERAL LAW.

PLEASE READ YOUR CERTIFICATE CAREFULLY. THIS CERTIFICATE DESCRIBES THE BENEFITS THAT ARE AVAILABLE TO YOU UNDER THE POLICY. THE POLICY ONLY PAYS BENEFITS FOR THE DIAGNOSIS OF THE CRITICAL ILLNESSES LISTED IN THE CERTIFICATE. THE POLICY IS ISSUED IN THE STATE OF CALIFORNIA.

ARTERY BYPASS, AORTIC SURGERY, ACUTE RESPIRATORY DISTRESS SYNDROME, BONE MARROW TRANSPLANT AND CARCINOMA IN SITU (CANCER THAT IS NOT INVASIVE AND HAS NOT SPREAD BEYOND ITS TISSUE OF ORIGIN) ARE CONSIDERED PARTIAL BENEFITS, FOR WHICH BENEFIT PAYMENT IS PROVIDED AT A REDUCED AMOUNT. THIS POLICY PAYS NO BENEFITS FOR BASAL CELL CARCINOMA, SQUAMOUS CELL CARCINOMA, PRE-MALIGNANT LESIONS, BENIGN TUMORS OR BENIGN POLYPS. READ THE DEFINITIONS OF EACH CRITICAL ILLNESS CAREFULLY TO DETERMINE WHAT CONDITIONS ARE INCLUDED AND EXCLUDED.

Group Number: G000C35S

NOTICE(S)

If a problem occurs, please first contact the Policyholder or Your benefits administrator. If, after doing so, You still have a question or concern, You may contact Us at:

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

The Department of Insurance should be contacted only after the contacts between You and the Policyholder or Your benefits administrator and Your insurance company or its representatives have failed to produce a satisfactory solution to the problem. To contact the Department of Insurance, write or call:

Consumer Division
Department of Insurance, Los Angeles Office
300 South Spring Street
Los Angeles, California 90013
1-800-927-4357

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

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.

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CERTIFICATE OF INSURANCE

UNITED OF OMAHA LIFE INSURANCE COMPANY

Home Office:
Mutual of Omaha Plaza
Omaha, Nebraska 68175

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

United of Omaha Life Insurance Company certifies that Group Policy Number GUDE-C35S (the Policy) has been issued to Legacy Transportation Services Inc. (the Policyholder). The Policy provides Group Critical Illness Insurance.

Insurance is provided for Employees of the Policyholder subject to the terms and conditions of the Policy. This Certificate is made a part of the Policy.

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

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

This Certificate replaces any certificate previously issued under the Policy.

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

James T. Blackledge
Chief Executive Officer

Jay D. Vankat
Corporate Secretary

SCHEDULE

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

CLASS(ES)

All Eligible Employees

CRITICAL ILLNESS INSURANCE FOR YOU (THE EMPLOYEE)

You may elect to be insured for an amount of critical illness (CI) insurance from $5,000 to $30,000 in increments of $5,000.

Your amount of CI insurance is also referred to as Your CI Principal Sum. If You have questions regarding the amount of Your CI insurance, You may contact the Policyholder.

CRITICAL ILLNESS INSURANCE FOR YOUR DEPENDENT(S)

Provided You have elected some amount of insurance, You may elect to have Your Spouse insured for an amount of critical illness (CI) insurance from $1,000 to $30,000, in increments of $1,000, provided the amount elected does not exceed 100% of Your CI Principal Sum.

Provided You have elected some amount of CI insurance, the amount of CI insurance for Your eligible Dependent child(ren) is 50% of Your CI Principal Sum, but in no event more than $10,000.

Any amount of CI insurance for Your Dependent(s) will be rounded to the next higher multiple of $1,000, if not already an even multiple of $1,000. Any amount of CI insurance for a Dependent is the Dependent's CI Principal Sum. If You have questions regarding the amount of CI insurance for Your Dependent(s), You may contact the Policyholder.

GUARANTEE ISSUE AMOUNT(S) AND EVIDENCE OF INSURABILITY

Guarantee issue is only available if the total number of Employees insured under the Policy attains or remains above 10 Employees or 20% of the eligible Employees, whichever is greater. If the total number falls below the required level, the Guarantee Issue Amount(s) may be reduced or rescinded.

Guarantee Issue Amount For You (The Employee)

Your Guarantee Issue Amount is $30,000. 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.

If You are eligible for and elect insurance under the Policy as both an Employee and Spouse, the Guarantee Issue Amount available to You under the Policy is $60,000.00.

Guarantee Issue Amount For Your Spouse

The Guarantee Issue Amount for Your Spouse is $30,000. Any amount of insurance in excess of this amount requires Evidence of Insurability, regardless of the amount of insurance the Dependent was insured for under a Prior Plan.

Guarantee Issue Amount For Your Dependent Child(ren)

The Guarantee Issue Amount for Your Dependent child(ren) is $10,000. Any amount of insurance in excess of this amount requires Evidence of Insurability, regardless of the amount of insurance the Dependent was insured for under a Prior Plan.

Insurance is only available on a guarantee issue basis:

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

Evidence of Insurability

Evidence of Insurability is required for:

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

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

Evidence of Insurability will be waived for any Dependent child(ren) for whom insurance is elected within 31 days after the date a Dependent child(ren) become(s) eligible, if Dependent child insurance requires an election and Dependent child insurance for any other child(ren) is not already in effect under the Policy.

Evidence of Insurability will be waived for any Dependent child(ren) for whom insurance is elected within 31 days after the date a Dependent child(ren) become(s) eligible, if Dependent child insurance requires an election and Dependent child insurance for any other child(ren) is not already in effect under the Policy.

ELIGIBILITY

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

WHEN AN EMPLOYEE BECOMES ELIGIBLE FOR INSURANCE (ELIGIBILITY WAITING PERIOD)

An Employee who has completed an Eligibility Waiting Period of 60 days on or before the Policy Effective Date becomes eligible for insurance under the Policy on the Policy Effective Date.

An Employee who is not eligible for insurance under the Policy on the Policy Effective Date, or an Employee who is hired after the Policy Effective Date, becomes eligible for insurance under the Policy on the day following completion of an Eligibility Waiting Period of 60 days.

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

An Employee must be insured by an individual or group policy or contract that arranges or provides medical, hospital, and surgical coverage not designed to supplement other private or governmental plans.

WHEN A DEPENDENT BECOMES ELIGIBLE FOR INSURANCE

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

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

provided You elect insurance for yourself under the Policy.

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

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

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

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

A Dependent must be insured by an individual or group policy or contract that arranges or provides medical, hospital, and surgical coverage not designed to supplement other private or governmental plans.

CONTINUITY OF INSURANCE UPON TRANSFER OF INSURANCE CARRIER

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

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

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

The Policy will not provide insurance under this provision for any Employee who does not satisfy the criteria above unless approved in writing by Our authorized representative in Our home office.

Insurance under this provision is subject to the following conditions:

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

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

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

Insurance under this provision will end on the earliest of:

a) the day the Employee returns to Active Work for the Policyholder or begins employment with any other employer;
b) the last day the Employee would have been insured under the Prior Plan, if the Prior Plan had not ended or terminated;
c) the day the Employee's insurance under the Policy ends for any reason shown in the When Insurance Ends provision;
d) the last day of the twelfth month following the Policy Effective Date; or
e) the last day of the time period allowed by FMLA, USERRA or applicable federal or state law that allows for continuation.

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

WHEN INSURANCE BEGINS

An Employee must enroll for any insurance requiring an election by submitting a Written Request for insurance for the Employee and any Dependents. The Written Request must be submitted to the Policyholder no later than 31 days following the day the Employee and any Dependents become(s) eligible. If the Written Request for insurance is not submitted within the required time frame, the Employee and/or Dependents must provide Evidence of Insurability.

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

a) the Employee becomes eligible and is Actively Working; or
b) the Employee submits a Written Request to enroll for insurance, if required.

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

a) the Employee becomes insured;
b) the Employee acquires the eligible Dependent; or
c) the Employee submits a Written Request to enroll the Dependent for insurance, if required.

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

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

Insurance for a newborn child begins at the moment of live birth. Insurance for a newly adopted newborn child begins with the date of placement into Your custody, or at the moment of live birth if a written agreement to adopt the child was previously entered into by You. If Dependent child insurance requires an election and Dependent child insurance for any

other child(ren) is not already in effect under the Policy, a Written Request for insurance for any newborn or newly adopted Dependent child(ren) must be submitted to the Policyholder within 31 days following the day the Dependent child(ren) become(s) eligible in order to continue insurance beyond the 31-day period.

EXCEPTIONS TO WHEN INSURANCE BEGINS (DEFERRED EFFECTIVE DATE)

This provision does not apply if the Employee is eligible for insurance under the Continuity of Insurance Upon Transfer of Insurance Carrier provision. This provision also does not apply to any Dependent who was eligible and insured under any Prior Plan on the day before the Policy Effective Date.

Insurance for an Employee or Dependent who is:

a) confined in a Hospital as an inpatient;
b) confined in any institution or facility other than a Hospital; or
c) confined at home and under the care or supervision of a Physician;

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

Insurance for an Employee who is not Actively Working when insurance would otherwise begin will not take effect until the day after the Employee has completed one full day of Active Work.

In addition, insurance for a Dependent who is unable to perform the usual and customary duties and activities of a healthy individual of the same age and gender will not take effect until the day the Dependent is able to consistently perform such duties and activities. This exception does not apply to any Incapacitated Dependent child.

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

THE FIRST ENROLLMENT PERIOD

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

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

SUBSEQUENT ENROLLMENT PERIODS

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

WHEN ELECTION CHANGES ARE PERMITTED

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

The Policyholder has chosen to provide these insurance benefits under a Section 125 cafeteria plan. A cafeteria plan permits You to elect to pay Your share of the cost of insurance with pre-tax dollars and permits You to change Your election(s) only when specific life events occur, other than during an annual enrollment period. You may make an election change by submitting a Written Request to the Policyholder within 31 days from the date of a life event.

Life events are described in the Policyholder's cafeteria plan. Contact the Policyholder for information regarding the election changes that are permissible under the Policyholder's cafeteria plan.

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

CHANGES TO INSURANCE BENEFITS

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

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

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

REINSTATEMENT OF INSURANCE

You may be eligible to reinstate insurance that has ended in accordance with this provision. For any insurance requiring an election, You must submit a Written Request to reinstate insurance within 31 days of Your return to Active Work. We will require Evidence of Insurability if the amount of insurance being requested exceeds the amount of insurance in effect on the Employee's last day of Active Work. If insurance is reinstated for You, insurance may also be reinstated for any eligible Dependent(s).

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

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

Non-Payment of Premium or Voluntary Termination of Insurance

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

Involuntary Reduction in Hours

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

Rehired Employee Due to Layoff or Termination

If insurance ended because the Employee was no longer Actively Working due to layoff or termination of employment with the Policyholder, insurance may be reinstated without satisfying another Eligibility Waiting Period if the Employee is rehired and returns to Active Work within 90 days from the date insurance ended.

Rehired Employee Due to Leave of Absence

If insurance ended because the Employee was no longer Actively Working due to an approved leave of absence, insurance may be reinstated within 90 days from the date insurance ended without satisfying another Eligibility Waiting Period upon return to Active Work. If insurance ended because the Employee was no longer Actively Working due to military leave, insurance may be reinstated upon return to Active Work within 31 days of discharge from active duty without satisfying another Eligibility Waiting Period.

Transfer From Portability

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

WHEN INSURANCE ENDS

Insurance for You and Your Dependent(s), if applicable, will end:

a) on the last day of the month in which You are no longer eligible for insurance under the Policy;
b) on the last day of the month in which You begin active duty in the Armed Forces, National Guard or Reserves of any state or country (except for temporary active duty of 31 days or less);
c) on the day the Policy terminates; or
d) in accordance with the Grace Period provision.

Insurance for You will also end on the date that benefits paid for You reach the Policy benefit maximum.

Insurance for a Dependent will also end:
a) on the last day of the month in which the Dependent is no longer eligible for insurance under the Policy; or
b) on the date that benefits paid for the Dependent reach the Policy benefit maximum.

Insurance ending has no effect on benefits payable for any Critical Illness incurred by an Insured Person while insured under the Policy.

EXCEPTIONS TO WHEN INSURANCE ENDS

If insurance for You and Your Dependent(s), if applicable, would otherwise end, You or Your Dependent(s) may be able to continue insurance under one of the following provisions:
a) Continuation of Insurance for Layoff or Leave
b) Continuation of Insurance for Your Dependents in the Event of Your Death
c) Portability

CONTINUATION OF INSURANCE FOR LAYOFF OR LEAVE

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

You may be able to continue insurance from the day You cease to be Actively Working in the event of:
a) a temporary involuntary layoff; or
b) a leave of absence approved by the Policyholder due to any personal reason.

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

Insurance may be continued for You and Your Dependent(s).

Any insurance continued under this provision will be subject to the following conditions:
a) insurance may not be continued beyond the earliest of:
    1. 12 weeks for Your temporary involuntary layoff;
    2. 12 weeks for Your leave of absence due to any personal reason; or
    3. the time period allowed by FMLA, USERRA or applicable federal or state law that allows for continuation;
b) the amount of insurance for any Insured Person may not be increased while insurance is continued under this provision;
c) We receive notification of the approved layoff or leave from the Policyholder within 31 days from the date You cease Active Work; and
d) We continue to receive premium payment when due (premiums must be paid by You or on Your behalf).

Insurance under this provision will end on the last day of the month which coincides with or follows the earliest of the day:
a) the time period in a) in the preceding paragraph has been satisfied;
b) Your temporary involuntary layoff becomes permanent, if insurance is continued under this provision due to Your temporary involuntary layoff;
c) You return to Active Work;
d) You begin full-time employment with an employer other than the Policyholder; or
e) the Policy terminates.

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

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

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

CONTINUATION OF INSURANCE FOR YOUR DEPENDENTS IN THE EVENT OF YOUR DEATH

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

When insurance under the Policy would otherwise end because of Your death, Your Dependent(s) may be able to continue insurance under this provision if the following conditions are satisfied:

a) We receive notification of Your death and intent to continue insurance for Your Dependent(s) from the Policyholder within 31 days from the date of Your death or the date insurance would otherwise end; and
b) We continue to receive timely premium payment when due (premiums must be paid by Your Dependent(s) or on Your Dependent(s) behalf).

The amount of insurance for any Insured Person may not be increased while insured under this provision.

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

a) that is 3 months from the date of Your death; or
b) the Policy terminates.

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

If continued insurance under this provision ends, Your Dependent(s) may be able to continue or obtain insurance under the Portability provision.

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

PORTABILITY

You have the right to continue receiving group critical illness insurance under this provision if You are under age 70 when insurance would otherwise end for any of the following reasons:

a) You cease to be Actively Working and are not eligible for insurance under any other continuation provision in this Certificate (if applicable);
b) Your employment, membership or association with the Policyholder ends; or
c) the Policy terminates and the Policyholder does not obtain a replacement policy with another insurance carrier within 31 days.

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

a) You enter active duty in the Armed Forces, National Guard or Reserves of any state or country for a period of more than 31 days;
b) divorce or legal separation of You and Your Spouse; or
c) Your death.

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

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

If an Insured Person requests to continue to receive group insurance under this provision, the amount of insurance available shall not exceed the amount in effect for the Insured Person under the Policy on the day insurance ended.

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

The Group Critical Illness Insurance Portability Policy

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

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

We may change the benefits and conditions of the Portability Policy and associated premium rates at any time. We will provide notice of any change at least 31 days before the change is effective.

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

Notice of the Right to Continue Insurance Under this Provision

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

a) 15 days after notice has been received (if notice is received within 90 days after the start of the Portability Period); or
b) 60 days after the end of the Portability Period, even if notice is not received.

How to Request Continued Insurance Under this Provision

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

ANNUAL OPEN ENROLLMENT RIDER

This rider is made a part of Group Policy GUDE-C35S. It is subject to all of the Policy provisions. When the Policy and this rider are in conflict, the rider prevails. This rider is effective the later of the Policy Effective Date or the day You and/or Your Spouse become insured under the Policy.

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

You may submit a Written Request to increase the amount of insurance for You, Your Spouse and Your Dependent child(ren).

An increase in the amount of insurance will result in a higher premium payment for You. Please contact the Policyholder for more information about Your premium.

REQUESTING AN INCREASE

We will accept Your Written Request within a time period designated by the Policyholder and approved by Our authorized representative in Our home office. You may only submit one Written Request under this rider once per Policy Year.

EVIDENCE OF INSURABILITY

We will require Evidence of Insurability for the first increase that results in a total amount of insurance that exceeds the Guarantee Issue Amount for You, Your Spouse, and/or Your Dependent child(ren).

WHEN INCREASE BEGINS

If Your Written Request does not require Evidence of Insurability, an approved increase in the amount of insurance will become effective the first day of the month that follows the day You submit Your Written Request to increase the total amount of insurance.

If Your Written Request requires Evidence of Insurability, an approved increase in the amount of insurance will become effective the first day of the month that follows the day We approve Evidence of Insurability.

AMOUNT OF YOUR REQUEST

You may increase Your amount of insurance up to Your Guarantee Issue Amount, in increments as shown in the Schedule. Your total amount of insurance, including any requested increase, may not exceed Your maximum benefit amount.

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

You may increase Your Dependent child(ren)'s amount of insurance. Your Dependent child(ren)'s amount of insurance will be equal to 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(ren) to the next higher multiple of $1,000. Your Dependent child(ren)'s total amount of insurance, including any requested increase, may not exceed Your Dependent child(ren)'s maximum benefit amount.

IF ELIGIBLE BUT HAVE NOT ELECTED COVERAGE

An Employee who previously declined insurance under the Policy may submit a Written Request to enroll for insurance for the Employee, the Employee's Spouse, and/or the Employee's Dependent child(ren) during a Subsequent Enrollment Period.

An Employee may request an amount of insurance up to the Employee's Guarantee Issue Amount, in increments as shown in the Schedule.

An Employee may request an amount of insurance for the Employee's Spouse up to the Spouse's Guarantee Issue Amount.

An Employee may request an amount of insurance for the Employee's Dependent child(ren). The Employee's Dependent child(ren)'s amount of insurance will be equal to 50% of the Employee's new amount of insurance. We will round any amount of insurance for the Employee's Dependent child(ren) to the next higher multiple of $1,000, if not already an even multiple of $1,000.

LIMITATIONS AND EXCLUSIONS

Any election of or increase in insurance is subject to the Pre-existing Condition limitation of the Policy, as well as all additional limitations and exclusions as outlined in the Certificate.

An Employee, an Employee's Spouse, and/or an Employee's Dependent child(ren) are not eligible under this rider if that Employee, Employee's Spouse, and/or Employee's Dependent Child(ren) were previously declined for insurance through Evidence of Insurability.

If You have submitted a claim with Us, other than for the Health Screening Benefit, You and Your Dependent child(ren) are not eligible to increase under this rider. You may request an increase for Your Spouse.

If Your Spouse has submitted a claim with Us, other than for the Health Screening Benefit, Your Spouse is not eligible to increase under this rider. You may request an increase in the amount of insurance for You and Your Dependent child(ren).

If Your Dependent child(ren) has/have submitted a claim with Us, other than for the Health Screening Benefit, You and Your Dependent child(ren) are not eligible to increase under this rider. You may request an increase in the amount of insurance for Your Spouse.

TERMINATION OF RIDER

UNITED OF OMAHA LIFE INSURANCE COMPANY

Corporate Secretary

PREMIUM PAYMENTS

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

PAYMENT OF PREMIUMS THROUGH PAYROLL DEDUCTION

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

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

Payment of premium does not guarantee eligibility for coverage.

OPTIONS FOR PAYMENT OF PREMIUM FOR CONTINUED INSURANCE

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

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

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

Payment of premium does not guarantee eligibility for coverage.

GRACE PERIOD

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

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

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

PREMIUMS AND PREMIUM CHANGES

The premium rate structure for insurance under the Policy is comprised of attained age rates per thousand dollars of insurance for each Insured Person, with specified age bands.

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

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

Premium amounts will change if:

a) You reach the Attained Age of the next higher age band in the premium rate structure for the Policy; or
b) premium rates under the Policy are changed.

CRITICAL ILLNESS INSURANCE BENEFITS

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

BENEFITS

Basic Benefits

In the event an Insured Person is Diagnosed with a Critical Illness while insured under the Policy, We will pay a critical illness (CI) benefit. The benefit amounts payable are shown in the following Critical Illness Benefits Table (the "CI Table"). The amount of CI insurance for each Insured Person, also referred to as the CI Principal Sum, is provided in the Schedule.

Once benefits have been paid for a Critical Illness for an Insured Person, no additional benefits are payable under this Basic Benefits section of the Policy for the Insured Person:

a) for that same Critical Illness; or
b) for any other Critical Illness in that same Benefit Category if 100% of the CI Principal Sum has been paid for the Insured Person in that category.

Once benefits have been paid for a Critical Illness for an Insured Person, benefits remain payable under the Policy for:

a) any other Critical Illness in that same Benefit Category for the Insured Person until 100% of the CI Principal Sum has been paid in the category, if a Partial Benefit was paid for a previous Critical Illness for the Insured Person; or
b) a Critical Illness in a different Benefit Category for the Insured Person if the date of Diagnosis for a subsequent Critical Illness occurs at least 3 months from the date of Diagnosis of a previous Critical Illness for the Insured Person.

If more than one Critical Illness is incurred by an Insured Person at the same time, only the highest applicable benefit is payable. Benefit payments are subject to any policy benefit maximum stated in this Critical Illness Insurance Benefits section of the Policy. Benefit payment is also subject to the definitions, limitations, exclusions and other provisions of the Policy.

Critical Illness Benefits Table (the "CI Table")

Benefit Category/Critical Illness	Benefit
Heart/Circulatory/Motor Function Category	
Heart Attack (Myocardial Infarction)	100% of the CI Principal Sum
Heart Transplant/Placement on UNOS List	100% of the CI Principal Sum
Heart Valve Surgery	25% of the CI Principal Sum
Coronary Artery Bypass	25% of the CI Principal Sum
Aortic Surgery	25% of the CI Principal Sum
Stroke	100% of the CI Principal Sum
ALS (Lou Gehrig's) Disease*	100% of the CI Principal Sum
Advanced Alzheimer's Disease*	100% of the CI Principal Sum
Advanced Parkinson's Disease*	100% of the CI Principal Sum
Organ Category	
Major Organ Transplant/Placement on UNOS List	100% of the CI Principal Sum
End Stage Renal Failure	100% of the CI Principal Sum
Acute Respiratory Distress Syndrome (ARDS)	25% of the CI Principal Sum
Childhood/Developmental Category (These benefits are available to children only.)	
Cerebral Palsy*	100% of the CI Principal Sum
Structural Congenital Defects*	100% of the CI Principal Sum
Genetic Disorders*	100% of the CI Principal Sum
Congenital Metabolic Disorders*	100% of the CI Principal Sum
Type 1 Diabetes*	100% of the CI Principal Sum
Cancer Category	
Invasive Cancer	100% of the CI Principal Sum
Bone Marrow Transplant	50% of the CI Principal Sum
Non-Invasive Cancer (Carcinoma in Situ)	25% of the CI Principal Sum

To demonstrate how payment for a Partial Benefit works, assume that a person is insured under the Policy for a CI Principal Sum of $5,000. This person is Diagnosed with ductal breast cancer that has not spread outside of the breast. Under the Policy,

this would be considered Carcinoma in Situ (Non-Invasive Cancer), which offers a benefit of 25% of the CI Principal Sum. Since the CI Principal Sum is $5,000, the benefit payable under the Policy is $1,250.

Additional Category Occurrence Benefit

Once benefits have been paid for a Critical Illness for an Insured Person, no additional benefits are payable under the Policy for that same Critical Illness for the Insured Person, but with the additional category occurrence benefit, benefits are still payable for any other Critical Illness for the Insured Person in that same Benefit Category. This benefit allows an Insured Person to receive up to 200% of the CI Principal Sum in the Heart/Circulatory/Motor Function Category and the Organ Category.

An additional category occurrence benefit for an Insured Person is only payable if the date of Diagnosis for an additional Critical Illness occurs at least 6 months after the date of Diagnosis of a previous Critical Illness for the Insured Person in the same Benefit Category for which benefits were paid under the Policy. This benefit does not apply to the Cancer Category or the Childhood/Developmental Category. Additional benefit payments are subject to any policy benefit maximum stated in this Critical Illness Insurance Benefits section of the Policy. Benefit payment is also subject to the definitions, limitations, exclusions and other provisions of the Policy.

To demonstrate how this benefit works, assume that a person is insured under the Policy for a CI Principal Sum of $5,000. This person is Diagnosed with a Heart Attack and receives a benefit of 100% of the Principal Sum ($5,000). 12 months or more later, the same person is Diagnosed with a Stroke, and because the Additional Category Occurrence Benefit is included in the Policy, the person receives another benefit of 100% of the CI Principal Sum ($5,000) for a total of 200% of the CI Principal Sum in the Heart/Circulatory/Motor Function Category.

Reoccurrence Benefit

Once benefits have been paid for a Critical Illness for an Insured Person, a reoccurrence benefit is payable one time for a subsequent Diagnosis of that same Critical Illness. Benefits for some illnesses are only payable once per Insured Person under the Policy, as indicated in the CI Table. The amount of the reoccurrence benefit is the benefit shown in the CI Table for the reoccurring Critical Illness.

A reoccurrence benefit for an Insured Person is only payable if the initial and subsequent dates of Diagnosis for the same Critical Illness under the Policy occur at least 12 months apart without Treatment. Additional benefit payments are subject to any policy benefit maximum stated in this Critical Illness Insurance Benefits section of the Policy. Benefit payment is subject to the definitions, limitations, exclusions and other provisions of the Policy.

To demonstrate how this benefit works, assume that a person is insured under the Policy for a CI Principal Sum of $5,000. This person is Diagnosed with a Heart Attack and receives a benefit of 100% of the Principal Sum ($5,000). 12 months or more later, the same person is Diagnosed with another Heart Attack, and because the Reoccurrence Benefit is included in the Policy, the person receives another benefit of 100% of the CI Principal Sum ($5,000).

Health Screening Benefit

We will pay a health screening benefit of $50 for each Insured Person who has a Health Screening Test performed while insurance under the Policy is in force. This benefit is payable once per calendar year for each Insured Person. Payment of this benefit has no impact on any other benefits payable under this Policy. Benefit payment is subject to the definitions, limitations, exclusions and other provisions of the Policy.

Policy Benefit Maximum

For each Insured Person, the total amount of CI benefits payable under the Policy and any Prior Plan (if applicable) is subject to a benefit maximum of 400% of the CI Principal Sum in effect for the Insured Person. Any benefits paid for the health screening benefit are not applied toward the benefit maximum.

If the CI benefits paid for an Insured Person reach the benefit maximum, all insurance under the Policy for the Insured Person will terminate. Insurance for any other Insured Persons will remain in effect, subject to this maximum. If insurance terminates for You under this provision, Your Dependent(s), if applicable, may remain insured provided You continue to satisfy the eligibility requirements of the Policy.

LIMITATIONS AND EXCLUSIONS

Exclusions

The definitions of each Critical Illness provided in the Definitions section of this Certificate indicate which conditions are included and excluded for each Critical Illness. Please read each definition carefully.

We will not pay benefits for any Critical Illness that:

a) results, whether the Insured Person is sane or insane, from:
    1. an intentionally self-inflicted Injury or Illness; or
    2. suicide or attempted suicide;
b) results from an act of declared or undeclared war or armed aggression;
c) is incurred while the Insured Person is on active duty or training in the Armed Forces, National Guard or Reserves of any state or country and for which any governmental body or its agencies are liable;
d) results from participation in an illegal occupation;
e) is sustained or contracted in consequence of an Insured Person's being intoxicated or under the influence of any controlled substance unless administered on the advice of a Physician; or
f) is Diagnosed outside of the United States.

PAYMENT OF CLAIMS

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

NOTICE OF CLAIM AND CLAIM FORMS

Before benefits are paid, We must be given written proof of claim as described in the Proof of Claim section below.

As an option, notice of claim may be made to Us within 20 days, or as soon as reasonably possible, after an Insured Person has been Diagnosed with a Critical Illness. The notice should include:

1. The Policyholder's name and the Policy number or group number.
2. The Insured Person's name and mailing address.
3. Your name, mailing address and relationship to the Insured Person, if You are not the Insured Person for whom the claim is being filed.
4. The Claimant's name and mailing address, if the Claimant is other than You or the Insured Person.

Failure to give notice within this time frame shall not invalidate nor reduce any claim.

If notice of claim is given to Us, within 15 days We will provide the requested or necessary claim form(s), instructions and assistance to You, the Insured Person, or the beneficiary, or to the Policyholder for delivery to You, the Insured Person, or the beneficiary. A claim form can also be obtained at any time through Our website.

If We do not provide the requested or necessary form(s) within 15 days, written proof of claim may be submitted that includes the nature, date, cause and extent of the loss for which claim is made, in addition to the information listed previously in this section.

HOW TO OBTAIN PLAN BENEFITS

Forward the completed claim form to:
United of Omaha Life Insurance Company
Mutual of Omaha Plaza
Omaha, Nebraska 68175

CLAIM ASSISTANCE

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

PROOF OF CLAIM

We must be given written proof of claim within 90 days from the date of Diagnosis of a Critical Illness for an Insured Person. Failure to furnish such proof within this time period shall not invalidate nor reduce any claim if:

a) it was not reasonably possible to give proof within that 90-day period; and
b) proof is furnished as soon as reasonably possible, but not later than one year after the date of Diagnosis or loss, except in the absence of legal capacity.

We may require supporting information which may include, but which is not limited to, the following:

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

PHYSICAL EXAMINATION AND AUTOPSY

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

PAYMENT OF CLAIMS

Benefits will be paid immediately after We receive acceptable proof of claim and confirm liability.

Unless You have assigned this insurance, critical illness (CI) benefits for any Insured Person will be paid to You, except benefits unpaid at Your death or payable due to Your death will be paid to:

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

In the event benefits under the Policy are payable to Your estate, or to a minor or person otherwise not competent to give a valid release, We may pay an amount not exceeding $1,000 to any relative by blood or connection by marriage who is deemed by Us to be equitably entitled thereto. Any payment made by Us in good faith pursuant to this provision shall fully discharge Us to the extent of such payment.

BENEFICIARY DESIGNATION

In the event of Your death, a beneficiary should be designated to receive any benefits under the Policy that are unpaid at the time of Your death. Beneficiary records will be kept by the Policyholder, Plan Administrator or the office where beneficiary records for the Policy are kept. The most current beneficiary designation in effect under a Prior Plan will be accepted as a beneficiary designation under the Policy until changed (if applicable).

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

Your beneficiary may be changed at any time by You or Your assignee (if You have assigned this insurance). To make a change, a Written Request should be provided to the Policyholder, Plan Administrator or to the office where beneficiary records for the Policy are kept. If You do not know where the records are kept, then the Written Request may be sent to Us. When received by the Policyholder or Us, the change will take effect as of the date the Written Request is signed. The change will not apply to any payments or other action taken by Us before the Written Request was received.

CHANGE OF BENEFICIARY

The right to change of beneficiary is reserved to You, and the consent of the beneficiary or beneficiaries shall not be requisite to any change in beneficiary.

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 of acceptable form and content; 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.

MODE OF PAYMENT

CI benefits will be paid by Us in one lump sum.

REFUND TO US

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

We also have a right to a refund for any payments due to:

a) fraud or misrepresentation;
b) any error We make in processing a claim;
c) You or Your agent's failure to provide complete information; or
d) an Insured Person not being eligible for coverage.

You or the recipient of benefits must reimburse Us in full. We will determine the method by which the repayment is to be made, including without limitation, reducing or withholding any benefits payable to You, Your survivor(s) or Your estate under this or any other group insurance policy issued by Us. We will credit any such payments to the refund until the refund is fully recovered.

If it is found that We paid less benefits than We should have paid under the Policy, We will make additional payment(s), as necessary.

CLAIM REVIEW AND APPEAL PROCEDURES

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

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

CLAIM REVIEW PROCEDURES

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

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

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

INITIAL CLAIM DECISION

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

a) initial claim decision period: 45 days unless additional information is requested as set forth below;
b) extension period: 30 days; and
c) maximum number of extensions: 2.

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

CLAIM DENIALS

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

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

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

OPPORTUNITY TO REQUEST AN APPEAL

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

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

1. The Policyholder's name and the Policy number or group number.
2. The Insured Person's name and mailing address.
3. The name and mailing address of the Claimant filing the appeal, if different from the Insured Person.
4. The nature of the appeal.

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

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

RESPONSE TO APPEALS

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

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

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

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

STANDARD PROVISIONS

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

INSURANCE CONTRACT

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

The Policy (the application of the Policyholder, if any, and the individual applications, if any, of the Employees) constitute(s) the entire contract between the parties, and any statement made by the Policyholder or by any Employee shall, in the absence of fraud, be deemed a representation and not a warranty. No such statement shall be used in defense to a claim hereunder unless it is contained in a written application.

CHANGES IN THE INSURANCE CONTRACT

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

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

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

No change in the Policy shall be valid unless approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change the Policy or waive any of its provisions.

TIME LIMIT ON CERTAIN DEFENSES

After the Policy has been in force for a period of three years, no statements of the Policyholder contained in the application, and no statement relating to insurability made by any Employee eligible for coverage under the Policy shall be used to deny a claim or in contesting the validity of the insurance with respect to which such statement was made after the insurance has been in force prior to the contest for a period of three years during the lifetime of the person with respect to whom any such statement was made.

No claim for loss incurred (as defined in the Policy) commencing after three years from the effective date of the insurance coverage with respect to which the claim is made shall be reduced or denied on the ground that a disease or physical condition, not excluded from coverage by name or specific description effective on the date of loss, had existed prior to the effective date of the coverage with respect to which the claim is made.

LEGAL ACTIONS

No action at law or in equity shall be brought to recover on the Policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of the Policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

MISSTATEMENT OF AGE

If the age of any Insured Person insured under the Policy has been misstated, the amount payable shall be such as the premium paid for the insurance for the Insured Person would have purchased at the correct age.

CONFORMITY WITH STATE STATUTES

Any provision of the Policy which, on its effective date, is in conflict with the statutes of the state in which an Insured Person resides on such date is hereby amended to conform to the minimum requirements of such statutes.

DEFINITIONS

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

Actively Working, *Active Work* means an Employee is:

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

An Employee will be considered to be actively working on any day that is a regular paid holiday or day of vacation, or regular or scheduled non-working day, provided the Employee was actively working on the last preceding regular work day.

Acute Respiratory Distress Syndrome (ARDS) means Diagnosis of acute respiratory failure that results in inadequate oxygenation due to aspiration or infection. Diagnosis must be made by a qualified Physician. Evidence of infiltrates in both lungs in the absence of clinical heart failure and acute lung injury confirmed by testing of blood gases is required.

Adolescence means any biological age from age 12 through age 18.

Advanced Alzheimer's Disease means Diagnosis of Alzheimer's disease that has progressed to a classification of Stage 6 or greater of the Functional Assessment Staging Test (FAST). Diagnosis must be made by a qualified Physician, and based on neurological examination and cognitive testing for the involved condition/illness. There must be permanent clinical loss of the ability to do all of the following: remember, reason, and perceive; and understand, express and give effect to ideas. Other types of dementia are not included in this definition. Initial Diagnosis of Alzheimer's disease must occur while the Insured Person is insured under the Policy.

Advanced Parkinson's Disease means Diagnosis of Parkinson's disease that has progressed to a classification of Stage 4 or greater. There must be permanent clinical impairment of motor function with associated tremor, muscle rigidity and postural instability. Diagnosis must be made by a qualified Physician, and based on neurological examination and the results of imaging studies for the involved condition/illness. Parkinson's disease secondary to drug abuse is not included in this definition. Initial Diagnosis of Parkinson's disease must occur while the Insured Person is insured under the Policy.

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

ALS (Lou Gehrig's) Disease means Diagnosis of amyotrophic lateral sclerosis (ALS or Lou Gehrig's Disease). Diagnosis must be made by a qualified Physician according to the diagnostic criteria for the involved condition/illness. Other motor neuron diseases are not included in this definition. Initial Diagnosis of amyotrophic lateral sclerosis must occur while the Insured Person is insured under the Policy.

Aortic Surgery means Diagnosis of the need for surgery for disease to the aorta with excision and surgical replacement of a portion of the diseased aorta with a graft. The thoracic and abdominal aorta are included, but branches of the aorta are not included. Angiographic evidence to support the necessity of the surgery is required. Diagnosis must be made by a qualified Physician. The need for any other surgical procedures, such as stent placement or endovascular repair, or surgery following traumatic injury to the aorta, are not included in this definition.

Attained Age means the age of the Insured Person as of the Policy Anniversary that coincides with or follows the Insured Person's birthday. For example, if an Insured Person's 50th birthday is on April 1, 2023 and the Policy Anniversary is January 1, the Insured Person will reach the attained age of 50 on January 1, 2024.

Benefit Category means a grouping of similar Critical Illnesses as shown in the CI Table in the Critical Illness Insurance Benefits section of the Policy.

Bone Marrow Transplant means Diagnosis of the need for an autologous or allogeneic transplant of bone marrow or stem cells, necessitated by compromise of the bone marrow's ability to appropriately produce blood cells. Diagnosis must be made by a qualified Physician. The need for transplant of any other organs, parts of organs, tissues or cells is not included in this definition.

Cerebral Palsy means Diagnosis made during Childhood of cerebral palsy, which is the group of non-progressive disorders of movement and posture caused by abnormal development of or damage to the motor control centers of the brain. Evidence

of significant disturbances of sensation, cognition, communication, perception and/or behavior, or a seizure disorder is required. Diagnosis must be made by a qualified Physician, and confirmed by diagnostic testing after the child reaches the biological age of 18 months. Other similar conditions such as degenerative nervous disorders, genetic diseases, muscle diseases, metabolic disorders, nervous system tumors, coagulation disorders, or other injuries or disorders which delay early development (but can be outgrown) must be ruled out and are not included in this definition.

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

Childhood means any biological age from birth through age 11.

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

Clinical Diagnosis means a Diagnosis based on the study of symptoms and diagnostic test results. We will accept a clinical diagnosis if the diagnosis is consistent with professional medical standards and the following conditions are met:

a) medical evidence exists to support the Diagnosis; and
b) a Physician is treating the Insured Person for Invasive Cancer and/or Non-Invasive Cancer (Carcinoma in Situ).

Congenital Metabolic Disorders means Diagnosis made during Childhood of any of the following: Gaucher's disease (excluding type I); glutaric acidemia type 1; glycogen storage disease types I, II, IV and VII; infantile Tay-Sachs disease; Lesch-Nyhan syndrome; Niemann-Pick disease; or Zellweger syndrome. Diagnosis must be made by a qualified Physician, and based on screening or diagnostic tests, including gas chromatography/mass spectrometry (GC/MS) testing if available. A prenatal diagnosis of one or more of these defects/disorders for an eligible Dependent child is included in this definition upon the live birth of the Dependent child. In the event of a prenatal diagnosis, the date of Diagnosis under the Policy for the defect/disorder(s) will be the date of birth of the Dependent child.

Coronary Artery Bypass means Diagnosis of the need for surgery requiring median sternotomy (surgery to divide the breastbone) to correct narrowing or blockage of one or more coronary arteries with by-pass grafts. Angiographic evidence to support the necessity of the surgery is required. Diagnosis must be made by a qualified Physician. Balloon angioplasty, laser embolectomy, atherectomy, stent placement or other non-surgical procedures are not included in this definition.

Critical Illness means any illness shown in the CI Table in the Critical Illness Insurance Benefits section of the Policy for which an Insured Person is Diagnosed after the effective date of insurance under the Policy for the Insured Person. This definition does not include the reoccurrence of a cancer that was previously diagnosed before the effective date of insurance for an Insured Person unless, after the previous diagnosis and before the date of the subsequent diagnosis, the Insured Person is free of any Treatment of the cancer during the 12 consecutive months prior to the effective date of insurance under the Policy for the Insured Person, or any 12 consecutive months thereafter.

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

a) Your Spouse;
b) Your natural born or legally adopted child;
c) a child who is a party to a suit in which You are seeking to adopt the child;
d) Your stepchild or child of Your domestic or civil union partner or equivalent;
e) a child that You or Your Spouse are required to provide insurance for under the terms of a:
    1. Qualified Medical Child Support Order (QMCSO), National Medical Support Notice or equivalent; or
    2. decree, judgment or order issued by a court of competent jurisdiction; or
f) any other child who lives with You in a regular parent/child relationship and who qualifies as Your "dependent" as defined in the United States Internal Revenue Code.

A dependent does not include:

a) anyone who is a member of the Armed Forces, National Guard or Reserves of any state or country on active duty (except for temporary duty of 31 days or less);
b) Your divorced, legally separated or former Spouse;
c) a child who has reached the age of 26 unless the child is Incapacitated;
d) a child who is not dependent upon You for support and maintenance;
e) Your child if the child has been legally adopted by another person; or
f) a child placed in Your home by a social service agency which retains control over the child.

Diagnosed or *Diagnosis* means the definitive establishment of a Critical Illness as defined in this section of the Policy.

Eligibility Waiting Period means a continuous period of Active Work that an Employee must satisfy before becoming eligible for insurance as described in the When an Employee Becomes 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) performing work for the Policyholder at:
    1. the Policyholder's usual place of business;
    2. an alternative work site at the direction of the Policyholder; or
    3. a location to which the employee must travel to perform the job.

An employee does not include a person:

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

End Stage Renal (Kidney) Failure means Diagnosis of chronic and end stage (irreversible) failure of both kidneys to function, as a result of which the need for regular (at least weekly) dialysis or transplant is recommended to sustain life. Diagnosis must be made by a qualified Physician. Renal failure caused by a traumatic event or surgical trauma is not included in this definition.

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

Family means Your Spouse, former Spouse, children, parents, grandparents, grandchildren, brothers, sisters and the spouses (or domestic partners or equivalent) of such individuals, or Your Spouse's relatives of like degree.

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

Genetic Disorders means Diagnosis made during Childhood of any of the following: infantile onset ascending spastic paralysis; cystic fibrosis; Down syndrome; juvenile primary lateral sclerosis; muscular dystrophy; ostogenesis imperfecta (excluding type I); spinal muscular atrophy type I or II; or Vascular Ehlers-Danlos syndrome. Diagnosis must be made by a qualified Physician, and based on genetic testing. A prenatal diagnosis of one or more of these defects/disorders for an eligible Dependent child is included in this definition upon the live birth of the Dependent child. In the event of a prenatal diagnosis, the date of Diagnosis under the Policy for the defect/disorder(s) will be the date of birth of the Dependent child.

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

Health Screening Test means any of the following: abdominal aortic aneurysm ultrasound; blood test for triglycerides; bone marrow testing; bone density screening; breast ultrasound; CA 15-3 (blood test for breast cancer); CA 125 (blood test for ovarian cancer); carotid ultrasound; CEA (blood test for colon cancer); cervical cancer screening; chest X-ray; colonoscopy; CT angiography; EKG; double contrast barium enema; fasting blood glucose test; flexible sigmoidoscopy; hemoccult stool analysis; mammography; pap smear; PSA (blood test for prostate cancer); serum cholesterol test (for HDL and LDL levels); SPEP (blood test for myeloma); stress test (on a bicycle or treadmill); or thermography. Any other generally medically accepted cancer screening test is also included.

Heart Attack (Myocardial Infarction) means Diagnosis of the death of a portion of the heart muscle (myocardium) due to inadequate blood supply that has resulted in all of the following evidence of acute myocardial infarction:

a) typical physical symptoms (characteristic chest pain, for example);
b) new and serial characteristic electrocardiographic (EKG) changes consistent with myocardial infarction; and
c) the characteristic rise of cardiac enzymes, biochemical markers or Troponins recorded at the following levels or higher:
    1. Troponin T > 1.0 ng/ml; or
    2. AccuTnl > 0.5 ng/ml or equivalent threshold with other Troponin I methods.

The evidence must show a definite acute myocardial infarction. Diagnosis must be made by a qualified Physician. Diagnosis of other acute coronary syndromes (including but not limited to angina or established (old) myocardial infarction), any other disease or injury involving the cardiovascular system, or cardiac arrest not caused by a myocardial infarction are not included in this definition.

Heart Transplant/Placement on OPTN/UNOS List means Diagnosis of the need for transplantation of a healthy human heart, or inclusion on the Organ Procurement and Transplantation Network/United Network for Organ Sharing (OPTN/UNOS) waiting list for such a procedure, necessitated by the diagnosis of end-stage heart disease. Diagnosis must be made by a qualified Physician. The transplant of any other organs, parts of organs, tissues or cells is not included in this definition.

Heart Valve Surgery means Diagnosis of the need for surgery requiring median sternotomy (surgery to divide the breastbone) to replace or repair one or more heart valves. Diagnosis must be made by a qualified Physician. Evidence to support the necessity of the surgery is required.

Hospital means a facility that:

a) is accredited, approved, certified or licensed by the proper authority of the state in which it is located to provide care and treatment for injured or sick people on an inpatient basis;
b) is recognized as a general hospital by the Joint Commission;
c) provides 24-hour nursing service by Registered Nurses (RNs); and
d) has organized facilities and equipment for diagnosis and treatment of acute medical and surgical conditions on its premises or in facilities available to it on a prearranged basis.

A hospital does not include a facility or institution, or part thereof, which is licensed or used principally as a:

a) clinic (including dental, mental illness or substance abuse facilities), ambulatory medical center or urgent care center;
b) convalescent home, rest home, nursing home or home for the aged;
c) halfway house; or
d) rehabilitative, alternate care, extended care, skilled nursing or board and care facility.

Incapacitated means that a Dependent child, by reason of intellectual disability, developmental disability, mental illness or physical handicap, is continuously incapable of:

a) performing self-care activities (such as bathing, dressing, eating or moving, if younger than the age of 26; or
b) self-sustaining employment, if older than the age of 26.

Injury, Injuries means an accidental bodily injury that requires treatment by a Physician.

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

Invasive Cancer means Diagnosis of any malignant tumor or neoplasm with histological confirmation, characterized by the uncontrolled growth of malignant cells and invasion of tissue beyond the initial tissue. Diagnosis must be made by a Physician, and based upon Pathological Diagnosis or Clinical Diagnosis. The term “malignant tumor” includes leukemia, lymphoma and sarcoma. Malignant melanoma or other skin malignancies that have been histologically classified as having caused invasion beyond the epidermis (the outer layer of skin) with: a Clark’s level III or greater; Breslow’s depth of .75mm or greater; or AJCC TNM stage II or greater; are included in this definition.

Conditions which are not considered invasive cancer are not included in this definition, including all cancers which are defined as Non-Invasive Cancer (Carcinoma in Situ) in the Policy.

Major Organ Transplant/Placement on OPTN/UNOS List means the diagnosis of the need for transplantation of a healthy, complete human liver, lung, pancreas, small intestine or large intestine, or inclusion on the Organ Procurement and Transplantation Network/United Network for Organ Sharing (OPTN/UNOS) waiting list for such a procedure, necessitated by the diagnosis of end-stage organ disease (organ failure). Diagnosis must be made by a qualified Physician. The need for organ transplant as a direct result of life-threatening cancer, or the transplant of any other organs, parts of organs, tissues or cells, is not included in this definition.

Non-Invasive Cancer (Carcinoma in Situ) means Diagnosis of cancer in which the tumor or cells still lie within the tissue of origin without having invaded neighboring tissue or regional lymph nodes. Diagnosis must be made by a Physician, and be based upon Pathological Diagnosis or Clinical Diagnosis. Non-invasive cancer includes, but is not limited to:

a) early prostate cancer that is histologically classified as AJCC TNM Stage T1N0M0 or equivalent staging (prostate cancer that has not spread outside the prostate);

b) early breast cancer that is histologically classified as AJCC TNM Stage T1N0M0 or equivalent staging (breast cancer that has not spread outside the breast); and
c) 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 POLICY PAYS NO BENEFITS FOR BASAL CELL CARCINOMA, SQUAMOUS CELL CARCINOMA PRE-MALIGNANT LESIONS, BENIGN TUMORS OR BENIGN POLYPS.

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

Partial Benefit means a Critical Illness for which the benefit payable is less than 100% of the CI Principal Sum, as shown in the CI Table in the Critical Illness Insurance Benefits section of the Policy.

Pathological Diagnosis means a Diagnosis of Invasive Cancer or Non-Invasive Cancer (Carcinoma in Situ) based upon a microscopic study of fixed tissue or preparations from the hemic (blood) system. Diagnosis must be made by a qualified Physician. The date of Diagnosis under the Policy for Invasive Cancer or Non-Invasive (Carcinoma in Situ) is the day the tissue, preparation or culture are taken.

Physician means a legally qualified medical doctor licensed to practice medicine, prescribe drugs, perform surgery, or where required by state law, any other licensed practitioner of a healing art who is deemed to be the same as a legally qualified medical doctor. The physician must be acting within the scope of his/her license. A physician does not include the Insured Person or any Family member.

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

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

Policy Anniversary means January 1 of each Policy Year.

Policy Effective Date means January 1, 2023.

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

Prior Plan means any similar insurance policy:
a) replaced by insurance under part or all of the Policy; and
b) in effect and maintained or sponsored by the Policyholder on the day before the Policy Effective Date.

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

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

Spouse means the person to whom You are legally married, or Your domestic partner, civil union partner or equivalent, as recognized and allowed by applicable federal law, state law, or law of the county, city or local government in Your jurisdiction of residence. For residents of California, domestic partners are defined in California Family code Section 297.

Stroke means Diagnosis of the death or permanent damage of brain tissue due to inadequate blood supply or hemorrhage within the skull resulting in permanent neurological deficit with persisting clinical symptoms, categorized with a score of 3 or higher on the modified Rankin Scale (mRS). Diagnosis must be made by a qualified Physician, and damage evidenced by computerized axial tomography (CAT scan) or magnetic resonance imaging (MRI) and examination demonstrating lasting neurological deficits.

This definition does not include: Transient ischaemic attack; traumatic or infection-caused injury to brain tissue or blood vessels; brain injury associated with hypoxia, anoxia or hypotension; vascular disease affecting the eye or optic nerve; chronic cerebrovascular insufficiency; and ischemic disorders of the vestibular system. A transient ischaemic attack (also known as a "TIA" or "mini-stroke") is an event with stroke symptoms that, like a stroke, is caused by a blood clot. The only difference between a stroke and TIA is that with TIA the blockage is transient (temporary). TIA symptoms occur rapidly and

last a relatively short time. When a TIA is over, there is usually no permanent injury to the brain, whereas with a stroke, there is permanent injury to the brain.

Structural Congenital Defects means Diagnosis made during Childhood of any of the following: anal atresia; anencephaly; bilary atresia; cleft lip and/or palate; club foot; coractation; diaphragmatic hernia; gastroschisis; Hirschsprung's disease; hypoplastic left heart system; omphalocele; patent ductus arteriosis; pyloric stenosis; spina bifida; tetralogy of fallot; or transposition of the great arteries. Diagnosis must be made by a qualified Physician, and confirmed by diagnostic testing if applicable. A prenatal diagnosis of one or more of these defects/disorders for an eligible Dependent child is included in this definition upon the live birth of the Dependent child. In the event of a prenatal diagnosis, the date of Diagnosis under the Policy for the defect/disorder(s) will be the date of birth of the Dependent child.

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

Treatment means medical care or services (including diagnostic measures) received by an Insured Person, or the use of drugs or medicines by an Insured Person. For Invasive Cancer or Non-Invasive Cancer (Carcinoma in Situ), this definition does not include routine follow-up visits with a Physician to verify whether or not the cancer has returned, or maintenance drug therapy (ongoing hormonal therapy, immunotherapy or chemo-prevention therapy that is intended to decrease the risk of cancer reoccurrence following the full remission of a cancer.

Type 1 Diabetes means Diagnosis made during Childhood or Adolescence of diabetes that results from auto-immune destruction of insulin producing cells in the pancreas. Confirmation of the cause of low insulin production is required. Diagnosis must be made by a qualified Physician, and based on blood tests.

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

You, Your means the Employee who is 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 Mutual of Omaha Plaza, Omaha, Nebraska 68175.

EMPLOYER IDENTIFICATION NUMBER AND PLAN NUMBER

The Employer Identification Number (EIN) is: 77-0288215
The Plan Number is: 501

PLAN ADMINISTRATOR

The Plan is provided through and administered by:

Legacy Transportation Services Inc.
935 McLaughlin Avenue
San Jose, CA 95122
Phone: (408) 294-8800

AGENT FOR SERVICE OF LEGAL PROCESS

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

Legacy Transportation Services Inc.
935 McLaughlin Avenue
San Jose, CA 95122
Phone: (408) 294-8800

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

Legacy Transportation Services Inc.

Group Number: G000C35S

United of Omaha Life Insurance Company

Home Office:
Mutual of Omaha Plaza
Omaha, Nebraska 68175

