YOUR GROUP VOLUNTARY ACCIDENT BENEFITS

FOR EMPLOYEES OF:

Corient Services LLC

CLASS(ES): All Eligible Employees

EFFECTIVE DATE: January 1, 2025

PUBLICATION DATE: December 4, 2024

NOTICE(S)

THE POLICY PROVIDES LIMITED BENEFITS. THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR HOSPITAL OR MEDICAL EXPENSE INSURANCE, A HEALTH MAINTENANCE ORGANIZATION (HMO) CONTRACT, OR MAJOR MEDICAL EXPENSE INSURANCE.

THE INSURANCE PROVIDED UNDER THE POLICY DOES NOT SATISFY THE INDIVIDUAL MANDATE OF THE ACA BECAUSE THE COVERAGE DOES NOT MEET THE REQUIREMENTS OF MINIMUM ESSENTIAL COVERAGE. CONSUMERS MAY BE LIABLE FOR A FEDERAL TAX PENALTY UNLESS THEY PURCHASE A HEALTH BENEFIT PLAN (OR PLANS) THAT PROVIDE MINIMUM ESSENTIAL COVERAGE.

THE POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. IT DOES NOT FULLY SUPPLEMENT FEDERAL MEDICARE HEALTH INSURANCE. IF YOU ARE ELIGIBLE FOR MEDICARE, REVIEW THE *GUIDE TO HEALTH INSURANCE FOR PEOPLE WITH MEDICARE*, AVAILABLE FROM US OR ONLINE AT WWW.MEDICARE.GOV.

PLEASE READ YOUR CERTIFICATE CAREFULLY. THIS CERTIFICATE DESCRIBES THE BENEFITS THAT ARE AVAILABLE TO YOU UNDER THE POLICY. THE POLICY ONLY PAYS BENEFITS FOR ACCIDENTAL INJURIES AND TREATMENT OF ACCIDENTAL INJURIES AS LISTED IN THE CERTIFICATE. THE POLICY IS ISSUED IN THE STATE OF FLORIDA AND PROVIDES ALL OF THE BENEFITS REQUIRED BY APPLICABLE FLORIDA LAW.

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

Group Number: G000C29G

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IMPORTANT NOTICE TO PERSONS ON MEDICARE

THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

This insurance pays limited benefits, if you meet the conditions listed in the policy, for treatment and conditions that result from an accidental injury. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

- any expense or services covered by the policy are also covered by Medicare; or
- it pays the fixed dollar amount stated in the policy and Medicare covers the same event

Medicare generally pays for most of all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice care
- outpatient prescription drugs if you are enrolled in Medicare Part D
- other approval items and services

BEFORE YOU BUY THIS INSURANCE

✓ Check the coverage in **all** health insurance policies you already have.

✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company or at *www.medicare.gov*.

✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

NOTICE(S)

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

United of Omaha Life Insurance Company
Mutual of Omaha Plaza
Omaha, Nebraska 68175
Call Toll-Free: 1-800-948-9478
www.mutualofomaha.com

When contacting Us, please have Your Policy number available.

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

Premium amounts for insurance under the Policy are subject to change.

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CERTIFICATE OF INSURANCE

UNITED OF OMAHA LIFE INSURANCE COMPANY

Home Office:
Mutual of Omaha Plaza
Omaha, Nebraska 68175

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

United of Omaha Life Insurance Company certifies that Group Policy Number GUDH-C29G (the Policy) has been issued to Corient Services LLC (the Policyholder). The Policy provides Group Accident Insurance.

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

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

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

This Certificate replaces any certificate previously issued under the Policy.

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

James T. Blackledge
Chief Executive Officer

Jay A. Vankat
Corporate Secretary

SCHEDULE

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

CLASS(ES)

All Eligible Employees

ACCIDENT INSURANCE

Accident insurance offers financial protection for You and Your insured Dependent(s) by paying a benefit if You or an insured Dependent are Injured in an Accident. The benefit amount(s) payable is/are based on the type and amount of insurance in effect on the date the Accident occurs, subject to the definitions, limitations, exclusions and other provisions of the Policy.

You may elect insurance for Yourself and Your Dependent(s) under this Certificate for one of the following coverage options:

a) Yourself only;
b) You and Your Spouse;
c) You and Your Dependent child(ren); or
d) You, Your Spouse and Your Dependent child(ren).

Unless otherwise stated in this Certificate, the benefit amount payable is the same for You and Your insured Dependent(s). If You have questions regarding who is insured for accident insurance, You may contact the Policyholder.

Plan Type

This Certificate represents the accident insurance available under Full Plan 9H (FL-NC-CAT-NABM), as selected by the Policyholder. If You have questions regarding the plan type, You may contact the Policyholder.

Coverage Type

This Certificate provides insurance for Accidents that occur any time of day, regardless of whether You or Your insured Dependent(s) are working or not. This is known as “24-hour coverage” or “on and off-job coverage.”

EXPRESS BENEFIT

If You or an insured Dependent are Injured as the result of an Accident, We will pay a benefit amount of $200 upon notification of the Accident. The benefit can be paid in a very short time frame and based on minimal information (compared to a typical Accident claim).

This benefit is payable once per Accident for each Insured Person that is Injured as a result of the Accident. This benefit is subject to all of the applicable definitions, limitations, exclusions and other provisions of the Policy.

BASIC BENEFITS

The basic benefits payable under this Certificate are organized into the following categories:

Category	Benefit Amount
Initial Care & Emergency	Up to $2,500
Specified Injuries	Up to $25,000
Hospital, Surgical & Diagnostic	Up to $1,400 per day and $2,500 for admission
Follow-Up Care	Up to $1,750

Within each category, benefits are payable up to the amount shown, depending on the type of Injury sustained or the type of medical Treatment that is received as the result of an Accident. The specific benefit amounts, conditions and limitations that

are applicable to each Injury or Treatment are available in the applicable benefits section of this Certificate for each category. (For example, specific information for the Initial Care & Emergency category can be located in the section titled "Initial Care & Emergency Benefits.")

ADDITIONAL BENEFIT(S)

In addition to Basic Benefits, family care benefits (benefits for transportation, Lodging and Childcare) and a health screening benefit are available under this Certificate.

The specific benefit amounts, conditions and limitations that are applicable to the additional benefit(s) are available in the Additional Benefit(s) section of this Certificate.

CATASTROPHIC INSURANCE

In addition to Basic Benefits, benefits for catastrophic losses and Injuries are available under this Certificate.

Catastrophic insurance pays a benefit if You or an insured Dependent are in an Accident and experience a serious loss or Injury, such as death or dismemberment. The benefit amount payable is based on the amount of insurance that is in effect for You or an insured Dependent on the date the Accident occurs, subject to the definitions, limitations, exclusions and other provisions of the Policy.

Provided You have elected accident insurance, Your amount of catastrophic insurance is $75,000.

Provided You have elected accident insurance for Your Spouse, Your Spouse's amount of catastrophic insurance is $50,000.

Provided You have elected accident insurance for Your Dependent child(ren), the amount of catastrophic insurance for Your Dependent child(ren) is $20,000.

The amount of catastrophic insurance is also referred to as the Principal Sum. The Principal Sum for You or Your Spouse reduces by 50% when You reach the Attained Age of 70. If You have questions regarding the amount of catastrophic insurance for You or Your Dependent(s), You may contact the Policyholder.

The specific conditions and limitations that are applicable to catastrophic insurance are available in the Catastrophic Benefits section of this Certificate.

GUARANTEE ISSUE AMOUNT(S) AND EVIDENCE OF INSURABILITY

All amounts of insurance under the Policy are guarantee issue. Evidence of insurability (proof of good health) is not required for any amount of insurance under the Policy.

Insurance under the Policy is only available if the total number of Employees insured under the Policy attains or remains above 5 Employees or 12% of the eligible Employees, whichever is greater. If the total number falls below the required level, insurance may be reduced, rescinded or terminated.

ELIGIBILITY

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

WHEN AN EMPLOYEE BECOMES ELIGIBLE FOR INSURANCE

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

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

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

WHEN A DEPENDENT BECOMES ELIGIBLE FOR INSURANCE

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

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

provided You elect insurance for yourself under the Policy.

If both You and Your Spouse are eligible for insurance under the Policy as Employees of the Policyholder;

a) neither You nor Your Spouse may elect insurance as a Dependent of the other person under the Policy; and
b) either You or Your Spouse may elect insurance for Your Dependent child(ren) under the Policy, but not both.

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

CONTINUITY OF INSURANCE UPON TRANSFER OF INSURANCE CARRIER

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

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

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

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

Insurance under this provision is subject to uninterrupted payment of premium to Us when due.

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

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

Insurance under this provision will end on the earliest of:

a) the day the Employee returns to Active Work for the Policyholder or begins employment with any other employer;

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

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

WHEN INSURANCE BEGINS

An Employee must enroll for any insurance requiring an election by submitting a Written Request for insurance for the Employee and any Dependent(s). The Written Request must be submitted to the Policyholder no later than 31 days following the day the Employee or Dependent(s) become(s) eligible. If the Written Request for insurance is not submitted within the required time frame, the Employee and/or Dependent(s) may not enroll until a Subsequent Enrollment Period is offered.

An Employee will become insured on the latest of the day:
a) the Employee becomes eligible and is Actively Working; or
b) the Employee submits a Written Request to enroll for insurance, if required.

An eligible Dependent will become insured on the latest of the day:
a) the Employee becomes insured;
b) the Employee acquires the eligible Dependent; or
c) the Employee submits a Written Request to enroll the Dependent for insurance, if required.

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

Insurance for a newborn Dependent child begins at the moment of live birth. Insurance for a newly adopted newborn Dependent child begins with the date of placement into Your custody, or at the moment of live birth if a written agreement to adopt the child was previously entered into by You. If Dependent child insurance requires an election and Dependent child insurance for any other child(ren) is not already in effect under the Policy, a Written Request for insurance for any newborn or newly adopted Dependent child(ren) must be submitted to the Policyholder within 60 days following the day the Dependent child(ren) become(s) eligible in order to continue insurance beyond the 60-day period.

EXCEPTIONS TO WHEN INSURANCE BEGINS (DEFERRED EFFECTIVE DATE)

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

Insurance for an Employee or Dependent who is:
a) confined in a Hospital as an inpatient;
b) confined in any institution or facility other than a Hospital; or
c) confined at home and under the care or supervision of a Physician;

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

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

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

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

THE FIRST ENROLLMENT PERIOD

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

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

SUBSEQUENT ENROLLMENT PERIODS

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

WHEN ELECTION CHANGES ARE PERMITTED

An Employee may elect, drop, increase, decrease or change insurance as allowed by the Policyholder.

Life Events

If You experience a Life Event and You are currently insured under the Policy, You may submit a Written Request to change insurance within 31 days of the Life Event. If the Written Request is submitted more than 31 days after the date of a Life Event, You may not change insurance until a Subsequent Enrollment Period is offered.

An Employee who experiences a Life Event who previously declined insurance under the Policy may not enroll until a Subsequent Enrollment Period is offered.

CHANGES TO INSURANCE BENEFITS

Any allowable change in the benefits, class, plan type (as shown in Schedule) or amount of insurance for any Insured Person, whether requested by You or the Policyholder, or as a result of the terms of the Policy, will take effect on the first day of the month that follows the date of the request or the change.

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

REINSTATEMENT OF INSURANCE

You may be eligible to reinstate insurance that has ended in accordance with this provision. For any insurance requiring an election, You must submit a Written Request to reinstate insurance within 31 days of Your return to Active Work. If the Written Request is submitted more than 31 days after the date You return to Active Work, You may not re-enroll for insurance until a Subsequent Enrollment Period is offered. If insurance is reinstated for You, insurance may also be reinstated for any eligible Dependent(s).

Reinstated insurance will take effect on the date of the Written Request. If You are not Actively Working on the day the reinstated insurance would otherwise take effect, insurance will become effective on the day after You return to Active Work.

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

Non-Payment of Premium or Voluntary Termination of Insurance

If insurance ended due to the non-payment of premium or voluntary termination of insurance by the Employee, the Employee may not re-enroll for insurance until a Subsequent Enrollment Period is offered.

Involuntary Reduction in Hours

If insurance ended because the Employee was no longer Actively Working due to an involuntary reduction of hours worked, insurance may be reinstated if the Employee returns to Active Work within 90 days from the date insurance ended.

Rehired Employee Due to Layoff or Termination

If insurance ended because the Employee was no longer Actively Working due to layoff or termination of employment with the Policyholder, insurance may be reinstated if the Employee is rehired and returns to Active Work within 90 days from the date insurance ended.

Rehired Employee Due to Leave of Absence

If insurance ended because the Employee was no longer Actively Working due to an approved leave of absence, insurance may be reinstated within 90 days from the date insurance ended upon return to Active Work. If insurance ended because the Employee was no longer Actively Working due to military leave, insurance may be reinstated upon return to Active Work within 31 days of discharge from active duty.

Transfer From Portability

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

WHEN INSURANCE ENDS

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

a) on the last day of the month in which You reach the Attained Age of 80;
b) on the last day of the month in which You are no longer eligible for insurance under the Policy;
c) on the last day of the month in which You begin active duty in the Armed Forces, National Guard or Reserves of any state or country (except for temporary active duty of 31 days or less);
d) on the day the Policy terminates; or
e) in accordance with the Grace Period provision.

Insurance for a Dependent will also end on the last day of the month in which the Dependent is no longer eligible for insurance under the Policy.

Insurance ending has no effect on benefits payable for any Accident that occurred by an Insured Person while insured under the Policy.

EXCEPTIONS TO WHEN INSURANCE ENDS

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

a) Continuation of Insurance for Layoff or Leave
b) Continuation of Insurance for Your Dependents in the Event of Your Death
c) Portability

CONTINUATION OF INSURANCE FOR LAYOFF OR LEAVE

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

PORTABILITY

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

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

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

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

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

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

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

The Group Accident Insurance Portability Policy

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

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

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

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

Notice of the Right to Continue Insurance Under this Provision

The portability period is the period of time that is 60 days from the date insurance under the Policy would otherwise end ("Portability Period"). When insurance under the Policy would otherwise end, notice of the right to continue insurance under this provision may be given. If notice is not given at least 15 days after the start of the Portability Period, an extension of the period of time in which to request continued insurance under this provision will be allowed. Any extension of the Portability Period will expire on the earlier of:

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

How to Request Continued Insurance Under this Provision

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

PREMIUM PAYMENTS

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

PAYMENT OF PREMIUMS THROUGH PAYROLL DEDUCTION

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

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

Payment of premium does not guarantee eligibility for coverage.

OPTIONS FOR PAYMENT OF PREMIUM FOR CONTINUED INSURANCE

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

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

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

Payment of premium does not guarantee eligibility for coverage.

GRACE PERIOD

All premiums must be paid within the grace period. There is a grace period of 31 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 31-day period that follows. We will consider premium to be paid on the date We receive it.

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

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

PREMIUMS AND PREMIUM CHANGES

The premium rate structure for accident insurance under the Policy is comprised of a monthly rate for each coverage option shown in the Schedule that applies to You and Your Dependent(s).

If You request a change in Your plan type (as shown in the Schedule) or the amount of insurance for any Insured Person, the Policyholder will provide You with notice of Your new premium amount upon request if You are responsible for the payment of premiums for insurance.

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

Premium amounts will change if premium rates under the Policy are changed.

INITIAL CARE & EMERGENCY BENEFITS

Capitalized terms used in this section have the meanings assigned to them in the Definitions section of this Certificate. The benefits described in this section are subject to all of the applicable definitions, limitations, exclusions and other provisions of the Policy.

INITIAL CARE

If more than one form of Initial Care is received by an Insured Person for the same Accident, We will only pay the highest of the following benefits for the Insured Person:

a) Emergency Room Benefit;
b) Urgent Care Center Benefit; or
c) Initial Physician Office Visit Benefit.

We will reduce the amount payable for Initial Care by the amount paid for the Express Benefit for an Accident for an Insured Person.

Emergency Room Benefit

We will pay a benefit amount of $400 if an Insured Person receives Treatment in an Emergency Room for one or more Injuries sustained as the result of an Accident within 72 hours after the Accident. This benefit is payable once per Accident for each Insured Person.

Urgent Care Center Benefit

We will pay a benefit amount of $325 if an Insured Person receives Treatment in an Urgent Care Center for one or more Injuries sustained as the result of an Accident within 5 days after the Accident. This benefit is payable once per Accident for each Insured Person.

Initial Physician Office Visit Benefit

We will pay a benefit amount of $200 if an Insured Person receives Treatment from a Physician or Medical Professional in such individual's office or clinic for one or more Injuries sustained as the result of an Accident within 30 days after the Accident. This benefit is payable once per Accident for each Insured Person.

EMERGENCY TRANSPORTATION

Ground Ambulance Benefit

We will pay a benefit amount of $900 if an Insured Person is transported by a licensed professional ambulance company to or from a Hospital or between medical facilities for Treatment of one or more Injuries sustained as the result of an Accident. The ambulance transportation must occur within 30 days after the Accident. This benefit is payable twice per Accident for each Insured Person.

Air Ambulance Benefit

We will pay a benefit amount of $2,500 if an Insured Person is transported by a licensed professional air ambulance company to or from a Hospital or between medical facilities for Treatment of one or more Injuries sustained as the result of an Accident. The ambulance transportation must occur within 72 hours after the Accident. This benefit is payable once per Accident for each Insured Person.

SPECIFIED INJURY BENEFITS

Capitalized terms used in this section have the meanings assigned to them in the Definitions section of this Certificate. The benefits described in this section are subject to all of the applicable definitions, limitations, exclusions and other provisions of the Policy.

If an Insured Person sustains both a Fracture and Dislocation (or multiple Fractures and Dislocations) as the result of the same Accident, the maximum amount payable for all Fractures and Dislocations under the Policy is up to 400% of the amount payable for the Fracture or Dislocation with the highest applicable Open Reduction or Closed Reduction benefit amount.

FRACTURES (BROKEN BONES)

Benefits

We will pay the applicable benefit amount shown in the Fracture Benefits Table if an Insured Person receives Closed Reduction (Non-surgical) or Open Reduction (Surgical) Treatment for a Fracture sustained as the result of an Accident. Treatment must occur by a Physician or Medical Professional within 90 days after the Accident.

If a Fracture is diagnosed as a Chip Fracture, We will pay 25% of the amount listed in the table for the Closed Reduction for the bone/bone group involved.

The maximum amount payable for all Fractures sustained by an Insured Person for the same Accident is up to 250% of the amount payable for the Fracture with the highest applicable Open Reduction or Closed Reduction benefit amount.

Fracture Benefits Table

Bone/Bone Group (From Head to Toe)	Open Reduction Amount	Closed Reduction Amount
Skull, depressed (Cranial bones)	$12,000	$6,000
Skull, non-depressed (Cranial bones)	$6,000	$3,000
Bones of face (Except nose and lower jaw)	$2,400	$1,200
Nose (Nasal bones)	$2,050	$1,025
Lower jaw (Mandible)	$2,400	$1,200
Shoulder blade (Scapula)	$2,400	$1,200
Collarbone (Clavicle)	$2,050	$1,025
Breastbone (Sternum)	$2,400	$1,200
Rib	$2,050	$1,025
Upper arm (Humerus)	$2,400	$1,200
Forearm (Radius and/or ulna)	$2,400	$1,200
Wrist (Carpals)	$2,400	$1,200
Hand (Metacarpals, except fingers)	$2,400	$1,200
Fingers (Phalanges)	$600	$300
Vertebral body (Except vertebral processes)	$6,000	$3,000
Vertebral process	$2,400	$1,200
Tail bone (Coccyx)	$2,050	$1,025
Pelvis (Except tail bone and hip bones)	$6,000	$3,000
Hip bones (Illium, ischium and/or pubis)	$10,000	$5,000
Thigh (Femur)	$6,000	$3,000
Knee cap (Patella)	$2,400	$1,200
Lower leg (Tibia and/or fibia)	$6,000	$3,000
Ankle (Talus)	$2,400	$1,200
Foot (Metatarsals and calcaneus, except toes)	$2,400	$1,200
Toes (Phalanges)	$600	$300

Limitations

If an Insured Person sustains:

a) multiple Fractures to the same bone/bone group as a result of the same Accident, only the applicable Open Reduction or Closed Reduction benefit for the bone/bone group is payable; or

b) a Fracture:
   1. that is treated with both Open Reduction and Closed Reduction as a result of the same Accident, only the benefit for the Open Reduction of the Fracture is payable;
   2. to the bones of the face and the nose (Nasal bones) as a result of the same Accident, only the highest applicable Open Reduction or Closed Reduction benefit is payable;
   3. to a vertebral body and a vertebral process of the same vertebrae as a result of the same Accident, only the highest applicable Open Reduction or Closed Reduction benefit is payable; or
   4. to the tail bone (Coccyx), pelvis or hip bones (Illium, ischium and/or pubis) as a result of the same Accident, only the highest applicable Open Reduction or Closed reduction benefit is payable.

If We have paid a benefit for a Fracture previously sustained by an Insured Person, any new claim for that same Fracture will be payable only if the subsequent Fracture is the result of a separate and distinct Accident that occurred after the previous Fracture was completely healed.

DISLOCATIONS (SEPARATED JOINTS)

Benefits

We will pay the applicable benefit amount shown in the Dislocation Benefits Table if an Insured Person receives Closed Reduction (Non-surgical) or Open Reduction (Surgical) Treatment for a Dislocation sustained as the result of an Accident. Treatment must occur by a Physician or Medical Professional within 90 days after the Accident.

If a Dislocation is diagnosed as an Incomplete Dislocation, or if Treatment of a Dislocation occurs by a Physician or Medical Professional without the use of Anesthesia, We will pay 25% of the amount listed in the table for the Closed Reduction for the joint/joint group involved.

The maximum amount payable for all Dislocations sustained by an Insured Person for the same Accident is up to 250% of the amount payable for the Dislocation with the highest applicable Open Reduction or Closed Reduction benefit amount.

Dislocation Benefits Table

Joint/Joint Group (From Head to Toe)	Open Reduction Amount	Closed Reduction Amount
Lower jaw (Temporomandibular)	$3,700	$1,850
Shoulder (Glenohumeral)	$3,700	$1,850
Collarbone and breastbone (Sternoclavicular)	$3,700	$1,850
Elbow	$3,700	$1,850
Wrist (Radiocarpal and/or intercarpal)	$3,700	$1,850
Hand (Carpometacarpal and/or intrametacarpal)	$3,700	$1,850
Fingers (Interphalangeal and/or metacarpophalangeal)	$750	$375
Hip	$12,000	$6,000
Kneecap (Patella)	$7,500	$3,750
Ankle (Talocalcaneal and/or talocalcaneonavicular	$5,400	$2,700
Foot (Tarsometatarsal and/or intermetatarsal)	$5,400	$2,700
Toes (Interphalangeal and/or metatarsalphalangeal)	$750	$375

Limitations

If an Insured Person sustains a Dislocation:

a) that is treated with both Open Reduction and Closed Reduction as a result of the same Accident, only the benefit for the Open Reduction of the Dislocation is payable;
b) to the wrist (radiocarpal and/or intercarpal) and hand (carpometacarpal and/or intrametacarpal) joints/joint groups as a result of the same Accident, only the highest applicable Open Reduction or Closed Reduction benefit is payable; or
c) to the ankle (talocalcaneal and talocalcaneonavicular) and foot (tarsometatarsal and/or intermetatarsal) joints/joint groups as a result of the same Accident, only the highest applicable Open Reduction or Closed Reduction benefit is payable.

If We will pay/have paid a benefit for a Dislocation previously sustained by an Insured Person, any new claim for that same Dislocation will be payable only if the subsequent Dislocation is the result of a separate and distinct Accident that occurred after the previous Dislocation was completely healed.

LACERATION BENEFIT

We will pay the applicable benefit amount shown in the Laceration Benefits Table if an Insured Person receives Treatment to repair one or more Lacerations sustained as the result of an Accident with an appropriate Laceration Repair Method. The benefit amount is based on the total length of all Lacerations that require repair with a Laceration Repair Method.

Treatment must occur by a Physician or Medical Professional within 72 hours after the Accident. This benefit is payable once per Accident for each Insured Person.

Laceration Benefits Table

Total Length of All Lacerations	Benefit Amount
Less than 2 inches	$350
2 inches to 6 inches	$700
Greater than 6 inches	$1,500

If no Laceration is severe enough to require a Laceration Repair Method for repair, We will pay a benefit of 50% of the lowest benefit amount shown in the table above.

BURNS

Burn Benefit

We will pay the applicable benefit amount shown in the Burn Benefits Table if an Insured Person receives Treatment for burns sustained as the result of an Accident. The benefit amount is based on the severity of the Burn (Burn type), as diagnosed by a Physician or Medical Professional. If more than one type of Burn is sustained, only the highest applicable benefit amount is payable.

Treatment must occur by a Physician or Medical Professional within 72 hours after the Accident. This benefit is payable once per Accident for each Insured Person.

Burn Benefits Table

Severity of Burn (Burn Type)	Benefit Amount
Second degree burns which cover less than or equal to 9% of the total body surface area	$450
Second degree burns which cover 10% to 36% of the total body surface area	$500
Second degree burns which cover greater than 36% of the total body surface area	$2,500
Third degree burns which cover less than 18% of the total body surface area	$5,000
Third degree burns which cover 18% to 36% of the total body surface area	$15,000
Third degree burns which cover greater than 36% of the total body surface area	$25,000

Skin Graft Benefit

If an Insured Person receives a Skin Graft for a Burn for which a benefit is payable under the Policy, We will pay a Skin Graft benefit of 50% of the payable Burn benefit. This benefit is payable once per Accident for each Insured Person.

DENTAL CARE

Crown or Filling Repair Benefit

We will pay a benefit amount of $400 if an Insured Person sustains an Injury as the result of an Accident to one or more natural teeth which requires repair by placement of a crown or filling. Treatment must occur by a Dentist within 30 days after the Accident. This benefit is payable once per tooth per Accident for each Insured Person.

Extraction Benefit

We will pay a benefit amount of $175 if an Insured Person sustains an Injury as the result of an Accident to one or more natural teeth which results in extraction of the damaged tooth/teeth.

Treatment must occur by a Dentist within 30 days after the Accident. This benefit is payable once per Accident for each Insured Person.

HOSPITAL, SURGICAL & DIAGNOSTIC BENEFITS

Capitalized terms used in this section have the meanings assigned to them in the Definitions section of this Certificate. The benefits described in this section are subject to all of the applicable definitions, limitations, exclusions and other provisions of the Policy.

HOSPITAL

Admission Benefit

We will pay a benefit amount of $2,500 for the first time an Insured Person is Confined to a Hospital for Treatment of one or more Injuries sustained as the result of an Accident. The Confinement must begin within 365 days after the Accident. This benefit is payable once per Accident for each Insured Person.

We will not pay this benefit for Treatment in an Emergency Room, Outpatient Treatment, a stay of less than 20 hours in an Observation Unit or other observation area of a Hospital, or Treatment at a Rehabilitation Facility.

Daily Confinement Benefit

We will pay a benefit amount of $700 per day of Confinement if an Insured Person is Confined to a Hospital for Treatment of one or more Injuries sustained as the result of an Accident. The Confinement must begin within 365 days after the Accident. This benefit is payable for up to 365 days per Accident for each Insured Person. This benefit is only payable for one Hospital Confinement at a time, even if the Confinement is the result of more than one Accident.

We will not pay this benefit for Treatment in an Emergency Room, Outpatient Treatment, Treatment at a Rehabilitation Facility, or during the first 30 days of Confinement for an Insured Person Confined to an Intensive Care Unit.

Intensive Care Unit Confinement Benefit

We will pay a benefit amount of $1,400 per day of Confinement if an Insured Person is Confined to an Intensive Care Unit (ICU) for Treatment of one or more Injuries sustained as the result of an Accident. The Confinement must begin within 365 days after the Accident. This benefit is payable for up to 30 days per Accident for each Insured Person. This benefit is only payable for one ICU Confinement at a time, even if the Confinement is the result of more than one Accident.

This benefit is not payable if an Insured Person is Confined to any Hospital unit that does not meet the definition in the Policy of an Intensive Care Unit. We will not pay this benefit and the Daily Confinement Benefit concurrently.

Rehabilitation Facility Confinement Benefit

If an Insured Person is transferred to a Rehabilitation Facility for Treatment of one or more Injuries sustained as the result of an Accident immediately after a period of Confinement for which a Daily Confinement Benefit is payable, We will pay a benefit amount of $300 per day for the Insured Person's Confinement as a resident inpatient in a Rehabilitation Facility. The Insured Person's Confinement in the Rehabilitation Facility must begin within 365 days after the Accident. This benefit is payable for up to 60 days per Accident for each Insured Person.

This benefit is only payable for one Rehabilitation Facility Confinement at a time, even if the Confinement is the result of more than one Accident. We will not pay this benefit and the Daily Confinement Benefit concurrently.

SURGICAL

If any surgery listed below occurs concurrently with an Open Reduction for a Fracture or Dislocation of the same bone/bone group or joint/joint group as a result of the same Accident, only the highest applicable benefit is payable.

Exploratory Surgery or Arthroscopic Debridement Benefit

We will pay a benefit amount of $800 if an Insured Person undergoes Exploratory Surgery or Arthroscopic Debridement for one or more Injuries sustained as the result of an Accident. An Exploratory Surgery must occur by a Physician within 365 days after the Accident. An Arthroscopic Debridement must occur by a Physician within 365 days after the Accident. This benefit is payable once per Accident for each Insured Person.

We will reduce the benefit amount payable for any surgery listed below if this benefit was previously paid for the same Injury(ies) for an Accident for an Insured Person.

Abdominal, Cranial or Thoracic Surgery Benefit

We will pay a benefit amount of $5,000 if an Insured Person undergoes abdominal, cranial or thoracic surgery for the repair of one or more internal Injuries sustained as the result of an Accident. The surgery must occur by a Physician within 365 days after the Accident. This benefit is payable once per Accident for each Insured Person.

We will not pay this benefit for the repair of a hernia. No Exploratory Surgery Benefit, Arthroscopic Surgery Benefit or Brain Injury Diagnosis Benefit is payable if this benefit is payable for the same injury(ies). If abdominal, cranial or thoracic surgery occurs concurrently with an Open Reduction for a Fracture or Dislocation of the same bone/bone group or joint/joint group as a result of the same Accident, only the highest applicable benefit is payable.

Herniated Disc Surgery Benefit

We will pay a benefit amount of $2,700 if an Insured Person undergoes surgery to repair one or more Herniated Discs sustained as the result of an Accident. Initial Treatment must occur by a Physician or Medical Professional within 30 days after the Accident and surgery must occur by a Physician within 365 days after the Accident. This benefit is payable once per Accident for each Insured Person.

No Exploratory Surgery Benefit or Arthroscopic Surgery Benefit is payable if this benefit is payable for the same injury(ies).

Torn Knee Cartilage (Meniscus) Surgery Benefit

We will pay a benefit amount of $2,000 if an Insured Person undergoes surgery to repair torn knee cartilage (meniscus) sustained as the result of an Accident. Initial Treatment must occur by a Physician or Medical Professional within 30 days after the Accident and surgery must occur by a Physician within 365 days after the Accident. This benefit is payable once per knee per Accident for each Insured Person.

No Exploratory Surgery Benefit or Arthroscopic Surgery Benefit is payable if this benefit is payable for the same injury(ies). If an Insured Person undergoes surgery to repair torn knee cartilage (meniscus) and undergoes surgery to repair one or more ligaments, rotator cuffs or tendons as a result of the same Accident, the maximum amount payable for the surgeries is equal to 200% of the highest applicable benefit amount.

Ligament, Rotator Cuff or Tendon Surgery Benefit

We will pay a benefit amount of $2,000 if an Insured Person undergoes surgery to repair one or more torn, ruptured or severed ligaments, rotator cuffs or tendons sustained as the result of an Accident. Initial Treatment must occur by a Physician or Medical Professional within 30 days after the Accident and surgery must occur by a Physician within 365 days after the Accident. This benefit is payable once per Accident for each Insured Person.

No Exploratory Surgery Benefit or Arthroscopic Surgery Benefit is payable if this benefit is payable for the same injury(ies). If an Insured Person undergoes surgery to repair one or more ligaments, rotator cuffs or tendons and undergoes surgery to repair torn knee cartilage (meniscus) as a result of the same Accident, the maximum amount payable for the surgeries is equal to 200% of the highest applicable benefit amount.

Eye Procedure Benefit

We will pay a benefit amount of $600 if an Insured Person undergoes a procedure to remove a foreign object or surgery for an eye Injury sustained as the result of an Accident. The surgery or procedure must occur by a Physician or Medical Professional within 90 days after the Accident. This benefit is payable once per eye per Accident for each Insured Person.

We will not pay this benefit for an Injury that is limited to the Eyelid or for an eye examination (with or without Anesthesia). No Exploratory Surgery Benefit or Arthroscopic Surgery Benefit is payable if this benefit is payable for the same injury(ies).

Blood Products Benefit

We will pay a benefit amount of $650 if an Insured Person receives a transfusion of one or more Blood Products for Treatment of an Injury sustained as the result of an Accident. The transfusion must occur within 90 days after the Accident. This benefit is payable up to 3 times per Accident for each Insured Person.

We will not pay this benefit for platelet or plasma infusions.

Pain Management (Epidural Anesthesia) Benefit

We will pay a benefit amount of $450 if an Insured Person receives Epidural Anesthesia for Treatment of an Injury sustained as the result of an Accident. The Anesthesia must be administered within 90 days after the Accident. This benefit is payable up to 3 times per Accident for each Insured Person.

DIAGNOSTIC

X-Ray Benefit

We will pay a benefit amount of $150 if an Insured Person undergoes an X-Ray for Treatment of one or more Injuries sustained as the result of an Accident. The X-Ray must occur within 180 days after the Accident. This benefit is payable up to 3 times per Accident for each Insured Person.

Diagnostic Exam Benefit

We will pay a benefit amount of $400 if an Insured Person undergoes a Diagnostic Exam for Treatment of one or more Injuries sustained as the result of an Accident. The exam must occur within 180 days after the Accident. This benefit is payable once per Accident for each Insured Person.

Brain Injury Diagnosis Benefit

We will pay a benefit amount of $400 if an Insured Person is diagnosed with a Brain Injury sustained as the result of an Accident. The diagnosis must occur by a Physician or Medical Professional within 180 days after the Accident and be confirmed by a Diagnostic Exam. This benefit is payable once per Accident for each Insured Person.

We will reduce the benefit amount payable for cranial surgery if this benefit was previously paid for the same Injury(ies) for an Accident for an Insured Person.

FOLLOW-UP CARE BENEFITS

Capitalized terms used in this section have the meanings assigned to them in the Definitions section of this Certificate. The benefits described in this section are subject to all of the applicable definitions, limitations, exclusions and other provisions of the Policy.

FOLLOW-UP TREATMENT

Physician Follow-Up Office Visit Benefit

We will pay a benefit amount of $175 if an Insured Person receives Follow-Up Treatment for one or more Injuries sustained as the result of an Accident from a Physician or Medical Professional in such individual's office or clinic. The first Follow-Up Treatment must occur within 60 days after the Accident or within 30 days after the Insured Person is no longer Confined as a result of the Accident.

All Follow-Up Treatment must occur within 365 days after the Accident. This benefit is payable up to 6 times per Accident for each Insured Person.

We will not pay this benefit:

a) if any form of Initial Care was not received by the Insured Person for the same Accident;
b) for Follow-Up Treatment received on the same day that an Insured Person received any form of Initial Care for the same Accident; or
c) while an Insured Person is Confined.

Therapy Services Benefit

We will pay a benefit amount of $150 if an Insured Person receives Therapy for one or more Injuries sustained as the result of an Accident from a Therapist in such individual's office or clinic. The first Therapy visit must occur within 365 days after the Accident or within 30 days after the Insured Person is no longer Confined as a result of the Accident.

All Therapy visits must occur within 365 days after the Accident. This benefit is payable up to 6 times per Accident for each Insured Person.

We will not pay this benefit:

a) if any form of Initial Care was not received by the Insured Person for the same Accident;
b) for Therapy received on the same day that an Insured Person received any form of Initial Care for the same Accident; or
c) while an Insured Person is Confined.

MEDICAL DEVICE BENEFIT

We will pay a benefit amount of $400 if an Insured Person sustains an Injury as the result of an Accident which requires a Medical Device to assist the Insured Person with personal locomotion or mobility. The Medical Device must be prescribed by a Physician or Medical Professional and be received within 365 days after the Accident. This benefit is payable once per Accident for each Insured Person.

Proof of the expense incurred for the purchase of a Medical Device for an Insured Person must be submitted with the claim.

PROSTHETIC DEVICE(S) BENEFIT

We will pay a benefit amount of $1,750 if an Insured Person sustains an Injury as the result of an Accident and receives a Prosthetic Device after the Injury results in the loss of limb, hand, foot or sight of an eye. The Prosthetic Device must be prescribed by a Physician for functional use and be received within 365 days after the Accident. This benefit is payable up to 2 times per Accident for each Insured Person.

We will not pay this benefit for more than one Prosthetic Device for the same body part, or for the replacement of a Prosthetic Device for which We will pay/have paid a benefit for an Insured Person for the same Accident.

ADDITIONAL BENEFITS

Capitalized terms used in this section have the meanings assigned to them in the Definitions section of this Certificate. The benefits described in this section are subject to all of the applicable definitions, limitations, exclusions and other provisions of the Policy.

FAMILY CARE

Transportation Benefit

We will pay a benefit amount of $600 per round trip for travel by an Insured Person to a Hospital or other medical facility more than 50 miles away from the Insured Person's primary residence for Treatment (including Follow-Up Treatment) of one or more Injuries sustained as the result of an Accident. Treatment must be prescribed by a Physician and the same or similar Treatment must not be available within 50 miles of the Insured Person's primary residence. This benefit is payable for up to 3 round trips per Accident within 365 days after the Accident.

We will also pay a benefit amount of $600 if an Insured Person is Confined for Treatment of one or more Injuries sustained as the result of an Accident that occurred more than 200 miles away from the Insured Person's primary residence and is brought home (to the Insured Person's primary residence). Transportation to the Insured Person's primary residence must occur within 48 hours following discharge from the Hospital or Rehabilitation Facility, within 365 days after an Accident. This benefit is payable once per Calendar Year per Insured Person.

Mileage is measured as the distance from the Insured Person's primary residence to the facility at which the Treatment occurs. We will not pay this benefit if either the Ground Ambulance Benefit or Air Ambulance Benefit is payable for the same trip.

Lodging Benefit

We will pay a benefit amount of $300 per night of Lodging for which an expense is incurred if an adult Family member or adult companion accompanies an Insured Person who is Confined more than 50 miles away from the Insured Person's primary residence for Treatment of one or more Injuries sustained as the result of an Accident. This benefit is payable for up to 30 nights of Lodging per Accident within 365 days after the Accident.

This benefit is only payable if the adult Family member or adult companion is providing care for the Insured Person or is acting as an advocate on the behalf of the Insured Person while the Insured Person is receiving Treatment. This benefit is not payable if no care or advocacy is provided to the Insured Person by the adult Family member or adult companion.

This benefit is only payable for a Confinement for which We will pay a Daily Confinement Benefit, Intensive Care Unit Confinement Benefit or Rehabilitation Facility Confinement Benefit for the Insured Person. Only one benefit is payable per night of Lodging. Proof of the expense incurred by the adult companion for Lodging must be submitted with the claim. Mileage is measured as the distance from the Insured Person's primary residence to the Hospital or medical facility in which the Insured Person is Confined.

Childcare Benefit

We will pay a benefit amount of $40 per day for Childcare if an Insured Person is Confined for Treatment of one or more Injuries sustained as the result of an Accident and incurs expense for one or more Dependent children attending a Childcare Center. This benefit is payable for up to 30 days of Childcare per Dependent child per Accident within 365 days after the Accident.

A Dependent child does not have to be insured under the Policy for this benefit to be payable. This benefit is only payable for a Confinement for which We will pay a Daily Confinement Benefit or Intensive Care Unit Confinement Benefit for the Insured Person. Proof of the expense incurred by the Insured Person for Childcare must be submitted with the claim.

HEALTH SCREENING BENEFIT RIDER

This Rider is to be made part of the Certificate for Group Policy Number GUDH-C29G (the Policy) issued to Corient Services LLC (the Policyholder) for Class(es) All Eligible Employees.

This Rider is effective on the later of the Policy Effective Date or the day the Insured Person becomes insured under the Policy.

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

The benefits described in this Rider are subject to all of the applicable definitions, limitations, conditions, exclusions and other provisions of the Policy. In the event of a conflict between this Rider and any other provision of the Policy, including the Certificate, this Rider shall control.

HEALTH SCREENING BENEFIT

We will pay the health screening benefit amount of $50 for each Insured Person who has a Health Screening Test performed while insured under the Policy. This benefit is payable up to 1 time per Calendar Year for each Insured Person.

DEFINITION

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

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

To present inquiries, obtain information about coverage, and to provide assistance in resolving complaints, you may call us toll-free at 1-800-775-8805 or visit us through our website www.mutualofomaha.com.

UNITED OF OMAHA LIFE INSURANCE COMPANY

Corporate Secretary

CATASTROPHIC BENEFITS

Capitalized terms used in this section have the meanings assigned to them in the Definitions section of this Certificate. The benefits described in this section are subject to all of the applicable definitions, limitations, exclusions and other provisions of the Policy.

The Principal Sum is the amount of catastrophic insurance in effect for the Insured Person on the date of the Accident.

ACCIDENTAL DEATH

Basic Accidental Death Benefit

We will pay a benefit amount equal to 100% of the Principal Sum if an Insured Person dies as the result of an Accident. Death must occur within 365 days after the Accident. This benefit is payable once under the Policy for each Insured Person.

If one or more Catastrophic Benefits have been previously paid under the Policy for an Accident for an Insured Person, We will reduce the amount payable under this benefit by the amount paid for the previous Catastrophic Benefit(s) unless otherwise indicated in a benefit provision included in this Catastrophic Benefits section of this Certificate.

Common Carrier Accidental Death Benefit

We will pay a benefit amount equal to 300% of the Principal Sum if an Insured Person dies as the result of an Accident that occurs while a fare-paying passenger on a Common Carrier. Death must occur within 365 days after the Accident. This benefit is payable once under the Policy for each Insured Person.

We will not pay this benefit if an Insured Person was an operator or member of the crew on the Common Carrier conveyance at the time of the Accident. If this benefit is payable under the Policy for an Insured Person, We will not pay the Basic Accidental Death Benefit for that Insured Person.

If one or more Catastrophic Benefits have been previously paid under the Policy for an Accident for an Insured Person, We will reduce the amount payable under this benefit by the amount paid for the previous Catastrophic Benefit(s) unless otherwise indicated in a benefit provision included in this Catastrophic Benefits section of this Certificate.

Exposure & Disappearance

An Insured Person will be presumed to have died, for the purposes of the Basic Accidental Death Benefit or Common Carrier Accidental Death Benefit, if after the forced landing, stranding, sinking or wrecking of a vehicle:

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

Transportation of Remains Benefit

We will pay for expenses reasonably incurred for the transportation of remains, up to a maximum of $5,000, if an Insured Person dies as the result of an Accident and the death occurs more than 50 miles away from the Insured Person's primary residence. We must be contacted prior to the transportation of the remains to pre-authorize the services.

The Insured Person's bodily remains or ashes must be transported to a mortuary or funeral home within 30 miles of the Insured Person's primary residence by a duly licensed company that provides mortuary transport services. This benefit is payable once under the Policy for each Insured Person. This benefit amount is payable in addition to any other applicable benefits under the Policy.

Proof of the expenses incurred must be submitted with the claim. This benefit does not include the transportation expense of anyone accompanying the body or remains, visitation expenses or funeral expenses. In no event will the total amount paid under all group insurance policies issued by Us exceed the actual expense for the transportation of remains of an Insured Person. We will not pay this benefit if a same or similar benefit is payable under a third-party service contracted by Us.

DISMEMBERMENT & PARALYSIS

Benefits

We will pay the applicable benefit amount shown in the Dismemberment & Paralysis Benefits Table below if an Insured Person sustains one or more Injuries as the result of an Accident that results in Dismemberment and/or Paralysis. The Dismemberment or Paralysis must occur within 365 days after the Accident.

The maximum amount payable for all losses shown in the table sustained by an Insured Person for the same Accident is 100% of the Principal Sum.

Dismemberment & Paralysis Benefits Table

Loss	Benefit
Loss of Both Hands, Loss of Both Feet, Loss of Entire Sight of Both Eyes or any combination of two or more of these losses	100% of the Principal Sum
Loss of Speech and Loss of Hearing (Both ears)	100% of the Principal Sum
Loss of One Hand, Loss of One Foot, Loss of Entire Sight of One Eye or Loss of Hearing (Both ears)	50% of the Principal Sum
Loss of Thumb and Index Finger of the Same Hand	25% of the Principal Sum
Loss of Multiple Fingers or Loss of Multiple Toes	10% of the Principal Sum
Quadriplegia (Paralysis of both upper and both lower limbs)	100% of the Principal Sum
Triplegia (Paralysis of three limbs)	75% of the Principal Sum
Hemiplegia (Paralysis of an upper and a lower limb)	50% of the Principal Sum
Paraplegia (Paralysis of both lower limbs)	50% of the Principal Sum
Uniplegia (Paralysis of a limb)	25% of the Principal Sum

Limitations

If more than one loss shown in the Dismemberment & Paralysis Benefits Table is sustained by an Insured Person for the same Accident, We will pay only the highest applicable benefit. If a benefit was paid under the Policy for an Insured Person for any Dismemberment or Paralysis and the Insured Person later sustains a more severe loss shown in the table as a result of the same Accident, We will reduce the amount payable for the subsequent, more severe loss by the amount paid previously under this benefit.

REASONABLE MODIFICATION(S) BENEFIT

We will pay for expenses reasonably incurred for Home Alteration and/or Vehicle Modification, up to a maximum of 10% of the Principal Sum, if an Insured Person sustains one or more Injuries as the result of an Accident for which a Dismemberment or Paralysis benefit is payable under the Policy for:

a) Loss of Both Hands, Loss of Both Feet, Loss of Entire Sight of Both Eyes or any combination of 2 or more of these losses;
b) Loss of Speech and Loss of Hearing (Both ears);
c) Loss of One Hand, Loss of One Foot, Loss of Entire Sight of One Eye or Loss of Hearing (Both ears); or
d) Quadriplegia, triplegia, hemiplegia or paraplegia.

A Physician must certify that any modification is needed to accommodate a physical disability of the Insured Person. A modification must be made by someone experienced in such adaptations, and must be in compliance with any requirements established by the appropriate government authority. The expense for any modification cannot exceed the usual level of charges for similar alterations and/or modifications in the location where the expense is incurred.

The expense for any modification must be incurred within 365 days after the Accident. This benefit is payable once per Accident for each Insured Person. This benefit amount is payable in addition to any other applicable benefits under the Policy.

COMA BENEFIT

We will pay a benefit amount equal to 25% of the Principal Sum if an Insured Person sustains one or more Injuries as the result of an Accident that results in a Coma. The Insured Person must become Comatose within 30 days after the Accident and remain Comatose for 7 or more consecutive days. The Coma must be diagnosed by a Physician and be confirmed by an electroencephalogram (EEG). This benefit is payable once per Accident for each Insured Person.

EXCLUSIONS

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

We will not pay any benefits under the Policy for any loss or claim which does not result from an Accident or occurs more than 365 days after an Accident.

We will also not pay any benefits under the Policy for an Accident that:

a) results from any bodily infirmity, Sickness, or medical or surgical Treatment thereof;
b) results from cosmetic surgery or procedures;
c) results, whether an Insured Person is sane or insane, from:
    1. an intentionally self-inflicted Injury or Sickness; or
    2. suicide or attempted suicide;
d) occurs in consequence of an Insured Person's being voluntarily intoxicated or under the influence of any controlled substance or alcohol (as defined by the laws of the state in which the Accident occurred), unless administered on the advice of a Physician;
e) results from an Insured Person's intentional or voluntary use of poison, gas or fumes, whether by ingestion, injection, inhalation or absorption, including self-infliction of carbon monoxide poisoning emanating from a motor vehicle;
f) results from an Insured Person's voluntary participation in a riot, commission of a felony, participation in illegal activities or participation in an illegal occupation;
g) occurs while an Insured Person is incarcerated or imprisoned;
h) results from an act of declared or undeclared war or armed aggression;
i) occurs while an Insured Person is operating, learning to operate, riding as a passenger, boarding, departing or jumping from any aircraft (including those that are not motor driven, such as a hot air balloon), unless riding as a fare-paying passenger in a commercial aircraft on a regularly-scheduled flight or while Traveling on Business of the Policyholder;
j) occurs while an Insured Person is riding in or on any motor vehicle or aircraft engaged in racing, endurance tests, acrobatic tricks or stunts (for motor vehicles), or acrobatic or stunt flying (for aircraft);
k) occurs while an Insured Person is practicing for, participating in or officiating any semi-professional or professional competitive athletic contest for which any type of compensation or remuneration is received by the Insured Person;
l) occurs while an Insured Person is engaged in skydiving, scuba diving, parachuting, hang gliding, bungee jumping, sail gliding, parasailing, parakiting, mountain climbing, base jumping, rock climbing or other similar high risk activities or extreme sports; or
m) occurs while an Insured Person is on active duty or training in the Armed Forces, National Guard or Reserves of any state or country and for which any governmental body or its agencies are liable.

PAYMENT OF CLAIMS

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

NOTICE OF CLAIM AND CLAIM FORMS

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

As an option, notice of claim may be made to Us within 20 days from the date of the Accident or subsequent Injury or Treatment, or as soon as reasonably possible. The notice should include:

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

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

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

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

HOW TO OBTAIN PLAN BENEFITS

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

CLAIM ASSISTANCE

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

PROOF OF CLAIM

We must be given written proof of claim within 90 days from the date of the Accident or subsequent Injury or Treatment for an Insured Person. Failure to furnish such proof within this time period shall not invalidate nor reduce any claim if:

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

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

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

PAYMENT OF CLAIMS

Benefits will be paid immediately after We receive acceptable proof of claim and confirm liability, but not later than 30 days after receipt of such proof or confirmation.

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

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

Any benefits paid to a minor may be paid to the legally appointed guardian of the minor. Any benefits paid by Us in good faith will discharge Our liability to the extent of the benefits payment.

Any benefits paid to a minor may be paid to the legally appointed guardian of the minor. Any benefits paid by Us in good faith will discharge Our liability to the extent of the benefits payment.

BENEFICIARY DESIGNATION

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

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

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

The beneficiary's consent is not required to make a change unless the current beneficiary designation is irrevocable.

RIGHT OF ASSIGNMENT

The rights provided to You under the Policy for insurance are owned by You, unless You have previously assigned these rights to someone else, or You assign Your rights to an assignee. You should consult with a legal counsel prior to making an assignment.

We will recognize an assignee as the owner of the rights assigned only when:

a) the assignment is in writing and acceptable to Us; and
b) a signed or certified copy of the assignment has been received and approved by Us.

The assignment will not apply to any payments or other action taken by Us before the assignment was received and recorded in Our home office. We are not responsible for any legal, tax or other implications of any assignment.

FACILITY OF PAYMENT

In the event benefits under the Policy become payable to You or any person who is not legally competent to claim or receive benefits, a minor, or Your estate, We may pay an amount of up to $2,000 to any of the following:

a) a person related to You by blood or marriage;
b) a person or entity that has incurred expenses related to Your last illness or death;
c) the person who has assumed the care and support of You or any beneficiary;
d) a personal or legal representative of Your estate

Any benefits paid by Us in good faith will discharge Our liability to the extent of the benefits payment.

MODE OF PAYMENT

Benefits for each claim will be paid by Us in one lump sum, unless otherwise indicated in any benefit provision of this Certificate.

REFUND TO US

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

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

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

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

AUTHORITY TO INTERPRET POLICY

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

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

You or the claimant (in the event of Your death) have the right to request a review of Our decision. If, after exercising the Policy's review procedures, the claim for benefits is denied or ignored, in whole or in part, You or the claimant may file suit and a court will review Your or the claimant's eligibility or entitlement to benefits under the Policy.

CLAIM REVIEW AND APPEAL PROCEDURES

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

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

CLAIM REVIEW PROCEDURES

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

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

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

INITIAL CLAIM DECISION

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

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

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

CLAIM DENIALS

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

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

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

OPPORTUNITY TO REQUEST AN APPEAL

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

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

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

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

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

RESPONSE TO APPEALS

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

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

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

The period of time within which an appeal decision is required to be made will begin at the time an appeal is filed, without regard to whether all the information necessary to make an appeal decision accompanies the filing. If a period of time is extended as described above due to the Claimant's failure to submit information necessary to decide a claim, the period for making the appeal decision shall be "tolled" or suspended from the date on which the extension notice is sent until the earlier of:

a) the date on which We receive the response; or
b) the date established by Us in the notice of extension for the furnishing of the requested information.

STANDARD PROVISIONS

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

INSURANCE CONTRACT

The insurance contract consists of:

a) the Policy (of which this Certificate is made a part);
b) the Policyholder's signed application attached to the Policy; and
c) any signed application for You and Your Dependent(s) (if applicable).

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

CHANGES IN THE INSURANCE CONTRACT

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

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

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

INCONTESTABILITY

We will not contest this Policy after it has been in force two years, except for nonpayment of premium.

LEGAL ACTIONS

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

CONFORMITY WITH STATE AND FEDERAL LAW

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

DEFINITIONS

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

Accident, Accidental means a sudden, unexpected and unforeseeable event which results in one or more Injuries that occurs after the effective date of insurance under the Policy for an Insured Person and while insurance is in effect for an Insured Person.

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

a) performing the normal duties of his or her regular job for the Policyholder on a regular and continuous basis 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.

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

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

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

Ambulatory Medical Center means a licensed healthcare facility providing ambulatory (outpatient) surgical or medical treatment, other than a Hospital, Physician's office or clinic.

Anesthesia means a general or spinal anesthetic. Anesthesia does not include injection of local anesthetic or peripheral nerve blocks.

Arthroscopic Debridement means a minimally invasive surgical procedure performed to treat or repair an Injury through removal or modification of damaged cartilage or bone. Arthroscopic debridement includes cartilage shaving and trimming.

Attained Age means the age of the Insured Person as of the Policy Anniversary that coincides with or follows the Insured Person's birthday. For example, if an Insured Person's 50th birthday is on April 1, 2024 and the Policy Anniversary is January 1, the Insured Person will reach the attained age of 50 on January 1, 2025.

Basic Benefits means any benefit included in any of the benefit categories shown in the Basic Benefits section of the Schedule section of this Certificate.

Blood Products means whole blood, red blood cells, plasma, platelets or granulocytes.

Brain Injury means a traumatic brain injury (TBI) or a mild traumatic brain injury (MTBI), including cerebral contusions, cerebral lacerations, concussions or intracranial hemorrhage.

Burn means an Injury to flesh or skin caused by heat, electricity, chemicals, friction or radiation. A burn includes second and third degree burns in which damage penetrates to the dermis (underlying layers of the skin). A burn does not include a sunburn or a superficial (first degree) burn of the epidermis (the outer layer of the skin).

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

Catastrophic Benefits means any of the benefits shown in the Catastrophic Benefits section of this Certificate.

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

Childcare means care provided for one or more Dependent children on a regular basis for daily periods of less than 24 hours, whether the care is for daytime or nighttime hours. This care must be provided in a Childcare Center.

Childcare Center means a duly licensed independent childcare provider or duly licensed childcare facility that provides non-medical care for children in a group setting that is not owned or operated by the Insured Person or a member of the Insured Person's Family.

Chip Fracture means a fracture in which a fragment or piece of a bone is broken off near a joint at a place where a ligament is usually attached which is diagnosed as a chip fracture by a Physician or Medical Professional. Another term for chip fracture is "avulsion fracture." A chip fracture does not include a stress fracture or a hairline fracture.

Chiropractic Care means spinal manipulation services provided by a Chiropractor to correct a structural imbalance. Chiropractic care does not include massage therapy, care for chronic conditions or other injuries not related to structural imbalance.

Chiropractor means a duly licensed health care professional focused on the diagnosis and treatment of neuromuscular disorders, with an emphasis on treatment through manual adjustment and/or manipulation of the spine. The chiropractor must be acting within the scope of his/her license. A chiropractor does not include the Insured Person or any Family member.

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

Closed Reduction means a medical procedure to restore a broken bone or dislocated joint to the correct alignment without surgery. Closed reduction includes immobilization.

Coma, Comatose means an Insured Person is in a profound stupor or state of complete and total unconsciousness with no reaction to external stimuli, response to internal needs, and a Glasgow Coma Score of eight (8) points or less, for which intubation is required for respiratory assistance. A coma does not include a medically induced coma or a coma that is the result of any alcohol or drug use.

Common Carrier means a method of common public transport with defined published routes, time schedules and rates approved by regulators. A common carrier includes public airlines, railroads, subways, trolleys, boats and bus lines. A common carrier does not include taxis, limousines, any privately chartered mode of transportation or any mode of transportation owned, operated or leased for or by the Policyholder.

Confined, Confinement means the assignment to a bed as a resident inpatient on the advice of or as prescribed by a Physician with a charge for room and board in a:

a) Hospital or an Observation Unit (or other observation area of a Hospital) for a period of at least 20 consecutive hours; or
b) a Rehabilitation Facility.

Dentist means a person who is:

a) licensed to practice dentistry under the law of the jurisdiction in which the dental procedure is performed; and
b) operating within the scope of his or her license.

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

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

A dependent does not include:

a) anyone insured under the Policy as an Employee;

b) anyone who is a member of the Armed Forces, National Guard or Reserves of any state or country on active duty (except for temporary duty of 31 days or less);
c) Your divorced, legally separated or former Spouse;
d) Your Spouse after You reach the Attained Age of 80;
e) a child who has reached the age of 26 unless the child is Incapacitated;
f) Your child if the child has been legally adopted by another person; or
g) a child placed in Your home by a social service agency which retains control over the child.

Diagnostic Exam means any of the following:
a) bone scintigraphy;
b) computerized tomography (CT) scan;
c) electroencephalogram (EEG);
d) magnetic resonance imaging (MRI); or
e) single photon emission computed tomography (SPECT) scan.

A diagnostic exam does not include an X-Ray.

Dislocation means a complete, abnormal separation of a joint which is diagnosed as a dislocation by a Physician or Medical Professional and is confirmed by an X-Ray or appropriate Diagnostic Exam. The dislocations covered under the Policy are shown in the Dislocations section of the Specified Injury Benefits section of this Certificate. Another term for dislocation is "luxation."

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

Emergency Room means a specified area within a Hospital that is designated for the emergency care of Injuries. This area must:
a) be staffed and equipped to handle trauma;
b) be under the direct supervision of a Physician;
c) provide treatment by Physicians and/or Medical Professionals; and
d) provide care 7 days per week, 24 hours per day.

An Urgent Care Center is not an emergency room.

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

An employee does not include a person:
a) who resides outside the United States for a period in excess of 12 consecutive months unless written approval has been received from Our authorized representative in Our home office;
b) working for the Policyholder on a seasonal or temporary basis; or
c) performing services for the Policyholder as an independent contractor, including persons for whom income is reported on a 1099 form or subject to the terms of a leasing agreement between the Policyholder and a leasing organization.

Epidural Anesthesia means a form of regional anesthesia involving the injection of drugs through a catheter placed into the epidural space. Epidural anesthesia does not include spinal anesthesia, the injection of local anesthetic or peripheral nerve blocks.

Exploratory Surgery means surgery performed for diagnostic purposes, without repair and without the intent of treating a condition or Injury.

Express Benefit means the benefit identified in the Express Benefit section of the Schedule.

Eyelid means the moveable fold of skin and muscle that can be closed over the exposed portion of an eyeball.

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

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

Follow-Up Treatment means ongoing Treatment or physical evaluation which occurs after Initial Care has been received by the Insured Person.

Fracture means a break in a bone that can be detected by an X-Ray or similar diagnostic exam which is diagnosed as a fracture by a Physician or Medical Professional. The fractures covered under the Policy are shown in the Fractures section of the Specified Injury Benefits section of this Certificate. A fracture does not include a stress fracture or a hairline fracture.

Herniated Disc means a tear in the outer, fibrous ring (annulus fibrosus) of an intervertebral disc (discus intervertebralis) enabling the inner portion (nucleus pulposus) to herniate or extrude through the damaged outer rings. A herniated disc does not include a bulging disc.

Home Alteration means internal or external structural modifications to an Insured Person's primary residence, such as widening of doorframes, replacement doors, ramps, stairs or hand rails, or modifications to walkways.

Hospital means a facility that:

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

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

a) clinic (including dental, mental illness or substance abuse facilities), Ambulatory Medical Center or Urgent Care Center;
b) convalescent home, rest home, nursing home or home for the aged;
c) halfway house; or
d) rehabilitative, alternate care, extended care, skilled nursing or board and care facility.

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

a) performing two or more Activities of Daily Living (ADLs), if younger than the age of 26; or
b) self-sustaining employment, if older than the age of 26.

Incomplete Dislocation means an incomplete, abnormal separation or misalignment of a joint which is diagnosed as an incomplete dislocation by a Physician or Medical Professional and is confirmed by an X-Ray or appropriate Diagnostic Exam. Another term for incomplete dislocation is "subluxation" or "partial dislocation."

Initial Care means any of the benefits shown in the Initial Care section of the Initial Care and Emergency Benefits section of this Certificate.

Injured means the occurrence of an Injury.

Injury, Injuries means a bodily injury that is the direct result of an Accident which requires treatment by a Physician or Medical Professional. An injury must be independent of bodily infirmity, Sickness or medical or surgical treatment thereof, and all other causes. An injury includes an infection that is the natural result of an Accidental wound and Accidental food poisoning.

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

Intensive Care Unit (ICU) means a place which is a specifically designated area of a Hospital that provides the highest level of medical care and:

a) is restricted to patients who are critically ill or injured and who require intensive comprehensive observation and care;

b) is separate and apart from the surgical recovery room and from rooms, beds and wards customarily used for patient Confinement;
c) is permanently equipped with special lifesaving equipment and medical apparatus for the care of the critically ill or injured;
d) is under constant and continuous observation by a specially trained nursing staff assigned exclusively to the unit on a 24 hour basis; and
e) has a Physician assigned to the unit on a full-time basis.

An intensive care unit may include Hospital units with the following (or similar) names: intensive care unit, critical care unit, neonatal intensive care unit, burn unit or transplant unit. An intensive care unit is not any of the following step-down units: a progressive care unit, an intermediate care unit, a private monitored room, a sub-acute intensive care unit, a modified/moderate care unit, an Observation Unit or any facility that does not satisfy the requirements of this definition.

Laceration means a cut or tear of the skin or flesh.

Laceration Repair Method means sutures (stitches), tissue adhesives (glue), staples or skin-closure strips.

Life Event means:
a) a change in Your legal marital status or domestic partnership (or equivalent);
b) a change in the number of Your Dependents.

Lodging means a duly licensed establishment, such as a hotel, inn, lodge, motel or other facility that provides sleeping accommodations to the general public in exchange for a fee that is not owned or operated by the Insured Person or a member of the Insured Person's Family.

Loss of a Thumb and Index Finger of the Same Hand means Severance of the thumb and index finger of the same hand at or proximal to the metacarpophalangeal joints (the joints that connect the fingers and the hand).

Loss of Both Feet, Loss of One Foot means Severance of the foot or both feet above the ankle joint. Loss of a foot includes the Severance of an entire leg or Severance of any part of a leg that includes an entire foot.

Loss of Both Hands, Loss of One Hand means Severance of at least four whole fingers from one or both hands. Loss of a hand includes the Severance of an entire arm or Severance of any part of an arm that includes an entire hand.

Loss of Entire Sight of Both Eyes, Loss of Entire Sight of One Eye means total and permanent loss of sight of one or both eyes which cannot be corrected by any means, or Severance of one or both eyes.

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

Loss of Multiple Fingers means the Severance of more than one finger at or proximal to the first interphalangeal joint at which the finger is attached to the hand. Loss of multiple fingers does not include Loss of a Thumb and Index Finger of the Same Hand.

Loss of Multiple Toes means the Severance of more than one toe at or proximal to the first interphalangeal joint at which the toe is attached to the foot.

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

Medical Device means a device or appliance that is intended by its manufacturer to assist a person with personal locomotion or mobility due to a malfunctioning part of the body, including (but not limited to) crutches, a cane, a wheelchair, a walker, a back brace or a leg brace.

Medical Professional means a person who is duly licensed to provide Treatment, such as a physician's assistant (PA), nurse practitioner (NP/APRN) or registered nurse (RN). The medical professional must be acting within the scope of his/her license. A medical professional does not include the Insured Person or any Family member.

Observation Unit means a specified area within a Hospital, apart from an Emergency Room, where a patient can be monitored by a Physician or Medical Professional following Outpatient Treatment or Treatment in an Emergency Room.

This area must:

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

Occupational Therapy means the Treatment provided by an occupational Therapist of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those tasks required by the person's occupation. Occupational therapy does not include diversional, recreational or vocational therapies (such as arts, crafts or hobbies).

Open Reduction means a medical procedure to restore a broken bone or dislocated joint to the correct alignment with surgery.

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

Outpatient Treatment means Treatment, including surgery, received by an Insured Person at a Hospital or appropriately licensed Ambulatory Medical Center for which there is no charge for room and/or board.

Paralysis means total and permanent loss of use of a limb without Severance. This loss must be determined by a Physician to be complete and irreversible. Forms of paralysis include quadriplegia, triplegia, hemiplegia, paraplegia and uniplegia.

Physical Therapy means Treatment provided by a physical Therapist through physical means; hydrotherapy, heat or similar modalities; physical agents; or bio-mechanical and neuro-physiological principles and devices. Such therapy is given to relieve pain, restore function and to prevent disability following an Injury or loss of a body part.

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

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

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

Policy Anniversary means January 1 of each Policy Year.

Policy Effective Date means January 1, 2025.

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

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

Prosthetic Device means an artificial device that replaces a missing body part, such as a limb or eye. A prosthetic device does not include hearing aids, dental aids (including dentures/false teeth), eye glasses, cosmetic prostheses (such as wigs) or joint replacements (such as an artificial hip or knee).

Rehabilitation Care Services means coordinated multidisciplinary physical restorative services (the combined use of medical, social, educational and vocational services) to enable an Insured Person who is disabled by an Injury to achieve the highest possible functional ability. Services are provided by or under the supervision of Physicians and/or Medical Professionals experienced in rehabilitative medicine.

Rehabilitation Facility means an appropriately licensed facility that provides Rehabilitation Care Services on an inpatient basis. A rehabilitation facility may be a unit within a Hospital if the unit is specifically designated for Rehabilitation Care Services and is separate and apart from the beds and wards customarily used for patient Confinement. A rehabilitation facility does not include:
a) a rest home or home for the aged;
b) a hospice care facility;
c) a place for alcoholics or drug addicts; or

d) an assisted living facility.

A rehabilitation facility also does not include a nursing home, an extended care facility or a skilled nursing facility, unless an Insured Person is receiving Rehabilitation Care Services at such home or facility.

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

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

Sickness means a physical or mental disease, illness, infection, disorder or condition, including pregnancy and any drug or alcohol disorder, which is not caused by an Accident. Sickness does not include an infection that is the natural result of an Accidental wound.

Skin Graft means a surgical procedure by which skin, skin stem cells or skin substitute is placed over a Burn to permanently replace damaged or missing skin, regenerate damaged or missing skin, or provide a temporary wound covering.

Speech Therapy means Treatment and assistance provided by a speech Therapist for disorders related to speech, language, cognitive communication, voice, swallowing and fluency.

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

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

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

Therapist means a person who is duly licensed to practice occupational, physical or speech therapy. An occupational therapist must possess the designation of "Occupational Therapist Registered (OTR)." A physical therapist must practice according to the code of ethics of the American Physical Therapy Association. A speech therapist must practice according to the code of ethics of the American Speech-Language-Hearing Association. The therapist must be acting within the scope of his/her license. A therapist does not include the Insured Person or any Family member.

Therapy means ongoing Chiropractic Care, Occupational Therapy, Physical Therapy or Speech Therapy which occurs after Initial Care has been received by the Insured Person.

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

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

Treatment means medical advice, consultation, care or services (including diagnostic measures) received by an Insured Person, or the use of drugs or medicines by an Insured Person.

Urgent Care Center means a licensed, free-standing healthcare facility providing immediate, short-term medical care without an appointment, other than a Hospital, Emergency Room, Physician's office or clinic.

Vehicle Modification means modification to or installation of assistive devices for one motor vehicle (not including a motorized wheelchair or scooter).

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

X-Ray means electromagnetic radiation that differentially penetrates structures within the body and creates images of the structures.

You, Your, Yourself means the Employee who is insured under the Policy and this Certificate.

ADDITIONAL SUMMARY PLAN DESCRIPTION INFORMATION

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

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

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

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

EMPLOYER IDENTIFICATION NUMBER AND PLAN NUMBER

The Employer Identification Number (EIN) is: 87-3513335
The Plan Number is: 501

PLAN ADMINISTRATOR

The Plan is provided through and administered by:

Corient Services LLC
2 S Biscayne Blvd
32 Floor
Miami, FL 33131
Phone: (732) 603-1628

AGENT FOR SERVICE OF LEGAL PROCESS

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

Corient Services LLC
2 S Biscayne Blvd
32 Floor
Miami, FL 33131
Phone: (732) 603-1628

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) employee 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 Accident Benefits

Corient Services LLC

Group Number: G000C29G

United of Omaha Life Insurance Company

Home Office:
Mutual of Omaha Plaza
Omaha, Nebraska 68175