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

YOUR GROUP VOLUNTARY TERM LIFE BENEFITS

FOR EMPLOYEES OF:

TK Services, Inc.

CLASS(ES):

All Other Eligible Non-California Employees

REVISION EFFECTIVE DATE:

February 1, 2024

PUBLICATION DATE:

January 2, 2024

NOTICE(S)

THIS CERTIFICATE DESCRIBES THE BENEFITS THAT ARE AVAILABLE TO YOU. PLEASE READ YOUR CERTIFICATE CAREFULLY. THE POLICY IS ISSUED IN THE STATE OF CALIFORNIA AND PROVIDES ALL THE BENEFITS REQUIRED BY APPLICABLE CALIFORNIA 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.

NOTICE(S)

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

United of Omaha Life Insurance Company
3300 Mutual of Omaha Plaza
Omaha, Nebraska 68175
Call Toll-Free: 1-800-948-9478
www.mutualofomaha.com

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

Consumer Division
Department of Insurance, Los Angeles Office
300 South Spring Street
Los Angeles, California 90013
1-800-482-4833
http://www.insurance.ca.gov

ABOUT LIVING BENEFITS (ACCELERATED BENEFIT)

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

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

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

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

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

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

The Living Benefits (Accelerated Benefit) provision will end with the termination of this Policy.

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CERTIFICATE OF INSURANCE

UNITED OF OMAHA LIFE INSURANCE COMPANY

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

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

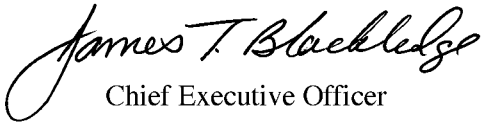
United of Omaha Life Insurance Company certifies that Group Policy Number GVTL-BPHV (the Policy) has been issued to TK Services, Inc. (the Policyholder).

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

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

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

This Certificate replaces any certificate previously issued under the Policy.



Chief Executive Officer

Corporate Secretary

SCHEDULE

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

CLASS(ES)

All Other Eligible Non-California Employees

LIFE INSURANCE BENEFITS

If you die while insured under the Policy, we will pay the amount of life insurance in effect at the time of your death to your beneficiary. If your Dependent dies while insured under the Policy, we will pay the amount of life insurance in effect at the time of your Dependent's death to you.

LIFE INSURANCE FOR YOU (THE EMPLOYEE)

You may elect to be insured for an amount of life insurance from $10,000 to $500,000, in increments of $10,000. In no event shall your amount of life insurance exceed 5 times your Annual Earnings, rounded to the next higher multiple of $10,000.

Your amount of life insurance is subject to any reductions indicated in the BENEFIT REDUCTIONS provision in this Schedule. If you have questions regarding the amount of your life insurance, you may contact the Policyholder.

LIFE INSURANCE FOR YOUR DEPENDENTS

You may elect to have your Spouse insured for an amount of life insurance from $5,000 to $250,000, in increments of $5,000, provided the amount elected does not exceed 100% of your amount of life insurance.

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

You may elect to have your eligible Dependent children insured for an amount of life insurance from $2,000 to $10,000, in increments of $2,000, provided the amount elected does not exceed 100% of your amount of life insurance. Each eligible Dependent child must have the same amount of insurance.

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

GUARANTEE ISSUE AMOUNTS AND EVIDENCE OF INSURABILITY

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

Guarantee Issue Amount For You (The Employee)

Your Guarantee Issue Amount is 5 times your Annual Earnings or $150,000, whichever is less, unless you were insured under a Prior Plan. If you were insured under a Prior Plan, your Guarantee Issue Amount is equal to the amount of insurance that was in-force for you under a Prior Plan the day before the Policy Effective Date, but in no event more than the maximum amount of insurance stated in the Life Insurance for You (the Employee) section of this Schedule.

Guarantee Issue Amount For Your Spouse

The Guarantee Issue Amount for your Spouse is 100% of your elected amount of life insurance or $50,000, whichever is less, unless your Spouse was insured under a Prior Plan. If your Spouse was insured under a Prior Plan, the Guarantee Issue Amount is equal to the amount of insurance that was in-force for your Spouse under a Prior Plan the day before the Policy Effective Date, but in no event more than the maximum amount of insurance for your Spouse stated in the Life Insurance for your Dependents section of this Schedule.

Guarantee Issue Amount For Your Dependent Children

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

Insurance for you and your Dependents, if applicable, is only available on a guarantee issue basis:

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

Evidence of Insurability

Evidence of Insurability is required for:

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

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

BENEFIT REDUCTIONS

As you grow older, the amount of life insurance for you will be reduced according to the following schedule:

At the Age of:	The Original Amount of Insurance Will Reduce to:
65	65%
70	50%

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

If you are age 65 or older on the date insurance becomes effective, the amount of life insurance for you will be reduced as shown above. Thereafter, the amount of life insurance will continue to reduce in accord with the schedule above.

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

LIFE INSURANCE BENEFITS EXCLUSION

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

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

ELIGIBILITY

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

WHEN YOU BECOME ELIGIBLE FOR INSURANCE (ELIGIBILITY WAITING PERIOD)

If you are Actively Working on the Policy Effective Date, you become eligible for insurance on the Policy Effective Date.

If you are not Actively Working on the Policy Effective Date, or if you are hired after the Policy Effective Date, you become eligible for insurance on the day you begin Active Work.

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

WHEN A DEPENDENT BECOMES ELIGIBLE FOR INSURANCE

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

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

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

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

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

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

WHEN YOUR INSURANCE BEGINS

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

You become insured on the first day of the month that coincides with or follows the latest of the day:

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

You must provide Evidence of Insurability if it is required. You become insure for any amount of insurance that requires Evidence of Insurability on the first day of the month that coincides with or follows the day we approve Evidence of Insurability.

WHEN YOUR DEPENDENT'S INSURANCE BEGINS

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

An eligible Dependent will become insured on the latest of the day:

a) you become insured, unless otherwise agreed to by our authorized representative in our home office;
b) you acquire the eligible Dependent; or
c) your Written Request to enroll the Dependent for insurance is properly completed and signed, if required.

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

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

Insurance for a newborn Dependent child begins at the moment of live birth, provided the child otherwise meets the definition of Dependent. Insurance for a newly adopted Dependent child begins with the date of placement into your custody, or at the moment of live birth if a written agreement to adopt the child was previously entered into by you, provided the child otherwise meets the definition of Dependent. If Dependent child insurance requires an election and Dependent child insurance for any other child is not already in effect, a Written Request for insurance for any newborn or newly adopted Dependent child must be submitted to the Policyholder within 31 days after the day the Dependent child becomes eligible in order to continue insurance beyond the 31-day period.

EXCEPTIONS TO WHEN YOUR INSURANCE BEGINS

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

If you are:

a) not Actively Working due to Injury or Sickness;
b) Totally Disabled;
c) confined in a Hospital as an inpatient;
d) confined or assigned to a bed as a resident inpatient in any institution or facility other than a Hospital; or
e) confined at home and under the care or supervision of a Physician;

on the day insurance would otherwise begin, insurance will not take effect until the day after you are released by your Physician and you return to Active Work.

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

EXCEPTIONS TO WHEN YOUR DEPENDENT'S INSURANCE BEGINS

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

If your Dependent is:

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

on the day insurance is to begin, insurance will not take effect until the day after your Dependent is no longer confined.

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

Insurance for a newborn Dependent child, regardless of confinement, will begin in accordance with the WHEN YOUR DEPENDENT'S INSURANCE BEGINS provision, provided the child otherwise meets the definition of Dependent.

CONTINUITY OF INSURANCE UPON TRANSFER OF INSURANCE CARRIER

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

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

a) were insured under the Prior Plan on the day before the Policy Effective Date;
b) are otherwise eligible, but not Actively Working on the Policy Effective Date due to:
    1. Injury or Sickness; or

2. a leave of absence protected under:
    a. the federal Family and Medical Leave Act (FMLA) or Uniformed Services Employment and Reemployment Rights Act (USERRA) and any amendments thereto; or
    b. any other applicable federal or state law that allows for continuation of insurance in certain instances;

c) are not insured under any provision of the Prior Plan;
d) are not a retired Employee;
e) are not Totally Disabled on the Policy Effective Date; and
f) are approved by our authorized representative in our home office for insurance under this provision.

Insurance under this provision is subject to the following conditions:

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

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

Insurance under this provision will end on the earliest of:

a) the day you return to Active Work for the Policyholder or begin employment with any other employer;
b) the last day you would have been insured under the prior Plan, if the Prior Plan had not ended or terminated;
c) the day your insurance ends for any reason shown in the WHEN INSURANCE ENDS provision;
d) the last day of the twelfth month following the Policy Effective Date; or
e) the last day of the time period allowed by FMLA, USERRA or applicable federal or state law that allows for continuation.

If you are eligible for insurance under this provision, you will not be eligible for insurance under any continuation provision or the PORTABILITY provision in this Certificate.

If your insurance under this provision ends and you have not returned to Active Work, you and your Dependents may be able to obtain insurance under the CONVERSION provision.

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

FIRST ENROLLMENT PERIOD

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

If you do not elect insurance during your or any Dependent's First Enrollment Period, future elections may only be made in accordance with the SUBSEQUENT ENROLLMENT PERIODS provision, or as otherwise provided under the WHEN ELECTION CHANGES ARE PERMITTED provision.

SUBSEQUENT ENROLLMENT PERIODS

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

WHEN ELECTION CHANGES ARE PERMITTED

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

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

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

If you experience a Life Event and previously declined insurance, you must submit Evidence of Insurability for any election of insurance to be considered by us.

Annual Increase Option
You may increase insurance during a Subsequent Enrollment Period.

You may submit a Written Request to increase the amount of insurance, provided the new amount of insurance does not exceed the maximum benefit amount shown in the Schedule section of this Certificate. You may increase your amount of insurance by up to $10,000, in increments as shown in the Schedule section of this Certificate.

If the increased amount of insurance requested exceeds your Guarantee Issue Amount, Evidence of Insurability will be required. If Evidence of Insurability is required under this provision, such evidence will only be required once and will serve as proof for any future requests to increase the amount of insurance under this provision.

CHANGES TO INSURANCE BENEFITS

Any allowable change in the benefits, class or amount of insurance, whether requested by you or the Policyholder, or as a result of the terms of the Policy, will take effect on the first day of the month that follows the date of the request or the change, or the first day of the month that follows the day we approve Evidence of Insurability (if required by us), whichever is later, unless otherwise stated or allowed in the Policy.

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

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

If your Dependent is:

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

on the day any increase in insurance would otherwise take effect, the increase becomes effective the first day of the month that coincides with or follows the day your Dependent is no longer confined.

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

REINSTATEMENT OF INSURANCE

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

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

Non-Payment of Premium or Voluntary Termination of Insurance
If insurance ends because you do not pay premium or you voluntary terminate insurance, we will require Evidence of Insurability to reinstate insurance.

Involuntary Reduction in Hours
If insurance ends because you are no longer Actively Working due to an involuntary reduction of hours worked, insurance may be reinstated if you return to Active Work within 90 days from the date insurance ended.

Rehired Employee Due to Layoff or Termination
If insurance ends because you are no longer Actively Working due to layoff or termination of employment with the Policyholder, insurance may be reinstated if you are rehired and return to Active Work within 90 days from the date insurance ended.

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

Transfer From Portability or Conversion
If insurance is obtained under the PORTABILITY or CONVERSION provision while you are not Actively Working, insurance may be reinstated up to the amount of insurance that was in effect on the last day of Active Work. Any insurance provided through the PORTABILITY policy will terminate upon reinstatement of insurance as an Actively Working Employee. Any Conversion policies issued to you or any of your Dependents must be surrendered to us. If Conversion policies are not surrendered, Evidence of Insurability will be required to reinstate insurance.

WHEN INSURANCE ENDS

Insurance ends:

a) for all Insured Persons on the last day of the month in which you are no longer Actively Working;
b) the last day of the month in which a Dependent is no longer eligible for insurance under the Policy;
c) the day your eligible Dependent child reaches the age of 26;
d) the last day of the month in which an Insured Person begins active duty in the Armed Forces, National Guard or Reserves of any state or country (except for temporary active duty of 31 days or less), unless otherwise allowed in the Policy;
e) the last day of the month in which you return to employment with the Policyholder;
f) the day the Policy terminates; or
g) in accordance with the Grace Period provisions.

EXCEPTIONS TO WHEN INSURANCE ENDS

If insurance for you and/or your Dependents would otherwise end, you and/or your Dependents may be able to continue or obtain insurance under one of the following provisions:

a) CONTINUATION OF INSURANCE FOR LAYOFF OR LEAVE
b) CONTINUATION OF INSURANCE FOR INJURY OR SICKNESS
c) CONTINUATION OF INSURANCE FOR PARTIAL DISABILITY
d) CONTINUATION OF INSURANCE FOR TOTAL DISABILITY WITH WAIVER OF PREMIUM
e) PORTABILITY
f) CONVERSION

CONTINUATION OF INSURANCE FOR LAYOFF OR LEAVE

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

You may be able to continue insurance for you and your Dependents from the day you cease to be Actively Working in the event of:

a) a temporary involuntary layoff; or

b) a leave of absence approved by the Policyholder due to any personal reason.

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

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

a) insurance may not be continued beyond the earliest of:
    1. 12 weeks for your temporary involuntary layoff;
    2. 12 weeks for your leave of absence due to any personal reason; or
    3. the time period allowed by FMLA, USERRA or applicable federal or state law that allows for continuation.
b) the amount of insurance for any Insured Person may not be increased while insurance is continued under this provision;
c) we receive verification of the approved layoff or leave from the Policyholder upon request; and
d) we continue to receive premium payment when due (premiums must be paid by you or on your behalf).

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

a) the time period in a) in the preceding paragraph has been satisfied;
b) your temporary involuntary layoff becomes permanent;
c) you return to Active Work;
d) you begin full-time employment with an employer other than the Policyholder; or
e) the Policy terminates.

Insurance under this provision also ends in accordance with the GRACE PERIOD provision.

If continued insurance under this provision ends and you have not returned to Active Work, you and your Dependents may be able to continue or obtain insurance under the CONTINUATION OF INSURANCE FOR INJURY OR SICKNESS provision, PORTABILITY provision or CONVERSION provision.

If your leave is due to an Injury or Sickness which may result in your Total Disability, we must receive notification of your potential Total Disability on our total disability claim form within 9 months of the date your Injury or Sickness occurred, or as soon as reasonably possible.

See the OPTIONS FOR PAYMENT OF PREMIUM FOR CONTINUED INSURANCE provision in the Premium Payments section of this Certificate for premium payment options.

CONTINUATION OF INSURANCE FOR INJURY OR SICKNESS

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

When your insurance would otherwise end because you are no longer Actively Working due to your Injury or Sickness, you may be able to continue insurance under this provision. The total continuation period under this provision and the CONTINUATION OF INSURANCE FOR LAYOFF OR LEAVE provision will not exceed 12 months. Insurance may be continued for you and your Dependents.

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

a) we receive verification of your Injury or Sickness from the Policyholder upon request; and
b) we continue to receive premium payment when due (premiums must be paid by you or on your behalf).

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

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

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

Insurance under this provision also ends in accordance with the GRACE PERIOD provision.

If continued insurance under this provision ends and you have not returned to Active Work, you and your Dependents may be able to continue or obtain insurance under the CONTINUATION OF INSURANCE FOR PARTIAL DISABILITY provision, CONTINUATION OF INSURANCE FOR TOTAL DISABILITY WITH WAIVER OF PREMIUM provision, PORTABILITY provision or CONVERSION provision.

If your leave is due to an Injury or Sickness which may result in your Total Disability, we must receive notification of your potential Total Disability on our total disability claim form within 9 months of the date your Injury or Sickness occurred, or as soon as reasonably possible.

See the OPTIONS FOR PAYMENT OF PREMIUM FOR CONTINUED INSURANCE provision in the Premium Payment section of this Certificate for premium payment options.

CONTINUATION OF INSURANCE FOR PARTIAL DISABILITY

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

When your insurance ends under the CONTINUATION OF INSURANCE FOR INJURY OR SICKNESS provision, you may be able to continue insurance under this provision due to your Partial Disability. Insurance may be continued for you and your Dependents.

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

a) you are Partially Disabled, but not Totally Disabled;
b) we receive verification of your Partial Disability from the Policyholder upon request; and
c) we continue to receive premium payment when due (premiums must be paid by you or on your behalf).

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

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

a) that is 12 months from the day you become eligible for insurance under this provision;
b) you return to Active Work;
c) your Injury or Sickness results in your Total Disability and you are eligible to continue insurance under the CONTINUATION OF INSURANCE FOR TOTAL DISABILITY WITH WAIVER OF PREMIUM provision;
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 Dependents may be able to obtain insurance under the CONTINUATION OF INSURANCE FOR TOTAL DISABILITY WITH WAIVER OF PREMIUM provision, PORTABILITY provision or CONVERSION provision.

If your Partial Disability may result in your Total Disability, we must receive notification of your potential Total Disability on our total disability claim form within 9 months of the date your Injury or Sickness occurred, or as soon as reasonably possible.

See the OPTIONS FOR PAYMENT OF PREMIUM FOR CONTINUED INSURANCE provision in the Premium Payments section of this Certificate for premium payment options.

CONTINUATION OF INSURANCE FOR TOTAL DISABILITY WITH WAIVER OF PREMIUM

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

When your insurance ends under the CONTINUATION OF INSURANCE FOR INJURY OR SICKNESS provision or CONTINUATION OF INSURANCE FOR PARTIAL DISABILITY provision, you may be able to continue insurance under this provision due to your Total Disability. After satisfaction of the Disability Elimination Period, and upon submission of proof of Total Disability, your insurance may be continued without payment of premium until insurance ends in accordance with this provision.

We must receive notification of your potential Total Disability on our total disability claim form within 9 months of the date your Injury or Sickness occurred, or as soon as reasonably possible.

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

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

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

Insurance may only be continued for you. If you are able to continue insurance under this provision, your Dependents may be able to obtain insurance under the PORTABILITY provision or CONVERSION provision.

If you are age 60 or older and become Totally Disabled, you and your Dependents may be able to obtain insurance under the PORTABILITY provision or CONVERSION provision.

About the Disability Elimination Period

The Disability Elimination Period is a period of 9 consecutive months. You do not have to be Totally Disabled while satisfying the Disability Elimination Period. Any period of time in which you are insured under the CONTINUATION OF INSURANCE FOR INJURY OR SICKNESS provision will apply toward satisfaction of the Disability Elimination Period provided premiums are paid by you or on your behalf. Your insurance will continue during the Disability Elimination Period.

If your group life insurance ends before you are able to satisfy the Disability Elimination Period, you may be able to obtain insurance under the CONVERSION provision until the Disability Elimination Period is satisfied. If your continuation of insurance for Total Disability is approved, your insurance will be continued for the amount of life insurance in effect for you under the Policy on the last day of Active Work, subject to any reductions shown in the Schedule, you must surrender your Conversion policy and any premiums paid for such policy will be refunded.

Proof of Total Disability

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

In order to confirm that you are Totally Disabled, we have the right to have you examined by a Physician of our choice at our expense.

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

When Continuation of Insurance for Total Disability is Approved

We will notify you in writing if your proof of Total Disability is approved by us.

Once you are approved for insurance under this provision, a recurrent disability caused by, resulting from or contributed to by the prior Total Disability will be treated as part of your prior claim and you will not be required to satisfy another Disability Elimination Period if:

a) you were continuously insured for the period between your prior claim and your recurrent disability; and
b) your recurrent disability occurs within 6 months of the end of your prior claim.

When Continuation of Insurance for Total Disability is Not Approved

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

If you are ineligible for insurance under this provision or your insurance under this provision ends, you and your Dependents will have 31 days from the date of our notice to submit a Written Request for insurance under the PORTABILITY provision or CONVERSION provision, if you have not returned to Active Work or you are not eligible for insurance under the CONTINUATION OF INSURANCE FOR PARTIAL DISABILITY provision.

When Insurance Under this Provision Ends

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

a) you are eligible to continue insurance under the CONTINUATION OF INSURANCE FOR PARTIAL DISABILITY provision; or
b) you return to Active Work.

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

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

In no event will insurance under this provision end less than one year from the day your Total Disability is approved by us.

Insurance under this provision also ends in accordance with the GRACE PERIOD provision.

PORTABILITY

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

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

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

a) you reach the Attained Age of 70, but your Spouse is under age 70;
b) you continue insurance under the CONTINUATION OF INSURANCE FOR TOTAL DISABILITY WITH WAIVER OF PREMIUM provision;
c) you enter active duty in the Armed Forces, National Guard or Reserves of any state or country for a period of more than 31 days;
d) divorce or legal separation of you and your Spouse; or
e) your death.

In the event your Spouse continues to receive insurance under this provision, each Dependent child may be insured under you or your Spouse, but not both.

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

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

a) the amount in effect on the day insurance ended; or
b) $500,000 for you and $250,000 each for your Dependents.

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

If you or your Spouse have received benefits under the LIVING BENEFITS (ACCELERATED BENEFITS) provision, you or your Spouse are not eligible to obtain insurance under this provision. If ineligible for this reason, you or your Spouse may be able to obtain insurance under the CONVERSION provision.

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

Notice of the Right to Continue Group Insurance Under this Provision

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

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

How to Continue Group Insurance Under this Provision

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

The Group Term Life Insurance Portability Policy

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

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

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

CONVERSION

This provision allows for conversion of life insurance.

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

The Conversion Policy issued under this provision will be:

a) any type of individual policy of life insurance then customarily issued by us for purposes of conversion, except term insurance;
b) issued without any supplemental benefits; and
c) for an amount of life insurance that is up to the amount of life insurance that ended or was reduced, less the amount of any other group life insurance the applicant becomes eligible for within 60 days after insurance ended or was reduced.

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

The Conversion Policy will become effective on the later of the date of issue or 60 days after the date insurance ended or was reduced.

Notice of the Right to Obtain Insurance Under this Provision

The conversion period is the period of time that is 60 days from the date insurance would otherwise end or reduce (Conversion Period). When insurance would otherwise end, notice of the right to convert may be given. If notice is not given at least 15 days after the start of the Conversion Period, an extension of the period of time to apply for continued insurance under this provision will be allowed. Any extension will expire on the earlier of:

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

If you or any of your Dependents are entitled to obtain a Conversion Policy and die within 60 days after insurance ends or reduces, we pay the amount of life insurance which could have been converted, even if you or your Dependents did not apply for a Conversion Policy.

How to Request Insurance Under this Provision

Insurance is available without providing Evidence of Insurability. You or your Dependents must submit a Written Request for insurance under this provision. The Written Request and the initial premium due must be submitted to us within the Conversion Period.

Conversion Insurance and Your Return to Active Work

If you or any of your Dependents are issued a Conversion Policy and again become eligible for insurance, insurance will become effective (subject to all eligibility requirements) only if any Conversion Policy(ies) is/are surrendered to us. If Conversion Policy(ies) are not surrendered, Evidence of Insurability will be required.

LIVING BENEFITS (ACCELERATED BENEFIT)

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

This section only applies to the life insurance offered by the Policy.

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

ABOUT LIVING BENEFITS

If you or your Spouse incur a Terminal Condition while insured, you, your Spouse or your legal representative may submit a Written Request for Living Benefits.

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

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

The amount of life insurance benefits payable for you or your Spouse in the event of death will be reduced by the amount of Living Benefits paid for you or your Spouse. Life insurance on other Insured Persons, if any, is not affected by payment of Living Benefits for you or your Spouse.

APPLYING FOR LIVING BENEFITS

To apply for Living Benefits, you, your Spouse or your legal representative must provide us:

a) a Written Request for Living Benefits; and
b) proof of your or your Spouse's Terminal Condition, including an attending Physician's written statement.

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

CONDITIONS OF LIVING BENEFITS

Living Benefits are subject to the following conditions:

a) Living Benefits are payable for you or your Spouse only once;
b) you can request Living Benefits in any $1,000 increment, subject to the limits specified in this section;
c) premium must continue to be paid on the full amount of life insurance, unless subject to waiver of premium under the CONTINUATION OF INSURANCE FOR TOTAL DISABILITY WITH WAIVER OF PREMIUM provision;
d) the amount of insurance you or your Spouse may obtain under the CONVERSION provision will be reduced by the amount of Living Benefits paid for you or your Spouse; and
e) the PORTABILITY provision is not available for you or your Spouse after payment of Living Benefits.

WHEN LIVING BENEFITS ARE NOT AVAILABLE

Living Benefits are not available:

a) when you or your Spouse have irrevocably assigned life insurance;
b) if such benefits were paid under a Prior Plan;
c) for any Terminal Condition caused by a suicide attempt or an intentionally self-inflicted Injury;
d) during any Conversion or Portability Period;
e) if the required premium is due and unpaid on the date the Written Request for Living Benefits is made;
f) if requested after insurance ends; or
g) if requested after the Policy terminates.

PREMIUM PAYMENTS

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

PAYMENT OF PREMIUM THROUGH PAYROLL DEDUCTION

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

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

Payment of premium does not guarantee eligibility for coverage.

OPTIONS FOR PAYMENT OF PREMIUM FOR APPROVED CONTINUATION OF INSURANCE

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

a) the Policyholder may pay the premium; or
b) you may pay premium to the Policyholder who will then submit premium to us.

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

Payment of premium does not guarantee eligibility for coverage.

GRACE PERIOD

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

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

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

PREMIUM AND PREMIUM CHANGES

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

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

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

Premium amounts will change if:

a) you or your Spouse reach the Attained Age of the next higher age band in the premium rate structure for the Policy; or
b) you or your Spouse reach an Attained Age when benefits are reduced as described in the BENEFIT REDUCTIONS provision in the Schedule section of this Certificate; or
c) premium rates under the Policy are changed.

CLAIMS PROVISIONS

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

CLAIM FORMS

Before benefits are considered, we must be given written proof of loss. A claim form can be requested from the Plan Administrator, from us or obtained on our website. A request for a claim form should be made within 20 days after a loss occurs or as soon as reasonably possible. If we do not provide a claim form within 15 days of the request, written proof of claim may be submitted that includes the nature, date, cause and extent of the loss for which the claim is made.

PROOF OF LOSS

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

INDEPENDENT EXAMINATION AND AUTOPSY

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

We will pay for these examinations; however, you may be responsible for fees associated with failure to notify the examination office of your appointment cancellation within the required amount of time specified by the examiner. We may recover this fee by reducing benefits that are payable. We will not require more than a reasonable number of examinations. Where not prohibited by law, we may also require an autopsy. We will pay for this autopsy.

HOW TO OBTAIN PLAN BENEFITS

Forward the completed claim form to:
United of Omaha Life Insurance Company
3300 Mutual of Omaha Plaza
Omaha, Nebraska 68175

CLAIM ASSISTANCE

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

PAYMENT OF CLAIMS

Benefits will be paid immediately after we receive written proof of loss and any other required supporting information.

Unless you have assigned this insurance, benefits for any Insured Person will be paid to you, except benefits payable due to your death will be paid to:

a) your designated beneficiary(ies); if none, then to
b) your surviving Spouse; if none, then to
c) your surviving natural and/or adopted children, in equal shares; if none, then to

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

You are the beneficiary of your Dependent's benefits. If you are not living at the time of the death of any of your Dependents, the following will apply:

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

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

CLAIM REVIEW AND APPEAL PROCESS

Claim Review

We will notify the Claimant in writing of our decision to either approve or deny a claim within:

a) 90 days of the date a life claim is received by us; or
b) 45 days of the date a continuation of insurance for total disability claim it is received by us.

If we deny a claim in whole or in part, we will explain the reasons for our denial in our notice. If the Claimant disagrees with the reasons given, the Claimant, or authorized representative of such person, may ask that we reconsider the claim through the appeal process.

Appeal Process

To appeal a denied claim, the Claimant must notify us and ask that we reconsider our original benefit decision within:

a) 60 days after receiving notice of our denial of a life claim; or
b) 180 days after receiving notice of our denial of a continuation of insurance for total disability claim.

The Claimant's appeal request must be submitted to us in writing or electronically and should state the reasons the Claimant believes the claim denial was incorrect. Any additional information, documents or other materials that might allow us to change our original decision should also be included. Appeal requests must be sent to us at our Omaha, Nebraska address shown in the CLAIMS ASSISTANCE provision.

We will notify the Claimant in writing of our final claim decision within:

a) 60 days after receiving a life appeal request; or
b) 45 days after receiving a continuation of insurance for total disability appeal request.

If we need more time due to circumstances beyond our control, we will inform the Claimant of our need for an extension prior to the end of this time frame.

Notice

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

BENEFICIARY DESIGNATION

In the event of your death, a beneficiary should be designated. Beneficiary records will be kept by the Policyholder, Plan Administrator or the office where beneficiary records for the Policy are kept. The most current beneficiary designation in effect under a Prior Plan will be accepted as a beneficiary designation under the Policy.

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

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

FACILITY OF PAYMENT

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

MODE OF PAYMENT

Life insurance benefits will be paid by us in one lump sum.

REFUND TO US

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

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

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

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

If it is found that we paid less benefits than we should have paid under the Policy, we will make additional payments, as necessary.

STANDARD PROVISIONS

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

INSURANCE CONTRACT

The insurance contract consists of:

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

CHANGES IN THE INSURANCE CONTRACT

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

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

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

INCONTESTABILITY

We will not contest this Policy after it has been in force two years, during an Insured Person's lifetime, except for nonpayment of premium.

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

LEGAL ACTIONS

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

CONFORMITY WITH STATE AND FEDERAL LAW

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

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

Actively Working, *Active Work* means you are:

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

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

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

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

Annual Earnings means your gross annual earnings received from the Policyholder and verified by premium we have received in effect immediately prior to the date of loss.

Your annual earnings include your contributions to deferred compensation plans.

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

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

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

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

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

a) your Spouse;
b) your natural born, legally adopted child or foster child;
c) your stepchild (or child of your domestic partner, civil union partner or equivalent);
d) a child that you or your Spouse are required to provide insurance for under the terms of a decree, judgment or order issued by a court of competent jurisdiction; or
e) any other child who lives with you in a regular parent/child relationship and who qualifies as your dependent as defined in the United States Internal Revenue Code.

A dependent does not include:

a) anyone insured 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 70;
e) a child who has reached the age of 26 unless the child is Incapacitated;
f) a stillborn child;
g) your child if the child has been legally adopted by another person; or
h) a child placed in your home by a social service agency which retains control over the child.

Disability Elimination Period means the period of time that must be satisfied before you are eligible to continue benefits, beginning on the date your Injury or Sickness occurred. The length of the disability elimination period is shown in the CONTINUATION OF INSURANCE FOR TOTAL DISABILITY WITH WAIVER OF PREMIUM provision.

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

Employee means a person who is:

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

An employee does not include a person:

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

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

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

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

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

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

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

Injury means bodily harm that:

a) is proximately caused by external means requiring treatment by a Physician;
b) and all other causes; and
c) occurs after the Policy Effective Date and while insurance is in effect for an Insured Person.

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

Life Event means:

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

Living Benefits means an advance payment of part of your or your Spouse's life insurance death benefit.

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

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

Physician means a legally qualified medical doctor who is licensed to practice medicine, prescribe drugs or perform surgery, or any other licensed healthcare provider 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 life insurance plan.

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

Policyholder means TK Services, Inc..

Policy Anniversary means February 1 of each Policy Year.

Policy Effective Date means February 1, 2020.

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, sponsored by or available through the Policyholder on the day before the Policy Effective Date.

Sickness means a physical or mental disease, illness, infection, disorder or condition, including pregnancy and any drug or alcohol disorder, that requires treatment by a Physician, occurs after the Policy Effective Date and while insurance is in effect for an Insured Person.

Spouse means the person to whom you are legally married. Spouse also includes your domestic partner, civil union partner or equivalent, as recognized by law in your jurisdiction of residence.

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

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

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

Total Disability, Totally Disabled means that because of an Injury or Sickness you are unable to perform with reasonable continuity the substantial and material duties of your occupation during the first 24 months following the date your Injury or Sickness occurred. After 24 months of Total Disability, you are unable to engage with reasonable continuity in another occupation in which you could reasonably be expected to perform satisfactorily in light of your age, education, training, experience, station in life, physical and mental capacity.

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 approved by us.

You, Your means the Employee who may be eligible or insured under the Policy.

ADDITIONAL SUMMARY PLAN DESCRIPTION INFORMATION

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

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

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

The Plan provides coverage for more than one class of Employees.

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: 95-3950647
The Plan Number is: 501

PLAN ADMINISTRATOR

The Plan is provided through and administered by:

TK Services, Inc.
23935 Madison St
Torrance, CA 90505
Phone: (323) 319-1900 x114

AGENT FOR SERVICE OF LEGAL PROCESS

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

TK Services, Inc.
23935 Madison St
Torrance, CA 90505
Phone: (323) 319-1900 x114

PLAN YEAR

Each 12-month period beginning on February 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 Term Life Benefits

TK Services, Inc.

Group Number: G000BPHV

United of Omaha Life Insurance Company

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