YOUR GROUP
TERM LIFE BENEFITS

FOR EMPLOYEES OF:

Central California Alliance for Health DBA Santa Cruz-Monterey Managed Medical Cae Comm.

CLASS(ES):

All Eligible Employees

REVISION EFFECTIVE DATE:

July 1, 2022

PUBLICATION DATE:

July 25, 2022

NOTICE(S)

THIS CERTIFICATE DESCRIBES THE BENEFITS THAT ARE AVAILABLE TO YOU. PLEASE READ YOUR CERTIFICATE CAREFULLY. BENEFITS ARE PROVIDED THROUGH A GROUP POLICY ISSUED IN THE STATE OF CALIFORNIA.

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.

FRAUD WARNING
For your protection California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Group Number: G000BN2N

NOTICE

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

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

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

Consumer Division
Department of Insurance, Los Angeles Office
300 South Spring Street
Los Angeles, California 90013
1-800-927-4357
http://www.insurance.ca.gov/01-consumers/

ABOUT LIVING BENEFITS (ACCELERATED BENEFIT)

LIFE INSURANCE BENEFITS (BENEFITS PAYABLE BY REASON OF THE DEATH OF YOU) 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.

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 at the time benefits are accelerated or whether You 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 income and not subject to federal taxation. Tax laws relating to Living Benefits are complex. You are advised to consult with a qualified tax advisor about circumstances under which You 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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TABLE OF CONTENTS

PAGE

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CERTIFICATE OF INSURANCE

UNITED OF OMAHA LIFE INSURANCE COMPANY

Home Office:
Mutual of Omaha Plaza
Omaha, Nebraska 68175

United of Omaha Life Insurance Company certifies that Group Policy Number GLUG-BN2N (the Policy) has been issued to Central California Alliance for Health DBA Santa Cruz-Monterey Managed Medical Cae Comm. (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 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.

James T. Blackledge
Chief Executive Officer

David A. Vanheat
Corporate Secretary

SCHEDULE

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

CLASS(ES)

All Eligible Employees

LIFE INSURANCE FOR YOU (THE EMPLOYEE)

Your amount of life insurance is an amount equal to 1.5 times Your Annual Earnings, but in no event less than $10,000 or more than $215,000. Your amount of life insurance will be rounded to the next higher multiple of $1,000.

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.

ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE FOR YOU

Your amount of accidental death and dismemberment (AD&D) insurance is equal to Your amount of life insurance.

Your amount of AD&D insurance is also referred to as the Principal Sum. Your amount of AD&D insurance is subject to any reductions indicated in the Benefit Reductions provision of this Schedule. If You have questions regarding the amount of Your AD&D insurance, You may contact the Policyholder.

EVIDENCE OF INSURABILITY

Evidence of Insurability is not required for any amount of insurance under the Policy, unless otherwise stated in this Certificate.

BENEFIT REDUCTIONS

As You grow older, the amount of life and AD&D insurance for You will be reduced according to the following schedule:

At the Age of:	The Original Amount of Insurance Will Reduce to:
70	65%
75	50%

Reductions become effective on the first day of the Policy 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 70 or older on the date insurance becomes effective, the amount of life and AD&D insurance for You will be reduced as shown above. Thereafter, the amount of life and AD&D insurance will continue to reduce in accord with the schedule above.

ELIGIBILITY

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

DEFINITIONS

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

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 an Employee must satisfy before becoming eligible for insurance as described in the When an Employee Becomes Eligible for Insurance (Eligibility Waiting Period) provision.

Partial Disability, Partially Disabled means that, because of a disability that renders You unable to perform with reasonable continuity the substantial and material acts necessary to pursue Your usual occupation in the usual or customary way 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 still able to satisfy the requirements of the Employee definition.

Recurrent Disability means a Total Disability which is related to or due to the same cause(s) of a prior Total Disability for which You were approved for coverage under the Continuation of Insurance for Total Disability with Waiver of Premium provision of the Policy.

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 of 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.

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

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.

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 eligible for benefits or continuation of insurance under any provision of the Prior Plan;
d) is not a retired Employee; and
e) is not Totally Disabled on the Policy Effective Date.

Insurance under this provision is subject to the following conditions:

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

We reserve the right to request any information We need about the Prior Plan 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; or
d) the last day of the twelfth month following the Policy Effective Date.

If an Employee is eligible for insurance under this provision, the Employee 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 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.

WHEN INSURANCE BEGINS

An eligible Employee will become insured on the first day of the month that follows the latest of the day:

a) the Employee begins Active Work; or
b) the Employee submits a Written Request to enroll for insurance, if applicable.

If the Employee is not Actively Working on the day insurance would otherwise begin, insurance will begin on the day the Employee returns to Active Work.

EXCEPTIONS TO WHEN INSURANCE BEGINS

This provision does not apply if the Employee is eligible for coverage under the Continuity of Insurance Upon Transfer of Insurance Carrier provision.

Insurance for an Employee who is:

a) Totally Disabled;
b) confined in a Hospital as an inpatient;
c) confined in any institution or facility other than a Hospital such as a skilled nursing facility, convalescent nursing home, extended care facility or residential care facility; or
d) 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.

Insurance for an Employee who is not Actively Working on the Policy Effective Date due to Injury or Sickness will not take effect until the day after the Employee has completed one full day of Active Work.

CHANGES TO INSURANCE BENEFITS

Any allowable change in Your 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.

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

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

REINSTATEMENT OF INSURANCE

You may be eligible to reinstate insurance that has ended in accordance with this provision.

Reinstated insurance will take effect on the first day of the month that follows the date You become eligible for insurance. 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:

Involuntary Reduction in Hours

If insurance ended because the Employee was no longer Actively Working due to an involuntary reduction of hours worked, insurance may be reinstated without satisfying another Eligibility Waiting Period if the Employee returns to Active Work and there was no break in employment with the Policyholder after the date insurance ended.

Rehired Employee Due to Layoff or Termination

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

Rehired Employee Due to Leave of Absence

If insurance ended due to an approved leave of absence, insurance may be reinstated within 90 days from the date insurance ended without satisfying another Eligibility Waiting Period upon return to Active Work. If insurance ended due to military leave, insurance may be reinstated upon return to Active Work immediately after discharge from active duty without satisfying another Eligibility Waiting Period.

Transfer From Portability or Conversion

If insurance was obtained under the Portability or Conversion provision while an Employee was 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 provision will terminate upon reinstatement of insurance as an Actively Working Employee.

WHEN INSURANCE ENDS

Insurance will end on the earliest of the day:

a) an Insured Person is no longer eligible for insurance under the Policy; or
b) 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).

Insurance will also end:

a) on the day the Policy terminates; or
b) in accordance with the Grace Period provision.

NOTICE TO YOU WHEN INSURANCE ENDS

The Policyholder is required to notify You when insurance under the Policy ends if:

a) You cease to be eligible for insurance under the Policy; or
b) the Policy is discontinued and is not replaced by another policy or plan with no interruption in coverage.

Notice shall be provided within 15 days from the date insurance ends for You, and shall include information about any options available to continue or obtain insurance.

EXCEPTIONS TO WHEN INSURANCE ENDS

If insurance for You would otherwise end, You 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 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 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.

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; or
    3. the time period allowed by FMLA, USERRA or applicable federal or state law that allows for continuation;
b) the amount of insurance may not be increased while insurance is continued under this provision;
c) We receive notification of the approved layoff or leave from the Policyholder within 31 days from the date You cease Active Work; and
d) We continue to receive premium payment when due (premiums must be paid by You or on Your behalf).

Insurance under this provision will end on the 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 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 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 shall control.

When Your insurance would otherwise end due to Your Injury or Sickness, You may be able to continue insurance under this provision. In such circumstances, the total continuation period under this provision and the Continuation of Insurance for Layoff or Leave provision, if You were previously insured under this provision, shall not exceed 12 months.

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

a) We receive notification of Your Injury or Sickness from the Policyholder within 31 days from the date You cease Active Work or Your insurance would otherwise end; and
b) We continue to receive timely premium payment when due (premiums must be paid by You or on Your behalf).

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

Insurance under this provision will end on the earliest of 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 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 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 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 shall control.

When You are no longer eligible to continue insurance 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 under this provision if the following conditions are satisfied:

a) You are Partially Disabled, but not Totally Disabled;
b) We receive notification of Your Partial Disability from the Policyholder within 31 days from the date You are no longer eligible to continue insurance under the Continuation of Insurance for Injury or Sickness provision; and
c) We continue to receive timely premium payment when due (premiums must be paid by You or on Your behalf).

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

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

a) You return to Active Work;
b) 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;

c) You begin full-time employment with an employer other than the Policyholder; or
d) the Policy terminates.

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

If Your insurance under this provision ends and You have not returned to Active Work, You 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 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 shall control.

This provision only allows for continuation of life insurance under the Policy. Accidental death and dismemberment insurance may not be continued under this provision.

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.

If You are age 60 or older and become Totally Disabled, You may be able to obtain insurance under the Portability or Conversion provision.

About the Disability Elimination Period

The Disability Elimination Period is a period of 9 consecutive months. 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.

Proof of Total Disability

You must submit to Us 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. Proof of Total Disability may include medical records, a physical examination and a Physician statement.

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 requested by You because You question or dispute the results of the examination by the Physician of Our choice, 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. Any premium paid for Your insurance from the day You ceased to be Actively Working will be refunded in a lump sum within 31 days of Your approval.

Once You are approved for insurance under this provision, a Recurrent 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 under the Policy 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 will have 31 days from the date of Our notice to submit a Written Request for insurance under the Portability 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 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.

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

PORTABILITY

You have the right to continue receiving group life and accidental death and dismemberment 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 with the Policyholder ends;
c) You retire; or
d) the Policy terminates and the Policyholder does not obtain group life coverage within 31 days.

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

a) the amount in effect under the Policy on the day insurance ended; or
b) $500,000.

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

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

The Group Term Life Insurance Portability Policy

Group 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 become insured under the

Portability Policy, You 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.

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 Group Insurance Under this Provision

The portability period is the period of time that is 31 days from the date insurance under the Policy ends ("Portability Period"). When insurance under the Policy ends, notice of the right to continue receiving 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 apply for a Portability Policy 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 must submit a Written Request for insurance under the Portability Policy. The Written Request and the initial premium due must be submitted within the Portability Period.

CONVERSION

This provision allows for conversion of life insurance. Conversion insurance is not available for accidental death and dismemberment insurance.

When Employment or Class Membership Ends or the Amount of Insurance Reduces

If group life insurance ends because Your employment or membership in a class (as shown under Class(es) on the Schedule) ends or Your benefit amount reduces, You may apply for an individual policy of life insurance other than term insurance ("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; and
b) issued without any supplemental benefits.

Premium shall be 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 31 days after the date insurance under the Policy ended or was reduced.

When the Policy or a Class Terminates

You may apply for a Conversion Policy if insurance under the Policy ends due to termination of the Policy or termination of Your class (as shown under Class(es) on the Schedule), provided You have been insured under the Policy or any Prior Plan for at least 5 consecutive years.

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;
c) for an amount of life insurance that does not exceed the lesser of:
    1. $10,000; or
    2. the amount of insurance that ended under the Policy less the amount of any other group life insurance for which the applicant becomes eligible within 31 days after insurance under the Policy ended.

Premium shall be 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 31 days after the date insurance under the Policy ended or was reduced.

Notice of the Right to Obtain Insurance Under this Provision

The conversion period is the period of time that is 31 days from the date insurance under the Policy ends or reduces ("Conversion Period"). When insurance ends under the Policy, 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 in which to apply for a Conversion Policy 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 are entitled to obtain a Conversion Policy and die within 31 days after insurance under the Policy ends or reduces, We will pay the amount of life insurance which could have been converted, even if You did not apply for a Conversion Policy.

How to Request Insurance Under this Provision

Insurance is available without providing Evidence of Insurability. You must submit a Written Request for a Conversion Policy. 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 are issued a Conversion Policy and again become eligible for insurance under the Policy, insurance under the Policy will become effective (subject to all eligibility requirements) only if any Conversion Policy(ies) is/are surrendered to Us.

PREMIUM PAYMENTS

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

OPTIONS FOR PAYMENT OF PREMIUM FOR CONTINUED INSURANCE

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

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

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

Payment of premium does not guarantee eligibility for coverage.

GRACE PERIOD

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

Insurance will stay in force during the grace period, unless You or the Policyholder provides Us with written notice that insurance 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.

PREMIUM CHANGES

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

Premium amounts will change if:

a) You reach an age at which benefits are reduced as described in the Benefit Reductions provision in the Schedule; or
b) premium rates under the Policy are changed.

LIFE INSURANCE BENEFITS

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

BENEFITS

In the event of death while insured under the Policy, We will pay the amount of life insurance in effect at the time of death for You. Benefits payable by reason of Your death will be paid to Your beneficiary.

BENEFICIARY DESIGNATION

At the time You elect(ed) insurance under the Policy or any Prior Plan, 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.

If You have not designated a beneficiary, or no beneficiary survives You, in the event of Your death, benefits will be paid to:

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

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.

BENEFICIARY CHANGE

Your beneficiary may be changed, subject to any restrictions or limitations in the Policy. 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 You may send the Written Request to Us. 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 received.

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. An amount, if paid, will be deducted from the amount of life insurance benefits payable.

LIVING BENEFITS (ACCELERATED BENEFIT)

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

This section only applies to the life insurance offered by the Policy. Accidental death and dismemberment (AD&D) insurance is not included under this section.

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.

DEFINITIONS

Living Benefits means an advance payment of part of Your life insurance death benefit.

Terminal Condition means an Injury or Sickness that is expected to result in Your death within the next 12 months as certified by an attending Physician's written statement.

ABOUT LIVING BENEFITS

If You incur a Terminal Condition while insured under the Policy, 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 in effect at the time of the request or $161,250, whichever is less. The minimum amount is 10% of the amount of life insurance in effect for You at the time of the request or $1,000, whichever is greater.

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

The amount of life insurance benefits payable for You in the event of death will be reduced by the amount of Living Benefits paid for You. Payment of Living Benefits has no effect on accidental death and dismemberment (AD&D) insurance benefits.

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;
b) satisfactory proof of Your Terminal Condition, which may include an attending Physician's written statement, medical records and a physical examination; and
c) a statement of consent from any beneficiary(ies) or assignee(s).

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 only once under the Policy;
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 may obtain under the Conversion provision will be reduced by the amount of Living Benefits paid for You; and
e) The Portability provision is not available for You after payment of Living Benefits.

WHEN LIVING BENEFITS ARE NOT AVAILABLE

Living Benefits are not available:

a) when You have irrevocably assigned life insurance under the Policy;
b) if such benefits were paid under a Prior Plan;
c) when all or a portion of the life insurance benefits under the Policy are to be paid to a former Spouse as part of a divorce agreement or pursuant to a court order;
d) for any Terminal Condition caused by a suicide attempt or an intentionally self-inflicted Injury;
e) during any Conversion or Portability Period;
f) if the required premium is due and unpaid on the date the Written Request for Living Benefits is made;
g) if requested after insurance under the Policy ends; or
h) if requested after the Policy terminates.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS RIDER

This rider is made a part of group Policy GLUG-BN2N. It is subject to all of the Policy provisions which are not inconsistent with the provisions of this rider.

This rider is effective the later of July 1, 2022 or the day You become insured under the Policy.

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

DEFINITIONS

Accident means an external, sudden, unexpected, unforeseeable and unintended event. Accident does not include Sickness, disease, bodily or mental infirmity or medical or surgical treatment thereof, or bacterial or viral infection, regardless of how contracted, except for bacterial infection that is the natural and foreseeable result of an accidental external bodily Injury or accidental food poisoning.

Airbag means any factory-installed, inflatable, supplemental restraint device which meets published federal safety standards.

Automobile means a licensed private passenger motor vehicle for use on public roadways.

Coma, Comatose means the Insured Person is in a profound stupor or state of complete and total unconsciousness with a Glasgow Coma Score of eight (8) points or less, as a result of an Injury.

Intoxicated means having a blood alcohol level, at the time of the Accident, which equals or exceeds the legal limit for operating a motor vehicle in the jurisdiction in which the loss occurs.

Loss of a Hand or Foot means Severance of at least four whole fingers from one hand or Severance of the foot above the ankle joint.

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

Loss of Sight means total and permanent loss of sight of the eye which cannot be corrected by any means.

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

Loss of a Thumb and Index Finger means Severance at or proximal to the metacarpophalangeal joints (the joints that connect the fingers and the hand).

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.

Participation in a Riot means a violent disorder of the public peace by three or more persons assembled together and acting with a common intent.

Seat Belt means a factory-installed lap and shoulder seat belt or other restraint device which meets published federal safety standards.

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

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 him or her to operate the aircraft.

EXPOSURE AND DISAPPEARANCE

An Insured Person will be presumed to have died, for the purposes of accidental death and dismemberment insurance, 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.

BENEFITS

Basic Benefits

In the event of a loss while insured under the Policy, We will pay accidental death and dismemberment benefits based upon the amount of the Principal Sum in effect at the time of the loss for You. Benefits for Your insurance will be payable to You or to the beneficiary for life insurance under the Policy, unless otherwise indicated in a benefit provision included in this section. Where not prohibited by law, We may require an autopsy. We will Pay for this autopsy.

If an Insured Person is Injured or dies as a result of an Accident, We will pay the benefit shown in the following Table. If an Accident causes more than one loss shown in the Table, We will pay only the largest benefit.

Accidental Death and Dismemberment Benefits Table (the "Table")

Loss	Benefit
Loss of Life	Principal Sum
Loss of Both Hands	Principal Sum
Loss of Both Feet	Principal Sum
Loss of Entire Sight of Both Eyes	Principal Sum
Loss of One Hand and One Foot	Principal Sum
Loss of One Hand and Entire Sight of One Eye	Principal Sum
Loss of One Foot and Entire Sight of One Eye	Principal Sum
Loss of Speech and Hearing (both ears)	Principal Sum
Loss of Entire Sight of One Eye	One-half Principal Sum
Loss of Speech or Hearing (both ears)	One-half Principal Sum
Loss of One Hand or One Foot	One-half Principal Sum
Loss of Thumb and Index Finger of same Hand	One-fourth Principal Sum
Quadriplegia (Paralysis of both upper and lower limbs)	Principal Sum
Triplegia (Paralysis of three limbs)	Three-quarters Principal Sum
Paraplegia (Paralysis of both lower limbs)	One-half Principal Sum
Hemiplegia (Paralysis of an upper and a lower limb)	One-half Principal Sum
Uniplegia (Paralysis of a limb)	One-fourth Principal Sum

Airbag Benefit

We will pay a benefit amount of 10% of the Principal Sum, up to a maximum of $21,500 if:

a) an Insured Person was Injured in an Accident while driving or riding in the front seat of an Automobile directly behind an Airbag;
b) the Insured Person's death resulted from such Injury; and
c) a copy of the police accident report is submitted with the claim.

We will not pay this benefit if the Accident occurs when the:

a) Automobile was being used for racing, stunting, or exhibition work;
b) Airbag was disengaged; or
c) Insured Person was breaking any laws of the jurisdiction in which the Accident occurred.

This benefit amount is payable in addition to any other applicable benefits under the Policy.

Common Carrier Benefit

We will pay a benefit amount of 100% of the Principal Sum, up to a maximum of $1,000,000 if:

a) an Insured Person was Injured in an Accident while riding as a fare-paying passenger in any public air, land or water conveyance provided by a common carrier primarily for passenger service; and
b) the Insured Person's death resulted from such Injury.

We will not pay this benefit if the Insured Person was an operator or member of the crew on the common carrier conveyance at the time of the Injury. This benefit amount is payable in addition to any other applicable benefits under the Policy.

Seat Belt Benefit

We will pay a benefit amount of 10% of the Principal Sum, up to a maximum of $21,500 if:

a) an Insured Person was Injured in an Accident while driving or riding in an Automobile and wearing a Seat Belt;
b) the Insured Person's death resulted from such Injury; and
c) a copy of the police accident report is submitted with the claim.

We will not pay this benefit if the Accident occurs when the:

a) Automobile was being used for racing, stunting, or exhibition work;
b) Seat Belt was used to restrain more than one person;
c) Automobile is equipped with an automatic Seat Belt and the lap belt is not fastened; or
d) Insured Person is breaking any laws of the jurisdiction in which the Accident occurred.

This benefit amount is payable in addition to any other applicable benefits under the Policy.

Coma Benefit

We will pay a monthly benefit amount of 5% of the Principal Sum. Benefits will be payable to the Insured Person's legal representative or legally appointed guardian at the end of the month for up to 20 months if:

a) the Insured Person was Injured in an Accident and, as a result, becomes Comatose within 31 consecutive days of the Injury; and
b) the Insured Person remains Comatose for 31 consecutive days.

If the Insured Person's Glasgow Coma Score temporarily becomes nine (9) points or higher and then reverts to eight (8) points or less, this will not cause a discontinuance in the benefit payment if the lapses and subsequent Coma recurrences are due to the same Injury.

Benefits will be payable until the earlier of:

a) the end of the month in which the Insured Person is no longer Comatose; or
b) the end of the month in which the Insured Person dies.

EXCLUSIONS

We will not pay for any loss which:

a) directly results, whether the Insured Person is sane or insane, from:
    1. an intentionally self-inflicted Injury or Sickness; or
    2. suicide or attempted suicide;
b) directly results from the Insured Person's Participation in a Riot or in the commission of a felony;
c) directly results from Your active participation in an act of declared or undeclared war or armed aggression;
d) is incurred while the Insured Person is on active duty or training in the Armed Forces, National Guard or Reserves of any state or country and for which any governmental body or its agencies are liable;
e) is not permanent, unless specifically provided;
f) occurs more than 365 days after the Injury, except that this 365 day limit will not apply if the Insured Person is Comatose or being kept alive by an artificial support system at the end of the 365 days;
g) does not result from an Accident;
h) is caused by intentional, self-infliction of carbon monoxide poisoning emanating from a motor vehicle;
i) directly results from Injuries the Insured Person receives in any aircraft while operating, riding as a passenger, boarding or leaving, unless riding as a passenger in a commercial aircraft on a regularly-scheduled flight or while You are Traveling on Business of the Policyholder;
j) directly results from an Injury received while riding in any aircraft engaged in:
    1. racing;
    2. endurance tests;
    3. acrobatic or stunt flying;
k) is caused by the Insured Person, and is a result of Injuries received while under the influence of any controlled drug, unless administered on the advice of a Physician;
l) is caused by the Insured Person and is a result of Injuries the Insured Person receives while voluntarily Intoxicated.

UNITED OF OMAHA LIFE INSURANCE COMPANY

Corporate Secretary

PAYMENT OF CLAIMS

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

NOTICE OF CLAIM AND CLAIMS FORMS

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

Notice of claim may be made to Us (or any of Our authorized agents) within 20 days, or as soon as reasonably possible, after a death and/or a loss under the Accidental Death and Dismemberment Benefits Rider occurs. The notice should include:

a) The Policyholder's name and the Policy number or group number.
b) The Insured Person's name and mailing address.
c) Your name, mailing address and relationship to the Insured Person, if You are not the Insured Person for whom the claim is being filed.
d) 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.

Upon receipt of notice of claim, We will furnish to You, the Insured Person, or the beneficiary such forms as We usually furnish for filing a proof of occurrence or proof of loss. 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 after giving notice, the claimant shall be deemed to have complied with the requirements of the provision by providing, within the time frame for submitting proof of loss, written proof of claim that includes the nature, date, cause and extent of the loss for which the claim is made, in addition to the information listed previously in this section.

HOW TO OBTAIN PLAN BENEFITS

Forward the completed claim form to:
Benefits Administrator
Central California Alliance for Health DBA Santa Cruz-Monterey Managed Medical Cae Comm.
1600 Green Hills Road
Suite 101
Scotts Valley, California 95066

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 LOSS

The Insured Person or the beneficiary has 90 days from the date of loss to furnish Us with a completed claim form. Failure to furnish such proof within this time period shall not invalidate nor reduce any claim if:

a) it was not reasonably possible to give proof within that 90-day period; and
b) proof is furnished as soon as reasonably possible, but not later than one year after the date of loss, unless the Insured Person or the beneficiary is not legally capable.

PHYSICAL EXAMINATION

We may occasionally require the person of the insured 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.

PAYMENT OF CLAIMS

Benefits will be paid after We receive written proof of loss. Benefits will be paid only if We determine that the claimant is entitled to benefits under the terms of the Policy.

Benefits will be paid to the Insured Person or the beneficiary in accord with the Life Insurance Benefits section and/or Accidental Death and Dismemberment Benefits Rider.

The following statement is required by California law: Any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of written proof of loss.

MODE OF PAYMENT

Life insurance benefits will be available in one lump sum. Accidental death and dismemberment benefits will be available in one lump sum unless otherwise indicated in the Accidental Death and Dismemberment Benefits Rider.

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 recover any payments due to:

a) fraud or misrepresentation; or
b) any error We make in processing a claim.

You or the recipient of benefits must reimburse Us in full. We will determine the method by which the repayment is to be made.

CLAIM REVIEW AND APPEAL PROCEDURES FOR LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

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

IMPORTANT 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.

DEFINITIONS

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

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.

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

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 where 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: 90 days
b) Extension period: 90 days

If additional information is needed, We will notify the Claimant within 15 days of Our receipt of the claim. Once the Claimant receives Our request for additional information, the Claimant will be given no less than 30 days to submit the additional information to Us. We will make Our determination within 60 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:

a) the Insured Person's name;
b) the name of the person filing the appeal if different from the Claimant;
c) the Policy number; and
d) the nature of the appeal.

The request for an appeal 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 60 days from Our receipt of the request for an appeal. However, if We determine that an extension is required, We will notify the Claimant in writing of the extension prior to the termination of the initial appeal period. In no event will the extension exceed 60 days from the end of the initial appeal period. The extension notice will indicate the special circumstances requiring the extension and the date by which We expect to render the appeal decision.

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

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

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

CLAIM REVIEW AND APPEAL PROCEDURES FOR CONTINUATION OF INSURANCE FOR TOTAL DISABILITY BENEFITS

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

DEFINITIONS

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

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, and 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.

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

CLAIM REVIEW PROCEDURES

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

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

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

INITIAL CLAIM DECISION

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

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

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 180 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 180 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:

a) the Claimant's name;
b) the name of the person filing the appeal if different from the Claimant;
c) the Policy number; and
d) the nature of the appeal.

The request for an appeal 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.

A document, record, or other information will be considered relevant to a claim if it:

a) was relied upon in making the claim decision;
b) was submitted, considered, or generated in the course of making the claim decision, without regard to whether it was relied upon in making the claim decision; or
c) demonstrates compliance with administrative processes and safeguards designed to ensure and verify that claim decisions are made in accordance with the Policy and that, where appropriate, Policy provisions have been applied consistently with respect to similarly situated claimants.

RESPONSE TO APPEALS

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

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

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

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

STANDARD PROVISIONS

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

INSURANCE CONTRACT

The insurance contract consists of:

a) the Policy;
b) the Policyholder's signed application attached to the Policy; and
c) any signed application for You.

Statements in an application are considered representations and not warranties. We will not use any statements in an Insured Person's application, unless contained in a written application, to deny a claim or to contest the validity of this insurance unless We provide You or Your beneficiary 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 Certificate after it has been in force during Your lifetime for two years from its effective date. Any contest may only be based on a statement made in an application for this Certificate and only if such application is attached to this Certificate. The statement(s) upon which any contest may be based must be material to the risk We assumed.

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.

GENERAL DEFINITIONS

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

Annual Earnings means Your gross annual earnings received from the Policyholder and in effect immediately prior to the date of loss, as determined by the Policyholder and verified by the premium received by Us.

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.

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

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 on a seasonal or temporary basis; or
c) performing services for the Policyholder as an independent contractor, including persons reporting income 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 health applications, questionnaires, physical exams or written documentation, as required by Us.

Hospital means an accredited facility licensed by the proper authority of the area 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 of a facility or institution 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.

Injured means the occurrence of an Injury.

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

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

Physician means any of the following licensed practitioners:

a) a doctor of medicine (MD), osteopathy (DO), podiatry (DPM) or chiropractic (DC);
b) a licensed doctoral clinical psychologist;
c) a Master's level counselor and licensed or certified social worker who is acting under the supervision of a doctor of medicine or a licensed doctoral clinical psychologist;
d) a licensed physician's assistant (PA) or nurse practitioner (NP); or
e) where required by law, any other licensed practitioner of a healing art who is acting within the scope of his/her license.

A physician does not include:

a) a naturopathic doctor;
b) an acupuncturist;
c) a physician in training; or
d) You, Your Spouse or a child, brother, sister or parent of You or Your Spouse or any person who lives with You.

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.

Policy Anniversary means January 1 of each Policy Year.

Policy Effective Date means January 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 policy or plan of benefits:

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

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

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

Spouse means the person to whom You are legally married, or Your domestic partner, civil union partner or equivalent, as recognized and allowed by federal law, or by state law in Your state 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; or
b) You submit evidence that all applicable requirements of the jurisdiction in which you reside regarding the establishment of a domestic or civil union partnership have been met.

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, Insured Person means the Employee who is insured under the Policy.

ADDITIONAL SUMMARY PLAN DESCRIPTION INFORMATION

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

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

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

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

EMPLOYER IDENTIFICATION NUMBER AND PLAN NUMBER

The Employer Identification Number (EIN) is: 77-0395311
The Plan Number is: 501

PLAN ADMINISTRATOR

The Plan is provided through and administered by:

Central California Alliance for Health DBA Santa Cruz-Monterey Managed Medical Cae Comm.
1600 Green Hills Road
Suite 101
Scotts Valley, CA 95066
Phone: (831) 430-4189

AGENT FOR SERVICE OF LEGAL PROCESS

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

Central California Alliance for Health DBA Santa Cruz-Monterey Managed Medical Cae Comm.
1600 Green Hills Road
Suite 101
Scotts Valley, CA 95066
Phone: (831) 430-4189

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 authorized to apply for and accept the Policy and any changes to the Policy on behalf of the Policyholder.

Group Term Life Benefits

Central California Alliance for Health DBA Santa Cruz-Monterey Managed Medical Cae Comm.

Group Number: G000BN2N

United of Omaha Life Insurance Company

Home Office:
Mutual of Omaha Plaza
Omaha, Nebraska 68175