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# YOUR GROUP TERM LIFE BENEFITS

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**FOR MEMBERS OF:**

**Toledo Electrical Welfare Fund**

**CLASS(ES):**

All Eligible Employees

**REVISION EFFECTIVE DATE:**

January 1, 2017

**PUBLICATION DATE:**

April 19, 2017

## **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 OHIO.**

### **FRAUD WARNING**

Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

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

**United of Omaha Life Insurance Company**  
**Mutual of Omaha Plaza**  
**Omaha, Nebraska 68175**  
**Call Toll-Free: 1-800-775-8805**  
**[www.mutualofomaha.com](http://www.mutualofomaha.com)**

When contacting Us, please have Your Policy number available.

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

## **ABOUT LIVING BENEFITS (ACCELERATED DEATH 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 DEATH BENEFIT) PROVISION.**

This disclosure is a brief summary of the Living Benefits (Accelerated Death 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 Death 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 Death 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.

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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-ABZ7 (the Policy) has been issued to Toledo Electrical Welfare Fund (the Policyholder).

Insurance is provided for Members 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.

  
Chief Executive Officer

  
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 MEMBER)**

Your amount of life insurance is \$10,000.

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 \$10,000.

Your amount of AD&D insurance is also referred to as the Principal Sum. 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.



## 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 Eligible, Active Eligibility* means a Member is:

- a) eligible for insurance according to the Policyholder's rules of eligibility as described in Toledo Electrical Welfare Fund Self-Funded Plan Summary Description – Plan A Actives and as approved by Our authorized representative in Our home office;
- b) is not Totally Disabled; and
- c) eligible for insurance under the Policy in accordance with the terms and conditions of this Eligibility section.

If the Policyholder's rules of eligibility for insurance conflict with any of the terms and conditions of this Eligibility section, the terms and conditions of this Eligibility section shall control. Any changes to the Policyholder's rules of eligibility after the Policy Effective Date will not be effective for purposes of becoming or remaining eligible for insurance under the Policy unless such changes have been approved by Our authorized representative in Our home office.

*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.

*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 completely and continuously unable to perform any work or engage in any occupation.

### WHEN A MEMBER BECOMES ELIGIBLE FOR INSURANCE

A Member who is Actively Eligible on the Policy Effective Date becomes eligible for insurance under the Policy on the Policy Effective Date.

An individual that becomes a Member after the Policy Effective Date becomes eligible for insurance under the Policy on the day the Member begins Active Eligibility.

The day on which a Member 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.

### WAIVER OF PARTICIPATION IN A NON-CONTRIBUTORY PLAN

A Member may choose to waive participation in the Policy if premiums are 100% paid by the Policyholder (if the plan is non-contributory), due to any of the following:

- a) for religious or faith-based reasons;
- b) to avoid possible federal and/or state income tax liability; or
- c) for any other reason approved by Us.

For the waiver of participation to be considered by Us, the Member must submit a Written Request. The request must be signed by the Member, and in community property states, the Member's Spouse, if applicable. The waiver will not be effective until the Written Request is received and recorded by Us.

The waiver will be irrevocable for one full year from the date it is recorded by Us. After one full year has passed, if the Member would like to become insured or reinstate insurance under the Policy, Evidence of Insurability will be required. Such

evidence must be obtained at the Member's own expense. Insurance will not begin until after We approve Evidence of Insurability.

## **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 a Member 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 Eligible 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 Member; 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 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 Member returns to Active Eligibility for the Policyholder or begins employment with any other employer;
- b) the last day the Member would have been insured under the Prior Plan, if the Prior Plan had not ended or terminated;
- c) the day the Member'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 a Member is eligible for insurance under this provision, the Member will not be eligible for insurance under any continuation provision in this Certificate.

If Your insurance under this provision ends and You have not returned to Active Eligibility, 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 Member will become insured on the first day of the month that coincides with or follows the latest of the day:

- a) the Member begins Active Eligibility; or
- b) the Member submits a Written Request to enroll for insurance, if applicable.

If the Member is not Actively Eligible on the day insurance would otherwise begin, insurance will begin on the day the Member returns to Active Eligibility.

## **EXCEPTIONS TO WHEN INSURANCE BEGINS**

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

Insurance for a Member or Dependent who is:

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

on the day insurance is to begin will not take effect until the day after the Member or Dependent is no longer confined or the Member is no longer Totally Disabled.

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

## **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 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 Eligible on the day any increase in insurance would otherwise take effect, the increase will become effective the day after You return to Active Eligibility.

## **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 coincides with or follows the date You become eligible for insurance. If You are not Actively Eligible on the day the reinstated insurance would otherwise take effect, insurance will become effective on the day after You return to Active Eligibility.

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

### **Transfer From Conversion**

If insurance was obtained under the Conversion provision while a Member was not Actively Eligible, insurance may be reinstated up to the amount of insurance that was in effect on the last day of Active Eligibility.

## **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**

one of the following provisions: one of the following provisions:

- a) Continuation of Insurance for Federal and State laws
- b) Continuation of Insurance for Total Disability with Waiver of Premium
- c) Conversion
- d) Conversion

## **CONTINUATION OF INSURANCE FOR FEDERAL AND STATE LAWS**

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

The federal Family and Medical Leave Act (FMLA) and Uniformed Services Employment and Reemployment Rights Act (USERRA) and any amendments thereto, as well as other applicable federal or state laws, may allow continuation of insurance in certain instances for leaves of absence, layoff or termination. You may be able to continue insurance from the day You cease to be Actively Eligible due to one (or more) of these laws.

If insurance is continued for You, it may also be continued for Your Dependent(s). Contact the Policyholder for additional information regarding the continuation options that may be available to You and Your Dependent(s).

Contact the Policyholder for additional information regarding the continuation options that may be available to You.

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

- a) insurance may not be continued beyond 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; and
- c) We continue to receive premium payment when due (premiums must be paid by You or on Your behalf).

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

- a) the time period in a) in the preceding paragraph has been satisfied;
- b) You return to Active Eligibility;
- 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 Eligibility, You may be able to continue or obtain insurance under the Portability provision.

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

## **CONTINUATION OF INSURANCE FOR 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.

You may be able to continue insurance under this provision from the day You cease to be Actively Eligible due to Your Total Disability. After satisfaction of the Disability Elimination Period, and upon submission of proof of Total Disability acceptable to Us, 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 Conversion provision.

### **About the Disability Elimination Period**

The Disability Elimination Period is a period of 9 consecutive months. Your insurance will continue during the Disability Elimination Period provided premiums are paid by You or on Your behalf when due.

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

### **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. Any premium paid for Your insurance from the day You ceased to be Actively Eligible 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 Conversion provision, if You have not returned to Active Eligibility.

### **When Insurance Under this Provision Ends**

Insurance under this provision will end on the day You return to Active Eligibility.

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.

## **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 Eligibility**

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 31 days for payment of premiums. This means that, except for the initial premium, if premium is not paid on or before the date it is due, the premium must be paid in the 31-day period that follows. We will consider premium to be paid on the date We receive it.

Insurance will stay in force during the grace period, unless You or the Policyholder provides Us with written notice that insurance 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 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 \$10,000 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 DEATH 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 50% of the amount of life insurance for You in effect at the time of the request or \$5,000, 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, including an attending Physician's written statement; 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; and
- d) The amount of insurance You may obtain under the Conversion provision will be reduced by the amount of Living Benefits paid for You.

## **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 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-ABZ7. 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 April 1, 2017 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, independent of Sickness and all other causes. 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. Accident does include bacterial infection that is the natural and foreseeable result of an accidental external bodily Injury or accidental food poisoning.

*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).

*Participation in a Riot* means actively participating in a tumultuous disturbance of the peace by three or more persons assembling together of their own authority with intent to mutually assist one another in an illegal or legal act.

*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.

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")**

<b>Loss</b>	<b>Benefit</b>
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

## EXCLUSIONS

We will not pay for any loss which:

- a) 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) results from the Insured Person's Participation in a Riot or in the commission of a felony;
- c) results from 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;
- g) does not result from an Accident;
- h) is caused by intentional, self-infliction of carbon monoxide poisoning emanating from a motor vehicle;
- i) 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) 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**

*Richard C. Anderl*  
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.

### **CLAIM FORMS**

Before benefits are paid, We must be given written proof of loss as described in this section.

### **HOW TO OBTAIN PLAN BENEFITS**

Forward the completed claim form to:  
Benefits Administrator  
Toledo Electrical Welfare Fund  
727 Lime City Road  
Suite 200  
Rossford, Ohio 43460

### **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 and other information needed to prove loss. 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.

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

### **PAYMENT OF CLAIMS**

Benefits will be paid immediately after We receive acceptable written proof of loss, but not later than 60 days after receipt of such proof. Benefits will be paid only if We determine that the claimant is entitled to benefits under the terms of the Policy. We may require supporting information which may include, but which is not limited to, the following:

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

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.

## **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.

## **AUTHORITY TO INTERPRET POLICY**

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

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

The Insured Person or beneficiary has the right to request a review of Our decision. If, after exercising the Policy's review procedures, the Insured Person or beneficiary's claim for benefits is denied or ignored, in whole or in part, the Insured Person or beneficiary may file suit and a court will review the Insured Person or beneficiary's eligibility or entitlement to benefits under the Policy.

The Policyholder, as Plan sponsor, agrees that the Policyholder retains full responsibility for the legal and tax status of its benefits program and releases Us from all responsibility for the reporting and the employment-based design of the program and from all other responsibilities not accepted in writing by Our authorized representative in Our home office.



## **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: 60 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
- a) 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 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 use any statements in an Insured Person's application to contest the validity of this insurance after it has been in force during the lifetime of the Insured Person for two years.

### 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 five 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.

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

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

*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. It must result in loss independently of Sickness and other causes.

*Member* means a person who is:

- a) a citizen or permanent resident of the United States; and
- b) an inside apprentice or teledata apprentice (divisions 3 through 6) in good standing with the Policyholder; or
- c) a class 26 (non bargained) employee whose employer executes a participation agreement with the board of trustees or active employee eligible; or
- d) active employees (journeymen) who are covered under an agreement between National Electrical Contractors Association, Ohio/Michigan Chapter and the International Brotherhood of Electrical Workers Local Union No. 8 (collective bargaining agreement) and do not regularly attend classes at the Joint Apprentice Training Committee.

A member does not include a person who resides outside the United States or Canada for a period in excess of 12 consecutive months unless written approval has been received from Our authorized representative in Our home office.

*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 December 1 of each Policy Year.

*Policy Effective Date* means December 1, 2008.

*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 applicable federal law, state law, or law of the county, city or local government in Your jurisdiction of residence. A spouse may include Your same sex or opposite sex domestic or civil union partner or equivalent if:

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

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

*You, Your, Insured Person* means the Member who is insured under the Policy.

**Group Term Life Benefits**

**Toledo Electrical Welfare Fund**

**Group Number: G000ABZ7**

**United of Omaha Life Insurance Company**

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



**Mutual of Omaha**