YOUR GROUP VOLUNTARY TERM LIFE BENEFITS

FOR MEMBERS OF:

Toledo Electrical Welfare Fund

CLASS(ES):

All Eligible Employees

REVISION EFFECTIVE DATE:

January 1, 2019

PUBLICATION DATE:

April 29, 2019

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.

Group Number: G000ABZ7

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

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 GVTL-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 and Your Dependent(s), if applicable, are eligible for the insurance, become insured and remain insured as described in this Certificate and according to the terms and conditions of the Policy.

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

This Certificate replaces any certificate previously issued under the Policy.

James T. Blackledge
Chief Executive Officer

Jay C. Vanbeat
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) AND YOUR DEPENDENT(S)

You may elect to be insured for an amount of life insurance equal to one of the following options:

Option 1: You may elect to be insured for an amount of life insurance from $10,000 to $40,000, in increments of $10,000. These premiums will be deducted from Your Supplemental Fringe Benefit Fund (SA). You may also elect to be insured for an additional amount of life insurance from $10,000 to $110,000, in increments of $10,000. These additional premiums will be paid by Electronic Funds Transfer from Your checking or savings account (see the Premium Payments form).

You may elect to have Your Spouse insured for an amount of life insurance from $5,000 to $75,000, in increments of $5,000, provided the amount elected does not exceed 50% of Your amount of life insurance.

You may elect to have Your eligible Dependent child(ren) insured for an amount of life insurance from $2,000 to $10,000, in increments of $1,000, provided the amount elected does not exceed 50% of Your amount of life insurance. Each eligible Dependent child must have the same amount of insurance.

Premiums for Your Dependent(s) will be paid by Electronic Funds Transfer from Your checking or savings account (see the Premium Payments form).

Option 2: You may elect to be insured for an amount of life insurance from $10,000 to $150,000, in increments of $10,000.

You may elect to have Your Spouse insured for an amount of life insurance from $5,000 to $75,000, in increments of $5,000, provided the amount elected does not exceed 50% of Your amount of life insurance.

You may elect to have Your eligible Dependent child(ren) insured for an amount of life insurance from $2,000 to $10,000, in increments of $1,000, provided the amount elected does not exceed 50% of Your amount of life insurance. Each eligible Dependent child must have the same amount of insurance.

Premiums for You and Your Dependent(s) will be paid by Electronic Funds Transfer from Your checking or savings account (see the Premium Payments form).

If You have questions regarding the amount of life insurance for You and Your Dependent(s), You may contact the Policyholder.

GUARANTEE ISSUE AMOUNT(S) AND EVIDENCE OF INSURABILITY

Guarantee issue is only available if the total number of Members insured under the Policy attains or remains above 10 Members or 13% of the eligible Members, whichever is greater. If the total number falls below the required level, the Guarantee Issue Amount(s) may be reduced or rescinded.

Guarantee Issue Amount For You (The Member)

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

Guarantee Issue Amount For Your Spouse

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

Guarantee Issue Amount For Your Dependent Child(ren)

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

Insurance for You and Your Dependent(s), if applicable, is only available on a guarantee issue basis:

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

Evidence of Insurability

Evidence of Insurability is required for:

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

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

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 Plan 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.

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

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

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.

Life Event means:

a) a change in Your legal marital status or domestic partnership (or equivalent);
b) a change in the number of Your Dependents; or
c) a significant cost or coverage change under any other employer or group sponsored life plan under which You or Your Dependent(s) are covered.

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.

WHEN A DEPENDENT BECOMES ELIGIBLE FOR INSURANCE

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

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

provided You elect insurance for yourself under the Policy.

If both You and Your Spouse are eligible for insurance under the Policy as Members of the Policyholder, neither You nor Your Spouse may elect insurance as a Dependent of the other person.

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

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

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

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.

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

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

Insurance under this provision will end on the earliest of:

a) the day the 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 or the Portability provision in this Certificate.

If Your insurance under this provision ends and You have not returned to Active Eligibility, You and Your Dependent(s) 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 must enroll for insurance by submitting a Written Request for insurance for the Member and any Dependent(s). The Written Request must be submitted to the Policyholder within 31 days following the day the Member or Dependent(s) become(s) eligible. If the Written Request for insurance is not submitted within 31 days following the day the Member or Dependent(s) become(s) eligible for insurance, the Member and/or Dependent(s) must provide Evidence of Insurability.

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;
b) the Member submits a Written Request to enroll for insurance, if applicable; or
c) We approve Evidence of Insurability, if required.

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.

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

a) the Member becomes insured, unless otherwise agreed to by Our authorized representative in Our home office;
b) the Member acquires the eligible Dependent;
c) the Member submits a Written Request to enroll the Dependent for insurance, if applicable; or
d) We approve Evidence of Insurability, if required.

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

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

Insurance for a Dependent child who became Incapacitated prior to reaching the age of 21, or age 25 if a Student, will begin in accordance with the When Insurance Begins provision, provided the child otherwise meets the definition of Dependent.

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

THE FIRST ENROLLMENT PERIOD

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

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

SUBSEQUENT ENROLLMENT PERIODS

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

WHEN ELECTION CHANGES ARE PERMITTED

A Member may elect, drop, increase, decrease or change insurance as allowed by the Policyholder. Any election of or increase in insurance for a Member or Dependent will require Evidence of Insurability unless otherwise stated or allowed in the Policy.

Life Events

Within 31 days of a Life Event, You may submit a Written Request to change insurance.

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

A Member who experiences a Life Event who previously declined insurance under the Policy must submit Evidence of Insurability for any change of insurance to be considered by Us.

CHANGES TO INSURANCE BENEFITS

Any allowable change in Your or Your Dependent's 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, or the first day of the month that follows the day We approve Evidence of Insurability (if required by Us), whichever is later.

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

If You are not Actively 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 for You and/or Your Dependent(s) in accordance with this provision. You must submit a Written Request to reinstate insurance within 31 days of Your return to Active Eligibility. We will require Evidence of Insurability if the amount of insurance being requested exceeds the amount of insurance in effect on the Member's last day of Active Eligibility.

Reinstated insurance will take effect on the first day of the month that coincides with or follows the date of the Written Request, or the first day of the month that follows the day We approve Evidence of Insurability (if required by Us), whichever is later. If You are not Actively 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:

Non-Payment of Premium or Voluntary Termination of Insurance

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

Transfer From Portability or Conversion

If insurance was obtained under the Portability or 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. Any insurance provided through the Portability provision will terminate upon reinstatement of insurance as an Actively Eligible Member.

WHEN INSURANCE ENDS

Insurance will end on the Policy Anniversary that coincides with or follows 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 or any of Your Dependent(s) 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 or any of Your Dependent(s), and shall include information about any options available to continue or obtain insurance.

EXCEPTIONS TO WHEN INSURANCE ENDS

If insurance for You and/or Your Dependent(s) would otherwise end, You and/or Your Dependent(s) may be able to continue or obtain insurance under 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) Portability
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 and Your Dependent(s) may be able to continue or obtain insurance under the Portability provision.

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

CONTINUATION OF INSURANCE FOR 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.

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.

Insurance may only be continued for You. If You are able to continue insurance under this provision, Your Dependent(s) may be able to obtain insurance under the Portability or Conversion provision.

If You are age 60 or older and become Totally Disabled, You and Your Dependent(s) 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. 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 and Your Dependent(s) 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 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.

PORTABILITY

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

a) You cease to be Actively Eligible and are not eligible for insurance under any other continuation provision in this Certificate (if applicable);
b) Your employment with the Policyholder ends; or
c) You retire; or
d) the Policy terminates and the Policyholder does not obtain group life coverage within 31 days.

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

a) You reach the Attained Age of 70, but Your Spouse is under age 70;
b) You continue insurance under the Continuation of Insurance for Total Disability with Waiver of Premium provision;
c) You enter active duty in the Armed Forces, National Guard or Reserves of any state or country for a period of more than 31 days;
d) divorce or legal separation of You and Your Spouse; or
e) Your death.

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

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

If an Insured Person requests to continue to receive group insurance under this provision, the amount of insurance for each Insured Person shall not exceed the lesser of:
a) the amount in effect under the Policy on the day insurance ended; or
b) $500,000 for You and $250,000 for Your Dependents.

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 and Your Dependent(s) 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 or Your Spouse become insured under the Portability Policy, You or Your Spouse will receive a certificate of insurance that describes the terms and conditions of 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 or Your Spouse 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.

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"). If group life insurance for any of Your Dependent(s) ends or reduces due to Your death, divorce, legal separation or failure to satisfy any other eligibility condition, Your Dependent(s) may also apply for a Conversion Policy.

The Conversion Policy issued under this provision will be:

a) any type of individual policy of life insurance then customarily issued by Us for purposes of conversion, except term insurance; 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 and/or Your Dependent(s) 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 or any of Your Dependent(s) 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 or Your Dependent(s) did not apply for a Conversion Policy.

How to Request Insurance Under this Provision

Insurance is available without providing Evidence of Insurability. You or Your Dependent(s) 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 or any of Your Dependent(s) 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.

PAYMENT OF PREMIUMS THROUGH ELECTRONIC FUNDS TRANSFER

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

Premiums will be automatically deducted from an account You designate through electronic funds transfer (EFT). The first premium is due to Us on the Policy Effective Date or Your effective date of insurance under the Policy, whichever is later. Subsequent premiums are due on the first or fifteenth day of each subsequent month.

If there is an error or problem with the EFT process, or if there are insufficient funds in the account You designate, premium payments must be made to Our home office or to a location We designate, using a payment method We accept.

Payment of premium does not guarantee eligibility for coverage**.**

OPTIONS FOR PAYMENT OF PREMIUM FOR CONTINUED INSURANCE

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

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

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

Payment of premium does not guarantee eligibility for coverage.

GRACE PERIOD

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

Insurance for You and/or Your Dependent(s) will stay in force during the grace period, unless You or the Policyholder provides Us with written notice that insurance for You and/or Your Dependent(s) will terminate during the grace period. If We receive such notice, insurance will terminate for You and/or Your Dependent(s) on the date requested.

If any premium due is not paid during the grace period, insurance for You and/or Your Dependent(s) 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 for You and/or Your Dependent(s), the Policyholder will provide You with notice of Your new premium amount upon request if You are responsible for the payment of premiums for insurance.

If there is a change in the amount of the premium for insurance for You and/or Your Dependent(s) in accordance with the terms of the Policy, or a change in the amount of insurance for You and/or Your Dependent(s) as the result of a request of the Policyholder, the Policyholder will provide You with notice of the change at least 15 days prior to the date of the change if You are responsible for the payment of premiums for insurance.

Premium amounts will change if:

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

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 or any of Your Dependent(s), if applicable. Benefits payable by reason of Your death will be paid to Your beneficiary. Benefits payable by reason of the death of Your Dependent(s), if applicable, will be paid to You.

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.

You are the beneficiary of Your Dependent(s) benefits. If You are not living at the time of the death of any of Your Dependent(s), the following will apply:

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

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

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, or to the death and subsequent burial of any of Your Dependent(s), if applicable. An amount, if paid, will be deducted from the amount of life insurance benefits payable.

LIFE INSURANCE BENEFITS EXCLUSION

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

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

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.

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 $55,000, 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. Life insurance on other Insured Persons, if any, is not affected by payment of Living Benefits for You.

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;
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.

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.

MODE OF PAYMENT

Life insurance benefits will be available in one lump sum.

REFUND TO US

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

We also have a right to 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 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
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 or Your Dependent(s).

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.

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.

Attained Age means the age of the Insured Person as of the Policy Anniversary that coincides with or follows the Insured Person's birthday. For example, if an Insured Person's 50th birthday is on March 1, 2020 and the Policy Anniversary is December 1, the Insured Person will reach the attained age of 50 on December 1, 2020.

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

Dependent means a citizen, permanent resident or lawful resident of the United States who, as indicated by evidence acceptable to Us, is:

a) Your Spouse;
b) Your natural born or legally adopted child;
c) Your stepchild; or
d) any other child who lives with You in a regular parent/child relationship and who qualifies as Your "dependent" as defined in the United States Internal Revenue Code.

A dependent does not include:

a) anyone insured under the Policy as a Member;
b) anyone who is a member of the Armed Forces, National Guard or Reserves of any state or country on active duty (except for temporary duty of 31 days or less);
c) Your divorced, legally separated or former Spouse;
d) Your Spouse after You reach the Attained Age of 70;
e) a child less than 14 days old;
f) a child who has reached the age of 21, or the age of 25 if a Student, unless the child is Incapacitated;
g) Your married child(ren);
h) Your child if the child has been legally adopted by another person; or
i) a child placed in Your home by a social service agency which retains control over the child.

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.

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

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

Hospital means 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.

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

Injury, Injuries means an accidental bodily injury that requires treatment by a Physician. It must result in loss independently of Sickness and other causes.

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

Member means a person who is:

a) a citizen or permanent resident of the United States; or
b) an inside apprentice of 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 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.

Student means Your Dependent child who attends an accredited high school, trade school, college, university or other institution of higher learning and is enrolled full-time as indicated by evidence acceptable to Us. Student includes a Dependent child who would otherwise qualify as a student but cannot maintain full-time enrollment due to Sickness or Injury.

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

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 means the Member who is insured under the Policy.

Group Voluntary 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