
**YOUR GROUP
SHORT-TERM DISABILITY
BENEFITS**

**Brotherhood of Locomotive Engineers & Trainmen - Norfolk
Southern - North**

Effective January 1, 2012

HOW TO OBTAIN PLAN BENEFITS

To obtain benefits see the Payment of Claims provision.

Forward your completed claim form to:

United of Omaha Life Insurance Company
Group Disability Management Services
Mutual of Omaha Plaza
Omaha, Nebraska 68175

CLAIM ASSISTANCE

If you need assistance with filing your claim or an explanation of how your claim was paid, contact the:

United of Omaha Life Insurance Company
Group Disability Management Services
Mutual of Omaha Plaza
Omaha, Nebraska 68175
Call Toll Free: 1-800-877-5176

When contacting the Company please have your policy number available. Your policy number is GUG-AKGH.

UNITED OF OMAHA LIFE INSURANCE COMPANY

A MUTUAL of OMAHA COMPANY

GROUP SHORT-TERM DISABILITY INSURANCE SUMMARY OF COVERAGE



Brotherhood of Locomotive Engineers & Trainmen - Norfolk Southern - North
GUG-AKGH
Effective: January 1, 2012
All Norfolk Southern Engineers

This Summary of Coverage provides a brief description of some of the terms, conditions, exclusions and limitations of Your employer's Policy. Definitions of capitalized terms in this Summary of Coverage can be found in the Certificate. For a complete description of the terms, conditions, exclusions and limitations of Your employer's Policy, refer to the appropriate section of the Certificate. In the event of a discrepancy between this Summary of Coverage and the Certificate, the Certificate will control. For a copy of the Certificate, contact the group Policyholder or Benefits or Plan Administrator.

This Summary of Coverage is not a contract. You are not necessarily entitled to insurance under the Policy because You received this Summary of Coverage. You are only entitled to insurance if You are eligible in accordance with the terms of the Certificate.

BENEFITS	
Elimination Period	If Your Disability is a result of an Injury, Your Elimination Period is 30 calendar days. If Your Disability is a result of a Sickness, Your Elimination Period is 30 calendar days.
Weekly Benefit	If You are Disabled and unable to generate Current Earnings greater than 20% of Your Weekly Earnings, the Weekly Benefit while Disabled is the lesser of: <ul style="list-style-type: none">• 100% of Your Weekly Earnings; or• \$350, the Maximum Weekly Benefit. If You are Disabled and able to generate Current Earnings that equal between 20% and 99% of Your Weekly Earnings, the Weekly Benefit will be the Weekly Benefit payable while Disabled, unless the sum of: <ul style="list-style-type: none">• the Gross Weekly Benefit while You are Disabled; plus• Current Earnings while You are Disabled; exceeds 100% of Your Weekly Earnings. If this sum exceeds 100% of Your Weekly Earnings, the Weekly Benefit will be reduced by that excess amount.
Maximum Benefit Period	The maximum number of weeks that benefits are payable for a continuous period of Disability is 52 weeks.

EMPLOYEE ELIGIBILITY

Eligibility Waiting Period	None
Confinement Rule	<p>If an eligible Member is confined due to an Injury or Sickness:</p> <ul style="list-style-type: none"> • in a Hospital as an inpatient; • in any institution or facility other than a Hospital; or • at home and under the supervision of a Physician; <p>insurance will begin on the day the Member returns to Active Eligibility.</p> <p>If an eligible Member is Actively Eligible and is not:</p> <ul style="list-style-type: none"> • confined; and • available for work because of an Injury or Sickness; <p>insurance will begin on the day the Member returns to Active Eligibility.</p>
When Insurance Begins	<p>If a Member's properly completed and signed enrollment form is received on or within 31 days following the day the Member becomes eligible, the Member will become insured on the later of:</p> <ul style="list-style-type: none"> • the day the Member becomes eligible; or • the date the enrollment form is properly completed and signed by the Member; <p>provided the Member is Actively Eligible on that day.</p>
When Your Classification or the Amount of Insurance Changes	<p>Any change in Your classification, coverage or amount of Your insurance will take effect on the day of the change, provided You are Actively Eligible on that day. If You are not Actively Eligible on the day of the change, the following conditions will apply:</p> <ul style="list-style-type: none"> • If the change involves an increase in the amount of insurance, the change will not take effect until the day You return to Active Eligibility. • If the change involves a decrease in the amount of insurance, the change will take effect on the day of the change. <p>In no event will any change take effect during a period of Disability.</p>
When Your Insurance Ends	<p>Your insurance will end at midnight at the main office of the Policyholder on the earliest of:</p> <ul style="list-style-type: none"> • the day the Policy ends; • the day any premium contribution for Your insurance is due and unpaid; • the day before You enter the Armed Forces on active duty (except for temporary active duty of 31 days or less); or • the day You are no longer eligible. <p>You will no longer be eligible when the earliest of the following occurs:</p> <ul style="list-style-type: none"> • You are not in an eligible classification described in the Schedule; • Your employment with the Policyholder ends; • You are not Actively Eligible; or • You do not satisfy any other eligibility condition described in the Policy.

DEFINITIONS

Definition of Disability	<p>Disability and Disabled means that because of an Injury or Sickness, a significant change in Your mental or physical functional capacity has occurred in which:</p> <ul style="list-style-type: none"> • during the Elimination Period, You are prevented from performing the Material Duties of Your Regular Job (on a part-time or full-time basis) or are unable to work Full-Time; and • after the Elimination Period, You are: <ul style="list-style-type: none"> • prevented from performing the Material Duties of Your Regular Job (on a part-time or full-time basis) or are unable to work Full-Time; and • unable to generate Current Earnings which exceed 99% of Your Weekly Earnings due to that same Injury or Sickness. <p>Disability is determined relative to Your ability or inability to work. It is not determined by the availability of a suitable position with Your employer.</p>
Definition of Weekly Earnings	<p>Weekly Earnings means Your gross income received from the Policyholder for the week immediately prior to the month in which Your Disability began. It includes bonuses, overtime pay, and shift differential received from the Policyholder. It also includes employee contributions to deferred compensation plans. It does not include commissions, other extra compensation, or Policyholder contributions to deferred compensation plans received from the Policyholder. Bonuses received from the Policyholder will be averaged over the 12 months immediately prior to Your Disability, or, if employed less than 12 months, the number of weeks worked.</p>

FEATURES

Continuation of Insurance During Disability	<p>If You become Disabled, Your insurance will continue with payment of premium for as long as You are entitled to receive Weekly Benefits.</p>
Vocational Rehabilitation	<p>If You are Disabled and are receiving Disability benefits as provided by the Policy, You may be eligible to receive vocational rehabilitation services. These services include, but are not limited to:</p> <ul style="list-style-type: none"> • job modification; • job placement; • retraining; and • other activities reasonably necessary to help You return to work.

EXCLUSIONS

General Exclusions	<p>We will not pay benefits for any Disability which is caused by, contributed to by, or resulting from:</p> <ul style="list-style-type: none"> • declared or undeclared war or any act of war or armed aggression; • Your participation in a riot, insurrection or rebellion; • Your commission of a felony for which You have been charged under state or federal law; • an intentionally self-inflicted Injury or Sickness, whether You are sane or insane; • attempted suicide, whether You are sane or insane; or • an occupational Sickness or Injury and You are eligible to receive benefits under Workers' Compensation or any other Act or law of like intent.
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	<p>We also will not pay benefits for any Disability:</p> <ul style="list-style-type: none">• while You are incarcerated or imprisoned for any period exceeding 60 days; or• that is solely a result of a loss of a professional license, occupational license or certification.
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Publication Date: February 3, 2012

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CERTIFICATE OF INSURANCE

UNITED OF OMAHA LIFE INSURANCE COMPANY

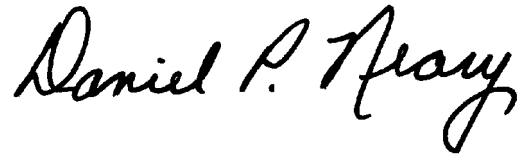
Home Office: Mutual of Omaha Plaza
Omaha, Nebraska 68175

United of Omaha Life Insurance Company certifies that Group Policy No(s). GUG-AKGH (policy) has been issued to Brotherhood of Locomotive Engineers & Trainmen - Norfolk Southern - North (Policyholder).

Insurance is provided for certain employees as described in the policy.

The benefits described in this Certificate are subject to the terms and conditions of the policy. Benefits are effective only if you are eligible for the insurance, become insured and remain insured as described in this Certificate.

UNITED OF OMAHA LIFE INSURANCE COMPANY



Chairman of the Board and Chief Executive Officer



Corporate Secretary

THIS SCHEDULE DESCRIBES THE AMOUNT OF BENEFITS AND CERTAIN OTHER REQUIREMENTS AND LIMITATIONS APPLICABLE TO BENEFITS FOR DISABILITY. OUR OBLIGATION TO CONSIDER BENEFITS DESCRIBED IN THIS SCHEDULE IS SUBJECT TO ALL TERMS OF THE POLICY, INCLUDING, BUT NOT LIMITED TO, ALL DEFINITIONS, GENERAL EXCLUSIONS AND RIDERS. PLEASE REFER TO THE TABLE OF CONTENTS IN THE CERTIFICATE TO LOCATE THE PROVISIONS OF THE POLICY.

SCHEDULE

The amount of insurance for You will be in accord with Your classification in this Schedule.

Classification(s)

All Norfolk Southern Engineers

For You SHORT-TERM DISABILITY BENEFITS

Elimination Period

If Your Disability is a result of an Injury, Your Elimination Period is 30 calendar days.

If Your Disability is a result of a Sickness, Your Elimination Period is 30 calendar days.

Definitions

Weekly Earnings means Your gross income received from the Policyholder or participating employer for the week immediately prior to the month in which Your Disability began.

It includes bonuses, overtime pay, and shift differential received from the Policyholder or participating employer. It also includes employee contributions to deferred compensation plans. It does not include commissions, other extra compensation, or Policyholder or participating employer contributions to deferred compensation plans received from the Policyholder or participating employer.

Bonuses received from the Policyholder or participating employer will be averaged over the 12 months immediately prior to Your Disability, or, if employed less than 12 months, the number of weeks worked.

Weekly Benefit - Disability

If You are Disabled and unable to generate Current Earnings greater than 20% of Your Weekly Earnings, the Weekly Benefit while Disabled is the lesser of:

- (a) 100% of Your Weekly Earnings; or
- (b) \$350, the Maximum Weekly Benefit.

If You are Disabled and able to generate Current Earnings that equal between 20% and 99% of Your Weekly Earnings, the Weekly Benefit will be the Weekly Benefit payable while Disabled, unless the sum of:

- (a) the Gross Weekly Benefit while You are Disabled; plus

(b) Current Earnings while You are Disabled;

exceeds 100% of Your Weekly Earnings. If this sum exceeds 100% of Your Weekly Earnings, the Weekly Benefit will be reduced by that excess amount.

Vocational Rehabilitation Incentive

While You are participating in a plan of vocational rehabilitation approved by Us, Your Weekly Benefit, as calculated above, will be increased by 5%.

Maximum Benefit Period

The maximum number of weeks that benefits are payable for a continuous period of Disability is 52 weeks.

ELIGIBILITY

Disability Insurance

Definitions

Terms defined in this provision may be used in, or apply to other provisions throughout this Policy, Certificate and any Riders. Definitions of other terms may be found in other provisions. Any singular word shall include any plural of the same word.

Active Eligibility or **Actively Eligible** means a Member is Actively Working on a regular and consistent basis for the Policyholder, and is:

- (a) qualified for insurance during the most recent Preponderance of Earnings Test Period by satisfying the Preponderance of Earnings Requirement;
- (b) is otherwise eligible for insurance according to the Policyholder's rules of eligibility as approved by Our authorized representative in Our home office; and
- (c) is 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.

Actively Working or **Active Work** means performing the normal duties of a regular job for the Policyholder or participating employer for the hours normally required by the Policyholder or participating employer for the hours normally required by the Policyholder or participating employer at:

- (a) the Policyholder's or participating employer's usual place of business;
- (b) an alternative work site at the direction of the Policyholder or participating employer; or
- (c) a location to which one must travel to perform the job.

A Member will be considered actively working on any day that is:

- (a) a regular paid holiday or day of vacation; or
- (b) a regular or scheduled non-working day;

provided the Member was actively working on the last preceding regular work day.

If a Member's customary place of employment is at home, the Member will be considered actively working if not confined on that day as described in the Confinement Rule.

Confinement Rule

1. If an eligible Member is confined due to an Injury or Sickness:
 - (a) in a Hospital as an inpatient;

- (b) in any institution or facility other than a Hospital; or
 - (c) at home and under the supervision of a Physician;
- insurance will begin on the day the Member returns to Active Eligibility.

2. If an eligible Member is Actively Eligible and is not:

- (a) confined; and
 - (b) available for work because of an Injury or Sickness;
- insurance will begin on the day the Member returns to Active Eligibility.

Member means a person who is:

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

The term Member does not include a person who is:

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

Preponderance of Earnings Requirement means that 50% plus \$0.01 or more of the Member's earnings during the most recent Preponderance of Earnings Test Period were earnings made as a locomotive engineer.

Preponderance of Earnings Test Period means July 1 through June 30. A Member that satisfies the Preponderance of Earnings Requirement during any test period will be considered Actively Eligible for the 12-month period beginning on the next January 1, provided all other eligibility conditions are satisfied.

Eligible Members

A Member who is Actively Eligible on January 1, 2012 becomes eligible for insurance under this Policy on January 1, 2012.

A Member who is not eligible for insurance under this Policy on January 1, 2012, or an individual that becomes a Member after January 1, 2012, becomes eligible for insurance under this Policy on the day the Member begins Active Eligibility.

When Insurance Begins

An eligible Member must request insurance by:

- (a) properly completing and signing an enrollment form acceptable to Us; and
- (b) submitting the form to the Policyholder.

If a Member's properly completed and signed enrollment form is received on or within 31 days following the day the Member becomes eligible, the Member will become insured on the later of:

- (a) the day the Member becomes eligible; or
- (b) the date the enrollment form is properly completed and signed by the Member, provided the Member is Actively Eligible on that day. If the Member is not Actively Eligible on that day, insurance will begin on the day the Member returns to Active Eligibility.

Evidence of Good Health

If a Member's properly completed and signed enrollment form is received more than 31 days after the Member becomes eligible, the Member must provide Us with evidence of good health. If such evidence is acceptable to Us, We will determine the day insurance begins.

If a Member was eligible for group disability coverage under a plan maintained by the Policyholder immediately prior to the effective date of this Policy but did not elect coverage under such plan, the Member may enroll for insurance under this Policy if the Member is otherwise eligible and provides Us with evidence of good health. If such evidence is acceptable to Us, We will determine the day insurance begins.

Reinstatement of Insurance

If an eligible Member wants to reinstate insurance after insurance has ended, the following will apply:

- (a) Rehire: If insurance ended because the Member ceased to be Actively Eligible under this Policy and the Member becomes Actively Eligible again within 90 days after insurance ended, the waiting period will be waived. All other Policy provisions, including Pre-existing Conditions, will apply.
- (b) If insurance ended because the eligible Member voluntarily let insurance lapse, the Member must provide evidence of good health to Us. If such evidence is acceptable to Us, We will determine the day insurance begins.

When Your Classification or the Amount of Insurance Changes

Any change in Your classification, coverage or amount of Your insurance as shown in the Schedule will take effect on the day of the change, provided You are Actively Eligible on that day. If You are not Actively Eligible on that day, the following conditions will apply:

- (a) If the change involves an increase in amount of insurance, the change will not take effect until the day You return to Active Eligibility.
- (b) If the change involves a decrease in the amount of insurance, the change will take effect on the day of the change.

In no event will any change take effect during a period of Disability.

When Your Insurance Ends

Your insurance will end at midnight at the main office of the Policyholder on the earliest of:

- (a) the day this Policy ends;
- (b) the day any premium contribution for Your insurance is due and unpaid;
- (c) the day before You enter the Armed Forces on active duty (except for temporary active duty of 31 days or less); or
- (d) the day You are no longer eligible. You will no longer be eligible when the earliest of the following occurs:
 - (1) You are not in an eligible classification described in the **Schedule**;
 - (2) Your employment with the Policyholder ends;
 - (3) You are not Actively Eligible; or
 - (4) You do not satisfy any other eligibility condition described in this Policy.

We will provide benefits for a payable claim which occurs while You are covered under this Policy.

Continuation of Insurance During Disability

If You become Disabled, Your insurance will continue with payment of premium for as long as You are entitled to receive Weekly Benefits.

Continuation of Insurance Under Family and Medical Leave

The federal Family Medical Leave Act of 1993 (FMLA) and any amendments thereto as well as certain state statutes provide continuation of coverage in certain instances for leaves of absence.

You may be eligible for continued coverage under FMLA and/or any state family medical leave laws. You should check with Your employer for additional information regarding the continued coverage that may be available to You.

Any continued coverage for family medical leave will not exceed the continued coverage provided by FMLA and/or state required family medical leave.

Any family medical leave continuation is subject to all terms and conditions of the Policy, including, without limitation, payment of premium and eligibility. Any continued coverage will end in accordance with the **When Your Insurance Ends** provision in Your Certificate.

Continuity of Coverage Upon Transfer of Insurance Carrier

If You are not Actively Eligible on the effective date of this Policy due to Injury or Sickness, upon payment of the premium, You will be insured under this Policy if You:

- (a) were covered under a group disability plan maintained by the Policyholder immediately prior to the effective date of this Policy; or
- (b) were covered under an individual worksite disability plan obtained through the Policyholder immediately prior to the effective date of this Policy; and
- (c) You resume Active Eligibility.

SHORT-TERM DISABILITY BENEFITS

Benefits

If, while insured under this provision, You become Disabled due to Injury or Sickness, We will pay the Weekly Benefit shown in the Schedule. Benefits will begin after You satisfy the Elimination Period shown in the Schedule.

Recurrent Disability

A Recurrent Disability will be treated as part of Your prior claim and You will not be required to satisfy another 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 10 days of the end of Your prior claim.

In order to prevent over-insurance because of duplication of benefits, benefits payable under this Recurrent Disability provision will cease if benefits are payable to You under any other group disability income policy or plan.

When Benefits End

Benefits will be paid during a period of Disability until the earliest of:

- (a) the day You are no longer Disabled;
- (b) the day You die;
- (c) the end of the Maximum Benefit Period shown in the Schedule;
- (d) the day You fail to provide Us satisfactory proof of continuous Disability and/or any Current Earnings;
- (e) the day You fail to comply with Our request to be examined by a Physician and/or vocational rehabilitation expert of Our choice;
- (f) the day You are not under Regular Care for the Injury or Sickness that caused the Disability; or
- (g) the day You are able to return to work on a part-time or full-time basis and do not do so.

General Exclusions

We will not pay benefits for any Disability which is caused by, contributed to by, or resulting from:

- (a) declared or undeclared war or any act of war or armed aggression;
- (b) Your participation in a riot, insurrection or rebellion;
- (c) Your commission of a felony for which You have been charged under state or federal law;
- (d) an intentionally self-inflicted Injury or Sickness, whether You are sane or insane;
- (e) attempted suicide, whether You are sane or insane; or

- (f) an occupational Sickness or Injury and You are eligible to receive benefits under Workers' Compensation or any other Act or law of like intent.

We also will not pay benefits for any Disability:

- (a) while You are incarcerated or imprisoned for any period exceeding 60 days; or
- (b) that is solely a result of a loss of a professional license, occupational license or certification.

VOCATIONAL REHABILITATION PROVISION

If You are disabled and are receiving disability benefits as provided by the policy, You may be eligible to receive vocational rehabilitation services. These services include, but are not limited to:

- (a) job modification;
- (b) job placement;
- (c) retraining; and
- (d) other activities reasonably necessary to help You return to work.

Eligibility for vocational rehabilitation services is based on Your education, training, experience and physical/mental capabilities. Before vocational rehabilitation services will be considered:

- (a) Your disability must not allow You to perform Your regular occupation;
- (b) You must not have the necessary skills to allow You to perform another occupation;
- (c) You must have the physical and mental capability for successful completion of a rehabilitation program; and
- (d) there must be reasonable expectation that rehabilitation services will help You return to active employment.

All vocational rehabilitation programs will be developed with input from You, Your physician, Your employer and Us and described on an Individual Written Rehabilitation Plan (IWRP), which states:

- (a) the vocational rehabilitation goals;
- (b) the responsibilities of Us, You and any third parties associated with the IWRP;
- (c) the times and dates of the vocational rehabilitation services; and
- (d) all costs associated with the services.

Either We, Your physician, or You may initiate consideration for Your participation in vocational rehabilitation. Failure to participate without good cause will result in reduction or termination of Disability benefits. Reduction of benefits will be based on Your income potential if You were employed after a vocational rehabilitation program.

Definitions

Good Cause means documented physical or mental impairments not identified in Your existing disability claim that:

- (a) renders You incapable of rehabilitation;
- (b) interferes with a medical program You are currently participating in; or
- (c) conflicts with any other program You are participating in that will allow You to return to active employment.

We will make the final determination of any vocational rehabilitation services provided, eligibility for participation and any continued benefit payments.

The definition of Disability will not apply during the term of the vocational rehabilitation program but will be reapplied after such program ends.

PAYMENT OF CLAIMS

How To File Claims

It is important for You to notify Us of Your claim as soon as possible so that a claim decision can be made in a timely manner. Before Your claim can be considered, We must be given a written proof of loss, as described below. In the event of Your death or incapacity, Your beneficiary or someone else may give Us the proof.

Proof of Loss Requirements

1. First, request a claim form from the Plan Administrator or from Us.

This request should be made:

- (a) within 20 days after a loss occurs; or
- (b) as soon as reasonably possible.

When We receive the request, We will send a claim form for filing proof of loss. If You do not receive the form within 15 days of Your request, You can meet the proof of loss requirement by giving Us a written statement of what happened. Such statement should include:

- (a) that You are under the Regular Care of a Physician;
 - (b) the appropriate documentation of Your job duties at Your regular job and Your Weekly Earnings;
 - (c) the date Your Disability began;
 - (d) the cause of Your Disability;
 - (e) any restrictions and limitations preventing You from performing Your regular job;
 - (f) the name and address of any Hospital or institution where You received treatment, including attending Physicians.
2. Next, You and Your employer must complete and sign Your sections of the claim form, and then give the claim form to the Physician. Your Physician should fill out his or her section of the form, sign it, and send it directly to Us.
 3. The claim form should be sent to Us within 90 days after the end of Your Elimination Period; or as soon as reasonably possible. If it is not possible to give Us proof within 90 days, it must be given to Us no later than one year after the time proof is otherwise required, unless the claimant is not legally capable.

How Claims are Paid

Benefits will be paid after We receive acceptable proof of loss.

Benefits will be paid to You, except benefits due but unpaid at Your death may be paid, at Our option, to:

- (a) any member of Your family; or
- (b) Your estate.

This provision does not apply to any Survivor Benefits payable under the Policy.

Examination

We sometimes require that a claimant be examined by a Physician or vocational rehabilitation expert of Our choice. We will pay for these examinations. We will not require more than a reasonable number of examinations.

Overpayments

We have the right to recover any overpayments due to:

- (a) fraud; and
- (b) any error We make in processing a claim.

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

We will not recover more money than the amount We paid You.

Authority to Interpret Policy

The Policyholder has delegated to Us the discretion to determine eligibility for benefits and to construe and interpret all terms and provisions of the Policy. Benefits under the Policy will be paid only if We decide, after exercising Our discretion, that the Insured 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 parties.

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

DISABILITY CLAIM REVIEW PROCEDURES

DEFINITIONS

An “**Adverse Benefit Determination**” means a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of Your eligibility to participate in a plan.

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;
- (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; or
- (d) constitutes a statement of policy or guidance with respect to the Policy concerning the denied benefit for the diagnosis, without regard to whether such advice or statement was relied upon in making the claim decision.

INITIAL CLAIM DECISION

Initial Claim Decision. We will make a claim decision regarding Your disability claim within 45 days after Our receipt of the claim.

Extensions. This 45 day period may be extended for up to 30 days, if We (1) determine that such an extension is necessary due to matters beyond Our control and (2) notify You, prior to the expiration of the initial 45 day period, of the circumstances requiring the extension and the date by which We expect to render a decision. If, prior to the end of the first 30 day extension period, We determine that, due to matters beyond Our control, a decision cannot be rendered within that extension period, the period for making the decision may be extended for up to an additional 30 days; provided that We notify You, prior to the expiration of the first 30 day extension period, of the circumstances requiring the extension and the date as of which We expect to render a decision.

Notice of Extension. Our notice of extension will specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a claim decision and the additional information needed to resolve those issues. You will have 45 days within which to provide the specified information.

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

NOTICE OF ADVERSE BENEFIT DETERMINATION

We will provide written or electronic notice of any Adverse Benefit Determination within 45 days after Our receipt of the claim, subject to the extensions described above. The notice will include:

- (a) the specific reason(s) for the Adverse Benefit Determination;
- (b) reference to the specific Policy provision(s) on which the Adverse Benefit Determination is based;
- (c) a description of any additional material or information necessary to complete the claim and the reason We need the material or information;
- (d) a description of the Policy's appeal procedures, including the time limits for such procedures;
- (e) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination, a statement that it was relied upon in making the Adverse Benefit Determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to You upon request; and
- (f) if the Adverse Benefit Determination was based on a medical necessity or experimental treatment or similar exclusion, a statement that it was relied upon in making the Adverse Benefit Determination and that an explanation of the scientific or clinical judgment for the determination will be provided free of charge to You upon request.

APPEALS OF ADVERSE BENEFIT DETERMINATIONS

You may appeal within 180 days following Your receipt of notification of an Adverse Benefit Determination.

The request for an appeal should include:

- (a) Your name;
- (b) the name of the person filing the appeal if different from You;
- (c) the Policy number; and
- (d) the nature of the appeal.

You will have the opportunity to submit written comments, documents, records, and other information relating to the claim.

You will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information Relevant to the claim.

Our review will take into account all comments, documents, records, and other information submitted by You relating to the claim, without regard to whether such information was submitted or considered in the initial claim decision.

Our review will not give deference to the initial Adverse Benefit Determination.

Our review will be conducted by an individual who is neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual.

We will identify any medical or vocational experts whose advice was obtained in connection with an Adverse Benefit Determination, without regard to whether the advice was relied upon in making the benefit determination.

In deciding an appeal of any Adverse Benefit Determination that is based in whole or in part on a medical judgment, the individual conducting the appeal will consult with a health care professional:

- (a) who has appropriate training and experience in the field of medicine involved in the medical judgment; and
- (b) who is neither an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of any such individual.

APPEAL DECISION

Notice of Appeal Decision. We will notify You of Our appeal decision within 45 days after receipt of Your timely appeal request, unless We determine that special circumstances require an extension of time for processing the appeal. We will provide You with written or electronic notice of Our appeal decision.

Notice of an Adverse Benefit Determination will include:

- (a) the specific reason(s) for the Adverse Benefit Determination;
- (b) reference to the specific Policy provision(s) on which the Adverse Benefit Determination is based;
- (c) a statement that You are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information Relevant to Your claim;
- (d) if an internal rule, guideline, protocol, or other similar criterion was used in making the Adverse Benefit Determination, a statement that it was used in making the Adverse Benefit Determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to You upon request; and
- (e) if the Adverse Benefit Determination was based on a medical necessity or experimental treatment or similar exclusion, a statement that it was relied upon in making the Adverse Benefit Determination and that an explanation of the scientific or clinical judgment for the determination will be provided free of charge to You upon request.

Notice of Extension. If We determine that an extension is required, We will notify You in writing of the extension prior to the termination of the initial 45 day period. In no event will the extension exceed 45 days from the end of the initial period. The extension notice will indicate the special circumstances requiring the extension and the date by which We expect to render the appeal decision.

Time Periods. The period of time within which an appeal decision is required to be made will begin at the time an appeal is timely 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 Your 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 to You until the earlier of (1) the date on which We receive Your response; or (2) the date established by Us in the notice of extension for the furnishing of the requested information.

STANDARD PROVISIONS

Insurance Contract

The insurance contract consists of:

- (a) the Policy;
- (b) the Policyholder's application attached to the Policy; and
- (c) Your application, if required.

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 You or Your beneficiary's consent; and
- (b) must be:
 - (1) in writing;
 - (2) made a part of the Policy; and
 - (3) signed by one of Our officers.

A change may affect any class of Insured Persons, including retirees if retiree coverage is included in the Policy.

Applications

We may use misstatements or omissions in Your application to contest the validity of insurance, reduce coverage or deny a claim, but We must first furnish You or Your beneficiary with a copy of that application. We will not use Your application to contest or reduce insurance which has been in force for two years or more during Your lifetime. However, if You are not eligible for insurance, there is no time limit on Our right to contest insurance or deny a claim.

Statements in an application are treated as representations, not as warranties.

Legal Actions

No legal action can be brought until at least 60 days after We have been given written proof of loss. No legal action can be brought more than three years after the date written proof of loss is required.

SHORT-TERM DISABILITY DEFINITIONS

Terms defined in this provision are used in, or apply to, other provisions throughout the Policy, Certificate and any Riders. Definitions of other terms may be found in other provisions. Any singular word shall include any plural of the same word.

Appropriate Care and Treatment means medical care and treatment that meet all of the following:

- (a) It is received from a Physician whose expertise, medical training and clinical experience are suitable for treating Your Injury or Sickness;
- (b) It is Medically Necessary;
- (c) It is consistent in type, frequency and duration of treatment with relevant guidelines based on national medical research or published by health care organizations and government agencies;
- (d) It is consistent with the diagnosis of Your condition; and
- (e) Its purpose is to improve Your medical condition and thereby aid in Your ability to return to work.

Current Earnings means any actual pre-tax weekly income You receive while You are working and eligible to receive a Weekly Benefit, or the pre-tax earnings You could receive if You were working at Your Maximum Capacity. If Your current earnings fluctuate, We reserve the option to average Your current earnings over the most recent three-week period to determine if Your claim should continue.

Deferred Compensation means contributions You make through a salary reduction agreement with Your employer to a plan or arrangement under Internal Revenue Code (IRC) §:

- (a) 401(k);
- (b) 403(b);
- (c) 408(k);
- (d) 457 Deferred Compensation arrangement; or
- (e) any other deferred compensation agreement or arrangement defined under the Internal Revenue Code.

Disability and Disabled means that because of an Injury or Sickness, a significant change in Your mental or physical functional capacity has occurred in which:

- (a) during the Elimination Period, You are prevented from performing the Material Duties of Your Regular Job (on a part-time or full-time basis) or are unable to work Full-Time; and
- (b) after the Elimination Period, You are:
 - (1) prevented from performing the Material Duties of Your Regular Job (on a part-time or full-time basis) or are unable to work Full-Time; and
 - (2) unable to generate Current Earnings which exceed 99% of Your Weekly Earnings due to that same Injury or Sickness.

Disability is determined relative to Your ability or inability to work. It is not determined by the availability of a suitable position with Your employer.

Elimination Period means the number of days of continuous Disability which must be satisfied before You are eligible to receive benefits. The elimination period is shown in the Schedule. The elimination period begins on the first day of Disability.

Full-Time means working the required number of hours to be considered a full-time employee of the Policyholder.

Gross Weekly Benefit means Your Weekly Benefit amount before any reduction for Current Earnings.

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 Your Disability. 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.

Injury means an accidental bodily injury which is the direct result of a sudden, unexpected and unintended external force or element, such as a blow or fall, that requires treatment by a Physician. It must be independent of Sickness or any other cause, including, but not limited to, complications from medical care. Disability due to such injury must begin while You are insured under the Policy. Injury does not include elective cosmetic surgery or procedures.

Material Duties means the essential tasks, functions, and operations relating to Your Regular Job that cannot be reasonably omitted or modified.

Maximum Capacity means, based on Your medical restrictions and limitations, the greatest extent of work You are able to do in Your Regular Job.

Medically Necessary means care that is ordered, prescribed or rendered by a Physician or Hospital and is determined by Us, or a qualified party or entity selected by Us, to be:

- (a) provided for the diagnosis or direct treatment of Your Injury or Sickness;
- (b) appropriate and consistent with the symptoms and findings or diagnosis and treatment of Your Injury or Sickness; and
- (c) provided in accordance with generally accepted professional standards and/or medical practice.

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; or
- (c) where required by law, any other licensed practitioner who is acting within the scope of his/her license.

A physician does not include You, a person who lives with You or is a part of Your family (Your spouse; or a child, brother, sister or parent of You or Your spouse).

Policyholder's Retirement Plan means any retirement plan:

- (a) which is part of any federal, state, county, municipal or association retirement system; and
- (b) for which You are eligible as a result of employment with the Policyholder.

Recurrent Disability means a Disability which is related to or due to the same cause(s) of a prior Disability for which You received a Weekly Benefit under this Policy.

Regular Care means:

- (a) You visit a Physician as frequently as is medically required, according to standard medical practice, to effectively manage and treat Your disabling condition; and
- (b) You receive Appropriate Care and Treatment.

Regular Job means the occupation You are routinely performing when Your Disability begins.

Rider means a provision added to the Policy or Your Certificate to expand or limit benefits or coverage.

Sickness means a disease, disorder or condition, including pregnancy, for which you are under the care of a Physician. Disability must begin while you are insured under the Policy. Sickness does not include elective cosmetic surgery or procedures.

We, Our, Us means the Insurance Company shown on Your Certificate of Insurance.

You, Your and Insured Person means an insured employee or member.

(The following provision applies only if You are a resident of the state of Kansas)

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- (a) does not require Your or Your beneficiary's consent; and
- (b) must be:
 - (1) in writing;
 - (2) made a part of the Policy; and
 - (3) signed by one of Our officers.

A change may affect any class of Insured Persons, including retirees if retired coverage is included in the Policy.

Applications

We may use misstatements in Your application to contest the validity of insurance, reduce coverage or deny a claim, but We must first furnish You or Your beneficiary with a copy of that application. We will not use Your application to contest or reduce insurance which has been in force for two years or more during Your lifetime. However, if You are not eligible for insurance, there is no time limit on Our right to contest insurance or deny a claim.

Statements in an application are treated as representations, not as warranties.

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.

Group Policy Number GUG-AKGH



MUTUAL *of* OMAHA

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